STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re: Blue Cross Blue Shield of Vermont 2024 Individual Market Rate Filing	)))	GMCB-002-23rr SERFF No. BCVT-133654578

In re: Blue Cross Blue Shield of Vermont 2024 Small Group Market Rate Filing	)))	GMCB-003-23rr SERFF NO. BCVT-133654592

RESPONSE OF BLUE CROSS VT TO
JUNE 7, 2023 BOARD QUESTIONS

Blue Cross and Blue Shield of Vermont provides the following responses to the Board's June 7, 2023 questions:

Question 1

Provide BCBSVT's 2022 Supplemental Health Care Exhibit.

Response

Please find attached the 2022 Supplemental Health Care Exhibits for Blue Cross Blue Shield of Vermont.

Question 2

For the most recent year for which data are available (please specify), provide the dollar value of payments and the percentages of payments made by BCBSVT under each alternative payment model category below across BCBSVT's individual and small group plans and identify the relevant program or payment arrangement(s).

Response

Table 1 below shows the total allowed charges and percentages of claims for the ACA market (individual and small group) for calendar year 2022 by the requested categories:

Table 1

Category	Allowed Charges	Percentage
1. Fee for Service – no link to Quality % Value	$118,081,654	42.4%
2A. Fee for Service – Link to Quality & Value – Foundational Payments for Infrastructure & Operations	$132,976	0.0%
2B. Fee for Service – Link to Quality & Value – Pay for Reporting		0.0%
2C. Fee for Service – Link to Quality & Value – Rewards for Performance		0.0%
3A. APMs Built on Fee-for-Service Architecture – APMs with Upside Gainsharing		0.0%
3B. APMs Built on Fee-for-Service Architecture – APMs with Upside Gainsharing/Downside Risk	$159,524,916	57.3%
3N: Risk based payments NOT linked to quality		0.0%
4A. Population-Based Payment – Condition-Specific Population-Based Payment		0.0%
4B. Population-Based Payment – Comprehensive Population-Based Payment	$385,460	0.1%
4C. Integrated Finance & Delivery System		0.0%
4N. Capitated payments NOT linked to quality	$206,487	0.1%

In this context, allowed charges include all payments to providers, such as Blueprint payments, VBIC payments, and OCV care coordination fees, along with fee-for-service claims and capitations. Categories 4B and 4N reflect Blueprint and VBIC payments, and capitations, respectively, for non-OCV attributed members. All payments for OCV-attributed members are included in category 3B.

Question 3

On page 18 of the actuarial memorandum, BCBSVT estimates that the addition of a hearing aid benefit will increase the allowed PMPM by $1.30. Explain how BCBSVT's estimate compares to the projected 0.10% allowed cost impact calculated by Wakely Consulting Group in the Benchmark Plan Benefit Valuation Report, which is available at https://dfr.vermont.gov/sites/finreg/files/doc_library/VT_Appendix%20B_Actuarial%20Report.pdf .

Response

We cannot compare the underlying assumptions of the calculations because the Wakely report does not provide the details of the utilization and cost assumptions underlying their allowed cost impact of 0.1%. That said, Blue Cross VT's estimated $1.30 PMPM of allowed charges for hearing aids increases the total allowed charges (lines D of exhibits 5) by 0.12% for individual and 0.14% for small group (see Table 2). Our estimate is based on reasonable assumptions and comparable to Wakely's projection.

Table 2

		Individual	Small Group
Projected Allowed Charges – without hearing aid coverage	A	$1,067.18	$921.77
Hearing Aid coverage	B	$1.30	$1.30
Projected Allowed Charges – with hearing aid coverage (Line D of Exhibit 5)	C = A + B	$1,068.48	$923.07
Increase due to hearing aids	D = C / A -1	0.12%	0.14%

Question 4

Explain whether BCBSVT observed an increase in cancellations or shifts in enrollment by metal level due to the high premium increases in 2023.

Response

Blue Cross VT experienced its highest retention in 2023 as compared to the last four years for the individual ACA markets. In the small group market, although our retention was slightly lower in 2023, it was higher than any year where the markets were merged. That slightly lower retention was driven by the move to other Blue Cross VT lines of business. Table 3 below shows the retention percentage in the ACA market by comparing February of each year to the prior December.

