BlueCross BlueShield of Vermont
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June 27, 2024

Kevin Ruggeberg, FSA, MAAA
Vice President & Consulting Actuary
Lewis & Ellis, Inc.

Subject: Your 06/20/2024 Questions re:
Blue Cross and Blue Shield of Vermont
2025 Vermont QHP Market Filings
(SERFF Tracking #: BCVT-134091560, BCVT-134096633)

Dear Mr. Ruggeberg:

In response to your requests on behalf of the Office of the Health Care Advocate dated June 20, 2024, here are *your questions* and our answers:

1. *Please provide more detail about the elements that comprise and factors that influence the "all other claims adjustment expenses" reported on page 4, line 8.2 of the 2023 SHCE. To provide context, these expenses amount to approximately $6,000,000 for each portfolio (roughly $12,000,000 combined), representing roughly 86% and 80% of the respective "total claims adjustment expenses" line. Additionally, the "all other claim adjustment expenses" line is 38% and 42% of the "underwriting Gain/Loss" line. Lastly, the related "claims adjustments expense ratio" (line 9) is .035 and .041 for the Individual and Small Group Employer portfolios, respectively. These "claims adjustment expense ratios" are substantially higher than those of BCBSVT's sole competitor in the Individual and Small Group markets. This situation is further complicated by the fact that BCBSVT reports a larger dollar amount as "all other claims expenses" as opposed to "cost containment expenses not included in quality-of-care expenses in Line 6.6" compared to its sole competitor.*

   This response was provided by Blue Cross VT Corporate Accounting department.

   Under statutory reporting guidelines, the administrative expense category of "claims adjustment expenses" encompasses all of the functions related to providing service and health care benefits to our customers. These functions include enrollment, claims processing, customer service, medical management, and maintenance of our provider network. The reported costs include the Blue Cross VT staff who perform those functions, as well as the expenses associated with contracted vendors and software applications that support them.

   "Cost containment expenses" are a subset of claims adjustment expenses. These are the functions specifically designed to control and minimize the cost of claims on behalf of our members, such as activities related to preventing fraud, waste and abuse, utilization management, subrogation, and third-party liability, among others.

   As they are the core functions of a health insurance company and they represent spending that directly benefits and serves our members, claims adjustment expenses naturally and appropriately comprise a significant portion of our administrative expenses.

   We have no insight in how other payers allocate their administrative expenses and therefore cannot comment on reasons for differences in reporting.

2. *BCBSVT mentions the effects of H.766 (Act 111) multiple times in the Actuarial Memorandum (Actuarial Mem. at 5, 18, 28, 48). According to BCBSVT's estimates, this law is expected to result in a reduction in savings of 1.8% and 1.9% for the Individual and Small Group markets, respectively. Please provide the "internal analyses or information provided by an external vendor" that are referenced in the Actuarial Memorandum (Actuarial Mem. at 18). This question is different than the justification of H.766 (Act 111) costs that Lewis and Ellis asked for in Objection #1 as it asks for specific documents that are referenced in the Actuarial Memorandum.*

Act 111 will increase our claims costs by reducing the effectiveness of our payment integrity programs, utilization management, prior authorization, and step therapy requirements. These programs are an integral part of Blue Cross VT's ongoing efforts to reduce unnecessary health care costs while maintaining access to quality care. Reducing the effectiveness of those programs increases health care claim expenses and thus increases premiums.

As we explained in the Actuarial Memorandum and in our response to L&E, we estimated the impact of Act 111 by looking at the impact on six of these critical programs. On June 17, the Legislature passed H.890, which delayed implementation of some portions of Act 111 for a year.[1] We are flagging the portions impacted by H.890 below.

First Pass Payment Integrity Program

Blue Cross VT's internal teams reviewed the description of the payment integrity rules under our first pass program. It is our belief that the current first pass payment integrity program will be permissible in 2025 per H.766 and H.890. The estimated reduction in savings attributed to this now-delayed portion of Act 111 on page 18 of the Actuarial Memorandum included [redacted] for the individual market and [redacted] for the small group market.

Second Pass Payment Integrity Program

Blue Cross VT's internal teams reviewed the description of the payment integrity rules under our second pass program. It is our understanding that the payment integrity rules under our second pass payment integrity program, except pre-payment coding validation, will be permissible in 2025 per H.890. The estimated reduction in savings attributed to this now-delayed portion of Act 111 on page 18 of the Actuarial Memorandum included [redacted] for the individual market and [redacted] for the small group market. We now estimate the prepayment coding validation prohibition will result in an increase in costs of [redacted] for the individual market and [redacted] for the small group market.

Blue Cross VT Internal Utilization Management Programs

For utilization management program that are not done by third-party vendors, Blue Cross VT tracks denials based on utilization management in internal systems. For each case, the code, quantity, and service setting are logged and then cost of services are attached based on a pricing guide. The requesting and rendering providers are also included in each case logged. Using this information, we observed that approximately [redacted] percent of services denied due to utilization management (prior authorization) were from primary care providers. We therefore estimated that [redacted] percent of the calculated savings from internal utilization management programs, which amounts to [redacted] for the individual market and [redacted] for the small group market, would not continue in 2025 due to the restrictions on prior authorizations for services. However, we note this estimate assumes that health systems do not implement strategies to abuse the intent of the law.

[1] The Governor has not yet signed H.890 as of this filing but we are not aware of any stated intent by the Governor to veto it.

Radiology Prior Authorization

Blue Cross VT has partnered with a third-party vendor to manage advanced imaging solutions for members. This vendor summarized the total number of procedures reviewed by physician specialty and the average estimated savings per procedure for the total Blue Cross VT book of business. Using that information, we calculated that [redacted] percent of the savings due to prior authorization from this vendor would not continue in 2025 due to the restrictions on prior authorizations for services. We applied this percentage to the total savings reported of [redacted] for the QHP lines of business in 2023.

Summary of Total Book of Business Savings				
Physician Specialty	Total Review Procedures	Impacted Procedures	Average Cost per Impacted Procedure	Total Savings
Primary Care Providers	[redacted]	[redacted]	[redacted]	[redacted]
Other Specialties	[redacted]	[redacted]	[redacted]	[redacted]
Total	[redacted]	[redacted]	[redacted]	[redacted]

Pharmacy Step Therapy

Blue Cross VT's pharmacy team, in concert with our Pharmacy Benefit Manager (PBM), estimated the limitations on step therapy to cost [redacted] PMPM in 2023. Our PBM provided the overall savings for both the current step therapy and prior authorization programs. From there, the pharmacy team estimated the percentage that would be impacted by the restrictions in 2025.

Based on its review of the current step therapy requirements and Act 111's new restrictions, the pharmacy team estimated that [redacted] percent of the step therapy savings would be eliminated. The current prior authorization program for retail pharmacy includes a component of step therapy as well. For some drugs, prior authorization also requires members to try other drug before getting a non-preferred drug. The pharmacy team estimated that [redacted] percent of the prior authorizations have a step therapy component and that [redacted] percent of those would be eliminated, which will increase costs.

Pharmacy Prior Authorization

We note that in our response to L&E's inquiry on this topic, the exhibit provided incorrectly noted that this was based on a PMPM estimate. Removing prior authorizations on one asthma controller medication from each class of medication and mode of administration is expected to impact the pharmacy rebates we are receiving from current preferred products. We therefore assumed that we would not be receiving rebates and excluded those from the projection and included this reduction in savings in the estimated reduction in savings for pharmacy in the table on page 18 of the actuarial memorandum. For simplicity, we chose to combine this with the other components of the adjustment to experience period of one-time events ($1+c_5$ on exhibits 5) instead of in the rebate projection.

3. *In Objection #1, Lewis and Ellis asked BVBSVT to project 2024 and 2025 Risk Based Capital (RBC). Please detail all material assumptions BCBSVT used to generate said projections. If possible, please assign a probability to each projection and the range of RBC values that fall within one standard deviation of the best projection point estimate. Note, we understand that BCBSVT may not be able to answer this question until later in June as indicated in its answers to Objection #1.*

Blue Cross VT was granted an extension to July 12 to respond to this question.