Table 3

Year	Individual ACA Retention	Small Group ACA Retention
2019	83.8%	75.5[1]%
2020	86.7%	75.8%
2021	88.9%	86.0%
2022	90.4%	91.2%
2023	91.6%	89.4%

The proportion of members re-enrolling in a leaner metal level was slightly higher in 2023 than in 2022 but lower than in 2020 and 2021. Table 4 shows enrollment changes for 2023 open enrollment. For members renewing in the same ACA market, Table 4 shows the percentage of members that renewed in the same metal level, in a richer plan, or in a leaner plan.

[1] 2019 small group retention reflects 13.4% of members joining the Association Health Plan.

Table 4

	Individual	Small Group
Member reenrolled in same metal level	85.8%	83.7%
Member reenrolled in richer metal level	2.3%	2.3%
Member reenrolled in leaner metal level	3.1%	3.0%
Member reenrolled in different ACA market (individual vs. small group)	0.4%	0.4%
Subtotal – Members reenrolled in ACA Market with Blue Cross VT	***91.6%***	***89.4%***
Member moved to Medicare Supplement with Blue Cross VT	0.2%	0.1%
Member moved to Large Group or Blue Edge with Blue Cross VT	0.4%	2.5%
Member Canceled	7.8%	7.9%
Total for December membership	**100.0%**	**100.0%**

Question 5

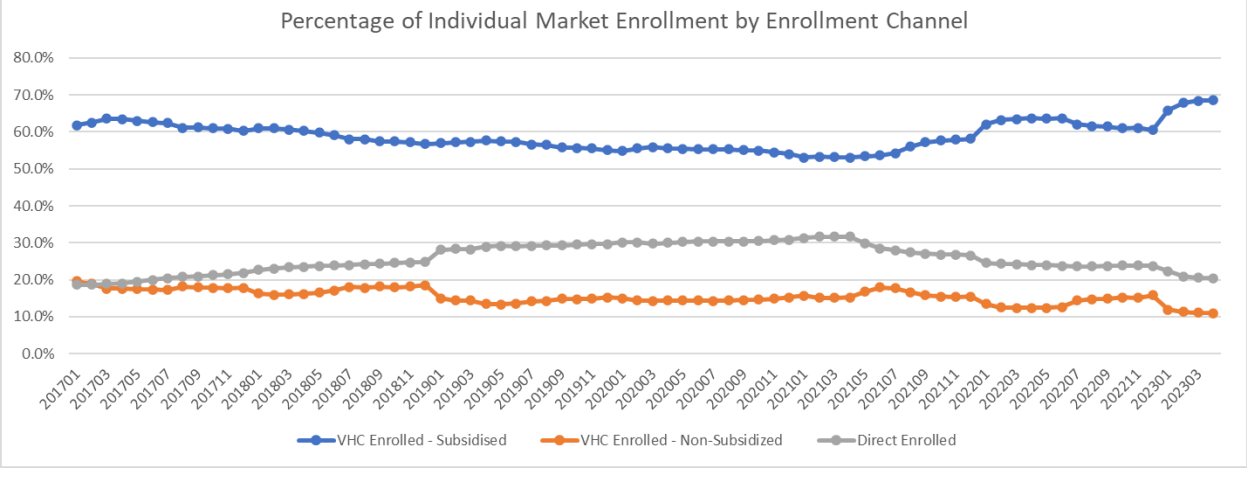
Explain whether the efforts described in Attachment E of the filing have been effective in reducing the number of subsidy-eligible direct enrollees.

Response

Blue Cross VT does not have income information for its members who are direct enrollees. We therefore do not know whether direct enrollees are subsidy-eligible.

We believe that the efforts described in Attachment E of the filing have been effective in reducing the number of subsidy-eligible direct enrollees because (1) the percentage of individual members enrolled directly with Blue Cross VT is at its lowest point since 2017 and (2) the percentage of members enrolled with a subsidy is at its highest point. Figure 1 illustrates this.

Figure 1



Question 6

Explain how BCBSVT determined that it will need $2.25 PMPM for payment reform efforts in 2024 and what it plans to spend these funds on.

Response

Blue Cross VT determined that it will need $2.25 PMPM for payment reform efforts in 2024 based on several considerations. We started with the current percentage of insured membership attributed to VBIC and ACO providers, which serves as a proxy for attribution to payment reform programs. We did not use this attribution percentage to continue payment streams established in 2023 but rather as an indicator of 2024 participation in payment reform programs.

To estimate the projected attribution in payment reform programs in 2024, we assumed that the VBIC attribution would double in the projection period. From there, we multiplied the current PMPMs for each program (VBIC and ACO) by the portion of membership attributed. This calculation determined the projected funding requirement for payment reform efforts in 2024 and yields $2.28 PMPM. We included $2.25 PMPM in these rates. Table 5 shows the details of this calculation.