4. *Please explain why the actual CTR as BCBSVT reports each year in the Actuarial Memorandum might vary from one year to the next. We provide the table below to demonstrate this phenomenon with the values at issue in bold.*

	Actual CTR (pricing)		
	2025 Filing Actuarial Mem.	*2024 Filing Actuarial Mem.*	*2023 Filing Actuarial Mem.*
2014	*1.0%*	*1.0%*	*1.0%*
2015	*-2.5%*	*-2.5%*	*-2.5%*
2016	*-3.8%*	*-3.8%*	*-3.8%*
2017	*1.0%*	*1.0%*	*1.0%*
2018	*-1.8%*	*-1.8%*	*-1.8%*
2019	*-0.7%*	*-0.7%*	*-0.7%*
2020	*7.2%*	*5.5%*	*5.5%*
2021	*-0.2%*	*0.4%*	*0.7%*
2022	*-5.2%*	*-4.5%*	*NA*
2023	*-8.8%*	*NA*	*NA*

The actual CTR included in the actuarial memorandum is calculated on an incurred basis, which means that we restated material events from the year they were paid (and therefore recorded in statutory financial statements) to the year they were incurred, which can impact prior years included in a prior actuarial memorandum. The main item restated in recent years is the risk adjustment transfer. The actual transfer for any given plan year is known about six months into the next year. These restatements do not impact the cumulative results, as they are simply moving components between years.

While answering this question, we did find a two items that were not properly reflected in the table. For 2020, the difference between the estimated and final risk adjustment transfer was not included in the table in the 2023 filing and was carried over through 2024 and 2025. For 2020 and 2021, we had been shifting estimated deferred care due to the UVMHN cyberattack in prior filings. This was not carried over in the 2025 table.

The tables below show the impacts of the restatements and corrections.

	Plan Year 2020
In 2023 Filing	5.5%
Adding restatement for Risk Adjustment	7.2%
Adding deferred claims from cyberattack	6.6%

	Plan Year 2021
In 2023 Filing	0.7%
Adding restatement for Risk Adjustment	-0.2%
Removing deferred claims from cyberattack	0.4%

	Plan Year 2022
In 2024 Filing	-4.5%
Adding restatement for Risk Adjustment	-5.2%

The table below shows the complete corrected table from section 1.5 of the actuarial memorandum. The only changes are for the 2020 and 2021 actual CTR (pricing) values.

Year	Member Months	Filed Contribution to Reserve	Approved Contribution to Reserve[2]	Actual Contribution to Reserve (Financial)	Actual Contribution to Reserve (Pricing)
2014	638,492	1.0%	-0.1%	1.0%	1.0%
2015	768,293	1.0%	1.0%	-1.1%	-2.5%
2016	835,541	2.0%	0.8%	-2.2%	-3.8%
2017	820,156	2.0%	1.0%	1.0%	1.0%
2018	630,163	2.0%	-3.8%	-1.8%	-1.8%
2019	520,854	1.5%	0.0%	-0.7%	-0.7%
2020	453,744	1.5%	1.5%	6.6%	6.6%
2021	411,961	1.5%	0.5%	0.4%	0.4%
2022	430,399	1.5%	1.0%	-5.2%	-5.2%
2023	498,644	1.5%	-0.3%	-8.8%	-8.8%
Cumulative	6,008,567	1.6%	0.1%	-1.4%	-1.7%

5. *Can the reported actual CTR (financial) be reconciled to the SHCE for the applicable year? If so, please state the method for doing so. If not, please explain why.*

The actual CTR (financial) and the results in Supplemental Healthcare Exhibit (SHCE) cannot be directly reconciled from the details within the SHCE. This is in large part due to the accounting differences between Generally Accepted Accounting Principles (GAAP) on which the actual CTR (financial) is based compared to the NAIC Statutory accounting that is the basis for SHCE reporting. The actual CTR (financial) makes additional adjustments to the GAAP financials to re-bucket risk adjustment restatement into the incurred year from which it originated and also removes the impact of the premium deficiency reserve (PDR) to provide a direct comparison to financial performance for a given calendar year.

The table below itemizes the financial components between GAAP, actual CTR (financial) and SHCE reporting for calendar year 2023 for the combined individual and small group markets.

[2] Includes explicit cuts to CTR as well as reductions to actuarial factors that were beyond those recommended by the Board's contracted actuary.

Item	Item Description	GAAP	GAAP adjusted (used for actual CTR (financial)	SHCE
(a)	Earned Premium	$375,001,825	$375,001,825	$375,001,825
(b)	Doubtful Premium	$1,044,486	$1,044,486	$0
(c)	2022 risk adjustment transfer restatement	($1,800,121)	$0	($1,800,121)
(d)	Federal taxes and federal assessments	$0	$0	$1,507,299
(e)	State insurance, premium and other taxes	$0	$0	($32,913)
(f)	Regulatory authority licenses and fees	$0	$0	($1,722,643)
(g) = sum (a) through (f)	**Net Premium**	**$374,246,190**	**$376,046,311**	**$372,953,447**
(h)	Net Claims	$381,172,623	$381,172,623	$381,172,623
(i)	GAAP to Statutory claims differences	$0	$0	($1,821,530)
(j)	Premium Deficiency Reserve	($3,276,000)	$0	($3,276,000)
(k) = sum (h) through (j)	**Total Net Claims**	**$377,896,623**	**$381,172,623**	**$376,075,092**
(l)	**Administrative Expenses**	**$27,868,522**	**$27,868,522**	**$26,912,072**
(m) = (g) - (k) - (l)	**Operating Gain/(Loss)**	($31,518,955)	($32,994,834)	($30,033,717)
(n) = (m) / (g)	**Actual CTR**	**-8.4%**	**-8.8%**	**-8.1%**

The list below describes the items and the differences between GAAP, GAAP adjusted, and SHCE items:

(a) Earned premium: Included billed premium (including APTC subsidies), net impact of high-cost risk pool, ceded premiums and 2023 risk transfer estimate.

(b) Doubtful premium: GAAP account includes the change in doubtful premium liability. Statutory accounting does not include this item.

(c) 2022 risk adjustment transfer restatement: Restated impact of the 2022 risk adjustment transfer realized in calendar year 2023 ($20,815,879 actual vs $22,616,000 booked)

(d) Federal taxes and federal assessments: SHCE includes this item (line 1.5) in premiums. GAAP accounting includes this item in administrative charges

(e) State insurance, premium and other taxes: SHCE includes this item (line 1.6) in premiums. GAAP accounting includes this item in administrative charges

(f) Regulatory authority licenses and fees: SHCE includes this item (line 1.7) in premiums. GAAP accounting includes this item in administrative charges

(g) Net Premium: Sum of items (a) to (f). Premium used to calculate the CTR

(h) Net Claims Expense: reflects paid claims, change in reserves for claims incurred but not reported, and reinsurance recoveries.

(i) GAAP to Statutory claims differences: Impact of different definition of claims between GAAP and Statutory accounting, such as ITS fees and change in unpaid claim administrative expense liability

(j) Premium Deficiency Reserve: We remove the PDR from the actual CTR (financials)

(k) **Total Net Claims: Sum of items (h) to (j)**

(l) Administrative Expenses: Reflects administrative charges under each accounting basis.

(m) Operating Gain/(Loss): Net premiums – total net claims – administrative expenses

(n) Actual CTR: Operating Gain/(Loss) divided by Net Premium

6. Please provide the actual and expected utilization trend for the last four years: 2020, 2021, 2022, and 2023.

In order to compare expected utilization trend with actuals, we adjust actuals to reflect non-utilization trend components that are also excluded from the trend analysis. This ensures that differences between actuals and expected are not due to other factors, such as demographics and morbidity, which are specifically adjusted in the filings outside of the trend factors.

Expected medical utilization trend includes both number of services and intensity of services. We therefore utilized the data provided in our response to L&E's question 2 dated June 14, 2024 for actual trends as that data was already normalized for all needed components.

Actual Medical Utilization		
	PMPM - After Cost and Other Normalization	Annual Trend
2019	$677.27	
2020	$601.43	-11.2%
2021	$702.67	16.8%
2022	$709.89	1.0%
2023	$737.60	3.9%

Expected Medical Utilization Trend				
	2019 to 2020	2020 to 2021	2021 to 2022	2022 to 2023
2020 Filing	3.3%			
2021 Filing	3.0%	3.0%		
2022 Filing		1.9%	1.9%	
2023 Filing			1.5%	1.5%
2024 Filing				0.8%

In each filing, we project non-specialty utilization and total allowed specialty trend. We are therefore providing actuals for non-specialty utilization, excluding over the counter COVID tests, to align with expected pharmacy utilization trend.