Table 5

Program	PMPM	Current Attribution	Projected Attribution
VBIC	$7.00	5.7%	11.4%
ACO	$3.25	45.5%	45.5%
Weighted Average PMPM on all Members		$1.88	$2.28

Blue Cross VT has not made a final decision on how these funds to support payment reform will be made to providers. We are currently assessing and developing options to support health care reform in Vermont. This may include enhancing and expanding the VBIC program as well as introducing new programs for other providers. Our aim is to use the revenue derived from the $2.25 PMPM to compensate community providers for improving quality, cost, and appropriateness of care.

While this funding was considered as part of the factors approved by the GMCB in the Large Group filing (BCVT-133551255), Blue Cross VT cannot finalize its payment reform programs for 2024 until all rate decisions are finalized. Our development and expansion of future health care reform programs depends on fully funded rates across all of our insurance markets. We have learned that successful programs do not segment members by type of insurance. Programs that operate

across all markets are simpler for providers and contribute to uniformity across the system.

Question 7

Describe how BCBSVT prospectively assesses its solvency and provide BCBSVT's best estimate of its RBC ratio at the end of 2023 and 2024.

Response

Blue Cross VT takes a rigorous approach to prospectively assessing its solvency and RBC levels. While we employ projections, we also recognize that RBC is influenced by many factors and at its core is a measurement of solvency at a given point in time. Projecting future RBC levels is challenging and difficult because of the relatively small size of our member reserves compared to the risks those reserves are intended to protect against, including volatility in medical and pharmacy claims; membership growth; and external factors such as performance of equity markets.

When we assess our outlook for future RBC levels, we begin by preparing an annual financial forecast for the coming fiscal year. That forecast incorporates known actual variances to the latest current year forecast. Then we create a multi-year deterministic model, based on the annual financial forecast, which projects financial performance and membership growth expectations for each business segment. This forecast includes approved premium rates and other assumptions aligned with our rate development. This multi-year view shows the trajectory of member reserves and RBC based on these deterministic assumptions.

Although a useful first step, the deterministic approach gives a false sense of certainty. This is because actual results will vary, often significantly, from projections due to the highly variable nature of factors that impact RBC. Therefore, we expand our modeling to include statistical (stochastic) modeling. The purpose of this step is to identify the most likely range of future RBC results using a range of potential future outcomes for certain key assumptions and a statistically significant number of scenarios.

Using the most recent series of modeling updates, our stochastic modeling indicates that the most likely range of RBC results at year-end 2023 is [redacted] percent to [redacted] percent. The most likely range of RBC results at year-end 2024 is [redacted] percent to [redacted] percent.

From the same stochastic modeling exercise, the following table outlines the Median RBC for 2023 and 2024, and the statistical probabilities of RBC being above the bottom of our ordered range and below the BCBSA monitoring level of 375%.

Table 6

	2023	2024
Median RBC	[redacted]	[redacted]
Probability greater than 590%	[redacted]	[redacted]
Probability less than 375%	[redacted]	[redacted]

See Exhibit 1 for details on the assumptions used in the modeling and additional outputs.

Finally, in addition to periodic modeling updates and related analyses, Blue Cross VT monitors trends emerging in actual financial results and performs a risk assessment of the near-term trends in RBC versus expectations. For example, Blue Cross VT's results to date in 2023 indicate significantly higher than expected (and priced for) medical and pharmacy claims in both its commercial insured lines and Medicare Advantage segment. This is offset somewhat by favorable investment gains so far in 2023, but overall year-to-date 2023 actual result are significantly unfavorable to forecast. As a result, Blue Cross VT's RBC is tracking towards the lower end of the modeled range.

Question 8

In a table format, show how the projected contribution to surplus from each filing and BCBSVT's projected RBC ratio at the end of 2024 would be impacted if the rates were reduced by 1%, 2%, 3%, 4%, and 5% (assuming no corresponding decrease in costs).

Response

Table 7 below shows the impact of these hypothetical reductions to ACA rates on the overall projected RBC for 2024, assuming all filing assumptions are otherwise unchanged.

Table 7

Hypothetical reduction to ACA rates	0% (as filed)	1%	2%	3%	4%	5%
2024 Projected RBC	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Question 9

The Board has been informed that BCBSVT recently modified its policy on audio-only telehealth visits to exclude certain CPT codes commonly billed

by primary care practices. Explain the changes BCBSVT made to its policy, the rationale for these changes, and the magnitude of the impact on providers.

Response

Blue Cross VT widely supports and promotes telehealth, including the audio-only modality: it increases access to care for rural and lower income populations, including those with transportation and childcare issues, and for parents who are juggling busy family and school schedules. We are constantly seeking to improve our members' access while being responsive to their concerns around the spiraling cost of care.

When we created our original audio-only payment policy during COVID, we did our best at the time to provide appropriate codes by working with a small group of internal experts. We knew our first attempt would be one of many and have made updates to the policy to expand access to audio-only care. In 2023, in collaboration with many stakeholders and societies, the American Medical Association (AMA) released a valuable resource of recommended audio-only payment codes in 'Appendix T'[2] of the CPT® manual as a guide. We adopted the AMA recommendations in their entirety, which added 23 CPT codes and removed 19 CPT codes from our payment policy.

Payment for audio-only codes is not just about access to care. This mode of treatment does open concerns about the quality and value of care, and particularly the health equity implications for low-income and rural Vermonters. For reference, a recent publication, Rethinking the Impact of Audio-Only Visits on Health Equity, in the RAND Blog from December 2021, is an excellent summary of our concerns around how health disparities are exacerbated by audio-only care, and cites the latest research on this modality.

Blue Cross VT's provider relations department has not had any providers express concerns or dissatisfaction with our current Telephone Only or Telemedicine payment policies. Those policies are available here: https://www.bluecrossvt.org/providers/provider-policies

Question 10

The Board is interested in better understanding how BCBSVT reimburses non-hospital-affiliated providers in its service area and what BCBSVT has assumed in the filings regarding reimbursement increases for these providers. To that end, please:

[2] American Medical Association. (2023). CPT® Errata and Technical Corrections [Electronic Resource]. Retrieved from address: https://www.ama-assn.org/system/files/cpt-corrections-errata-2023.pdf

a. **Describe the different fee schedules used by BCBSVT, the types of providers or services reimbursed under each fee schedule, and which markets the fee schedules apply to.**

[redacted]

b. **Describe the magnitude and timing of all increases to the fee schedules used to reimburse non-hospital-affiliated providers between now and the end of 2024, identify with specificity where in Exhibit 3A of the filing these increases are reflected, and explain whether the increases will be targeted to certain providers or codes.**

[redacted]

c. **How does BCBSVT define each provider type and how does this definition relate to the "professional" premium category of the URRT?**

Provider types are defined based on the specialty and credentials providers report to us as part of their enrollment in our network. For this filing, "professional" claims are identified as all non-facility claims, whether the service was provided in office or in hospital. Ancillary claims, such as durable medical equipment, are also included in this category.

Question 11

Explain how, if at all, BCBSVT assesses the equity and sufficiency of payments across care settings.

Response

As in past proceedings, we also challenge the assumption that equity in payments is achieved when payment rates for a specific service are identical. Providers are entitled to make margin on their services, although how much margin is likely a matter of policy debate. Two providers receiving the same payment for a specific service can make vastly different margins, depending on their relative efficiency, differences in their payor mix (including Medicare and Medicaid), and numerous other factors. Unfortunately, provider margin is unknown to Blue Cross VT, and largely unknown to policymakers. Blue Cross VT supports further exploration by the Board of provider margin, rather than focusing on specific payment rates in a vacuum.

Question 12

The Board is interested in understanding how the charge increases allowed in the individual and small group filings compare to actual charge increases implemented by BCBSVT. To that end, please provide, in a table format for each year since 2014:

Response

For this question, we assume "charge" increase refers to the prices charged by providers, not the premium rates (which are precisely as ordered by the Board). The

Board approves premium rates and rate increases based in part on assumptions about provider charges, and charge increases, in the rate filing. The Board's rate review decisions do not, however, mandate provider charges. For example, in some years, the Board's rate review decision assumes hospital commercial rate increases that are lower than the actual increases later approved by the Board in the hospital budget process. Blue Cross VT's proposed rates, and the Board's decision, are also based on assumed charge increases for hospitals not regulated by the Board, *before* Blue Cross VT has negotiated contracts with those facilities. Further, as discussed in more detail below, the question poses some additional analytical challenges.