Actual Pharmacy Non-Specialty Utilization		
	Days Supply PMPM	Annual Trend
2019	32.74	
2020	33.99	3.8%
2021	34.30	0.9%
2022	34.56	0.7%
2023	34.95	1.1%

Expected Pharmacy Non-Specialty Utilization Trend				
	2019 to 2020	2020 to 2021	2021 to 2022	2022 to 2023
2020 Filing	1.2%			
2021 Filing	3.0%	3.0%		
2022 Filing		3.0%	3.0%	
2023 Filing			2.0%	2.0%
2024 Filing				2.0%

7. *On page 24 of the Actuarial Memorandum, BCBSVT lists the percentage of claims recovered as a part of FWA programs by incurred period in a table. Setting incurred claims in 2020 aside due to issues BCBSVT notes in footnote 13, how should we interpret the table? For instance, part of the increased recoveries could indicate an improvement of BCBSVT's FWA activities. The increases could also be the result of a growing number of provider coding errors. The increases also might indicate that in 2021 and 2022 a significant amount of FWA was not detected or recouped.*

The increase in 2023 recoveries is attributed to our new payment integrity program implemented in 2023. As we explained in Attachment D, to enhance payment policy compliance and coding validation, to minimize fraud, waste, and abuse, and to comply with the Blue Cross and Blue Shield Association (BCBSA) requirements, Blue Cross VT implemented a secondary claims editor in 2023. This technology analyzes large volumes of claims data to identify patterns suggestive of fraudulent billing activities, in addition to capturing a larger array of coding errors than other vendors. This technology greatly expands Blue Cross VT's ability to find and correct instances of fraud, waste and abuse. These enhanced capabilities align with state and federal transparency goals and ensure that a member is only charged for the care they receive. As noted in our response to question 2, a portion of this second pass payment integrity program will be unavailable due to Act 111.

8. *Provide a breakdown of membership, the number of groups, and the claims PMPM by three cohorts:*

   a. *Cohort 1 are groups that, in 2022, were in BCBSVT's ASO Small Group portfolio but in 2023 were in BCBSVT's Exchange Small Group portfolio;*
   b. *Cohort 2 are groups that, in 2023, were in BCBSVT's Exchange Small Group portfolio but left the Exchange for BCBSVT's 2024 ASO Small Group portfolio;*
   c. *Cohort 3 are groups that, in 2023, were either in BCBSVT's Exchange Small Group or ASO Small Group Portfolios (i.e. the aggregate of both 2023 portfolios).*

The table below shows the membership, number of groups, and claims PMPM for the three requested cohorts.

	# of Groups	Total 2023 Member Months	Total 2023 Claims PMPM
Cohort 1	12	4,702	$882.93
Cohort 2	15	3,267	$522.38
Cohort 3	2,420	301,026	$829.49

Below are important notes to considerer when reviewing this data:

- Groups in Cohort 1 and 2 are also included in Cohort 3.
- One group is in both Cohort 1 and Cohort 2.
- Claims are on an allowed basis. We include medical and pharmacy for all groups. QHP group data also include the additional coverage for pediatric vision and pediatric dental.
- Any estimates of Blue Cross VT's impact on QHP should consider the impacts of risk adjustment on premiums. Risk adjustment is a mechanism to adjust for the relative risk between all QHP issuers in a market. Small groups in Blue Cross VT non-QHP have lower claims and would therefore have lower risk scores. This would reduce Blue Cross VT's average risk score, reducing the expected risk adjustment receivable and therefore increasing premium for the risk adjustment component.

Further, Blue Cross VT is not the only option for small groups looking for coverage options outside of the QHP market. The self-funded small group market is highly competitive with a significant market presence of many carriers and third-party administrators. When quoting options to small groups, we have seen groups come from and leave Cigna, United, Ultra, Allied, and Allstate. We also quote groups who do not currently offer coverage or offer an ICHRA to their employees. As healthcare claims costs continue to grow, driving up premiums, employers will continue to look for other options to best meet their healthcare needs.

9. *Please provide the total dollar amount of realized savings from CivicaRx since BCBSVT's initial investment in the company versus BCBSVT's total investment in the CivicaRx (i.e., initial investment plus any subsequent investments).*

Blue Cross VT's total capital contribution in CivicaRx since 2020 is $294,666.67. As of May 2024, only one drug – abiraterone – was available through the pharmacy benefit in a 250 mg dose. The ingredient cost of the CivicaScript version is over 95 percent less than from other manufacturers. This has saved members from all of our lines of business approximately $412,000 through April 2024.

10. *When did BCBSVT last:*

a. *audit OptumRx's performance under its contract with BCBSVT for pharmacy benefit management (PBM) services? Please thoroughly describe all aspects of any audits conducted.*

This response was provided by Blue Cross VT Internal Audit department:

We conducted an internal audit of OptumRx services in 2023. The audit scope covered the following areas:

- Completeness and availability of performance guarantee reporting and results to ensure that results provided are in sync with user experience and are well supported and monitored effectively.
- Completeness and accuracy of the calculation and accounting for rebate information, including rebates passed along to group customers.
- Completeness, effectiveness and availability of user reports and file to ensure required data is correct, available and usable.
- Effectiveness and timeliness of access support to ensure BCBSVT users are set up correctly and timely.

b. *perform any market comparison checks to evaluate whether BCBSVT is receiving the best possible terms for PBM services? Please thoroughly describe the process, including timelines, evaluation criteria, and benchmarks of any market comparison checks conducted.*

This response was provided in parts by Blue Cross VT Pharmacy department:

We performed a market check in early 2023 which resulted in a favorable adjustment to financial terms the period starting July 2023.

Blue Cross VT hired a consultant to conduct a market check analysis to compare our current PBM pricing against industry benchmarks. The market check gauges the effectiveness of the program and identifies opportunities to improve contractual terms around financial and operational performance components and performance guarantees.

The consultant furnished a market check report to Blue Cross VT that includes benchmarks for PBM pricing by channel (traditional retail, retail 90, mail, specialty pharmacy) and base administrative fees. For each channel, the consultant provided benchmark ranges by pricing component (brand and generic discounts, specialty, dispensing fees, and rebate levels).

The consultant completed the following activities and evaluation criteria:

- Collected pharmacy claims data from the PBM and contract information related to traditional and specialty pharmacy product prices related to all channels-retail, retail 90, mail, and specialty pharmacy.
- Reviewed the pharmacy vendor contract pricing sections, such as definitions, guarantees, and reconciliation methodology.
- Discussed Blue Cross VT objectives for prescription drug plans and the PBM contractual relationship.
- Identified comparable client types and offers.
- Reviewed current contract relative to best-in-class pricing, service, operational and performance guarantees, and contractual terms and definitions.
- Compared Blue Cross VT current PBM pricing with the consultants proprietary pricing data warehouse.
- Assessed program competitiveness and identified opportunities to improve contractual terms, and made recommendation as to whether a revision to the terms of the existing agreement or competitive procurement process was warranted. In addition, the consultant supported our contract negotiations with the PBM. The timeline for the market check process took approximately fifteen (15) weeks, with additional time for contract negotiation.

c. *solicit or receive bids or outreach from any PBM other than OptumRx?*

The last RFP was conducted in 2020 when OptumRx was selected over the incumbent ESI effective July 2021. At that time, we received bids from five PBM, including the three largest. We are in the process of extending the contract with OptumRx through December 2025 to align with BCBSM's renewal timeline which will allow for negotiations and programming through a larger scale contract.

11. *BCBSVT's PBM recently announced new products promising to "improve affordability and transparency in pharmacy benefits," including OptumRx Cost Clarity, "which bases costs on independent cost baselines, such as the National Average Drug Acquisition Cost (NADAC) and wholesale costs."3 In a subsequent announcement Optum referred to this model as "cost-plus pricing with lower ingredient costs."4 Optum described another new pricing model, Clear Trend Guarantee, as a "value-based model with shared savings" that will help plan sponsors "manage total lowest net cost."5 Has BCBSVT evaluated whether these new products from its PBM would lower costs for its members? If so, please describe in detail BCBSVT's findings.*

We have not yet explored either of these products with OptumRx, but we are continually exploring strategies with (and without) OptumRx to reduce drug costs. As with any new PBM payment options, it is important to account for the fine print that is not included in press releases. PBMs often charge additional administrative fees to make up for lower ingredients costs and these would be reflected in premiums. Blue Cross VT is committed to find ways to lower our members' total net costs, and to find solutions that fit our members' needs.

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

Sincerely,

Martine B Lemieux

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Martine B. Lemieux, F.S.A., M.A.A.A.
Chief Actuary

[3] https://www.unitedhealthgroup.com/newsroom/posts/2023/2023-04-24-optum-rx-enhancements-preserving-choice.html
[4] https://www.unitedhealthgroup.com/newsroom/posts/2024/2024-05-optum-rx-clear-trend-guarantee.html
[5] Id.