Variables affecting provider payment increases include the assumed versus actual split between facility and professional claims incurred; the timing of payment changes; the weighted average of the different types of services for Blue Cross VT's full book of business versus the hospital's book of business; and the multiple types of payment methodologies (for example, diagnosis-related group reimbursement (DRG), per diem, outlier provisions, fee schedules, discounts). Further, even if the Board's rate review decision assumes, in the aggregate, the same overall commercial rate increase approved for hospitals, the increases approved for individual hospitals in their separate orders may vary from the aggregate increase.

Other factors that create variances between hospital commercial rates included in filings and implemented hospital commercial rates include Blue Cross VT business decisions, such as the decision to support OneCare Vermont and pay an OCV care coordination fee in lieu of across the board increases to the Community Fee Schedule for a few years.

Blue Cross VT has multiple teams involved in establishing and negotiating hospital commercial rates for facilities in Vermont and New Hampshire, and Community Fee Schedules. Tracking down the back and forth between our teams and their hospital and provider contacts since 2014 is not feasible. We have seen turnover in both the internal and hospital teams, and even with unlimited time likely could not capture all information about these historical negotiations. Identifying and categorizing the individual negotiations for 14 Vermont hospital, eight New Hampshire hospitals, and all Community Fee Schedules, over the past ten years would take weeks of dedicated time from the multiple internal teams and that would still be an incomplete effort as some of the information might prove very difficult to track down.

However, we are providing relevant, confidential information in our responses to Questions 12.a and 12.b below that gives the Board a system-wide overview of payment rates over time. Our responses show the payment increases included in the 2018 to 2024 filings for hospitals under GMCB review, other facilities with which Blue Cross VT contracts directly, and Community Fee Schedule increases. Because Blue Cross VT changed the rate filing methodology starting with the 2018 filing, including 2014 to 2017 would not provide consistent historical information.

Each filing includes a two-year projection for payment increases. For the Board's reference, Table 8 below shows the timing of known and assumed increases by filing and calendar year.

Table 8

Timing of Known and Assumed Increases for each filing								
		Filing Year						
		2018	2019	2020	2021	2022	2023	2024
Calendar Year	2016	Known						
	2017	Assumption	Known					
	2018	Assumption	Assumption	Known				
	2019		Assumption	Assumption	Known			
	2020			Assumption	Assumption	Known		
	2021				Assumption	Assumption	Known	
	2022					Assumption	Assumption	Known
	2023						Assumption	Assumption
	2024							Assumption

a. The charge increases for independent providers allowed in BCBSVT's individual and small group filings and the actual increases implemented by BCBSVT. Explain any variances.

Please see attached CONFIDENTIAL – Exhibit 2, Response to Question 12, pages 1-2. The exhibit shows actual and estimated increases in aggregate for the categories included on page 3 of Exhibit 3A. "Not in Filing" entries mean that at the time of filing, no specific increase for the category and date combination was included.

b. The charge increases for hospitals allowed in the rate filing and the actual increases implemented by BCBSVT. Explain any variances.

Please see attached CONFIDENTIAL – Exhibit 2, Response to Question 12, pages 4-6 The exhibit shows actual and estimated increases in aggregate for the categories included on page 3 of Exhibit 3A. "Not in Filing" entries mean that at the time of filing, no specific increase for the category and date combination was included.

Dated: June 21, 2023

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CERTIFICATE OF SERVICE

I certify that on June 21, 2023, I served the above Response of Blue Cross VT to June 7, 2023 Board Questions on Michael Barber, Laura Beliveau, Tara Bredice, and Jennifer DaPolito of the Green Mountain Care Board and on Charles Becker and Eric Schultheis of the Office of the Health Care Advocate, by electronic mail.

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Exhibit 1
Details of the Blue Cross VT stochastic RBC Model and additional outputs.

The model uses the following assumptions:

Category	Line of Business	Assumption/Range
2023 Membership	All Lines of Business	Based on actual year-to-date members extended through year-end based on historical seasonal patterns
2024 Membership	ACA Market	Average membership remains flat from 2023, modeled normally with a mean of zero and standard deviation of 0.25% and 0.2% for the small group and individual markets, respectively.
	Medicare Supplement	Average membership gain of 1% based on 2021, 2022, and2023 results, modeled on a normal distribution with standard deviation of 1%
	Vermont Blue Advantage	[redacted]
	Large Groups (insured and self-funded)	Flat from actual 2023
	FEP, Host, CBA	Flat from actual 2023
2023 Claims	ACA Market	Normally distributed with a mean equal to the 2023 forecast (in turn based on the 2023 rate order), and a standard deviation of 1.1% based on an assessment of annual claims deviation since inception
	Medicare Supplement	Normally distributed with a mean equal to the 2023 forecast (in turn based on the 2023 rate orders) and a standard deviation of 2.1% based on an assessment of annual claims deviation over the past fourteen years
	Vermont Blue Advantage	[redacted]
	Insured Large Group	Based on 2023 forecast updated for actual renewal rates
	FEP, Host, CBA, Part D	From 2023 forecast
2024 Claims	ACA Market	Normally distributed with a mean equal to the expected results in these dockets and a standard deviation of 1.1%
	Medicare Supplement	Normally distributed with a mean equal to the expected results in the draft 2024 rate filings and a standard deviation of 2.1%
	Vermont Blue Advantage	[redacted]
	Insured Large Group	Based on approved 2024 filing
	FEP, Host, CBA, Part D	Held constant from 2023
Other Categories	Administrative Expenses	Assumed annual 4% growth from baseline of 2023 budget
	Administrative Revenue from Self-Funded groups	[redacted]

	Investment Returns	We received input on historical long-term investment returns and based on the allocation of our portfolio by asset class, we applied an expected annual return of 3.85% modeled on beginning market value of $138.8 million, varying with a standard deviation of 4.73%
	Pension	We received input on historical long-term investment returns and based on the allocation of our pension trust by asset class, we assumed a normally distributed mean of 5.68% and standard deviation of 9.79%; discount rate modeled based on an examination of historical experience using 50% reversion to a long-term mean of 4.2% with annual variability normally distributed at a standard deviation of 0.74%.
	Contribution to Reserve	3.0% assumed for insured Blue Cross VT lines of business in 2024.

Each of the 10,000 scenarios selects a random variable within the defined range for each variable assumption, then assembles all components to calculate a projected year-end 2023 and 2024 RBC. The graphs below show the range of results for 2023 and 2024. Each dot represents the number of scenarios that produced a given RBC, and the orange lines reflect one standard deviation from the median.

SUPPLEMENTAL HEALTH CARE EXHIBIT - PART 1

53295202221646100 2022 Document Code: 216

(To Be Filed by April 1 - Not for Rebate Purposes - See Cautionary Statement at https://content.naic.org/sites/default/files/inline-files/committees_e_app_blanks_related_shce_cautionary_statement.pdf)

REPORT FOR: 1. CORPORATION: BLUE CROSS AND BLUE SHIELD OF VERMONT 2. LOCATION: Berlin, VT 05602

NAIC Group Code 4745 BUSINESS IN THE STATE OF Vermont DURING THE YEAR 2022 NAIC Company Code 53295

Supp216.1 Vermont

	Business Subject to MLR									10	11	12	13	14	15
	Comprehensive Health Coverage			Mini-Med Plans			Expatriate Plans		9						
	1 Individual	2 Small Group Employer	3 Large Group Employer	4 Individual	5 Small Group Employer	6 Large Group Employer	7 Small Group	8 Large Group	Student Health Plans	Government Business (Excluded by Statute)	Other Health Business	Medicare Advantage Part C and Medicare Part D Stand-Alone Subject to ACA	Subtotal (Cols. 1 thru 12)	Uninsured Plans	Total (Cols. 13 + 14)
1. Premium:															
1.1 Health premiums earned (From Part 2, Line 1.11)	146,500,867	151,569,127	166,502,175								27,603,393	3,113,920	495,289,482	XXX	495,289,482
1.2 Federal high risk pools														XXX	
1.3 State high risk pools														XXX	
1.4 Premiums earned including state and federal high risk programs (Lines 1.1 + 1.2 + 1.3)	146,500,867	151,569,127	166,502,175								27,603,393	3,113,920	495,289,482	XXX	495,289,482
1.5 Federal taxes and federal assessments	(660,286)	(295,947)	(325,649)								2,599	21,828	(1,257,455)	(880,072)	(2,137,527)
1.6 State insurance, premium and other taxes (Similar local taxes of $.....)	15,284	16,174	16,357								1,848	1,013	50,676	63,788	114,464
1.6A Community Benefit Expenditures (informational only)															
1.7 Regulatory authority licenses and fees	756,496	751,888	296,394								20,469	190	1,825,437	18,119	1,843,556
1.8 Adjusted Premiums Earned (Lines 1.4 - 1.5 - 1.6 - 1.7)	146,389,373	151,097,012	166,515,073								27,578,477	3,090,889	494,670,824	XXX	495,468,989
1.9 Net assumed less ceded reinsurance premiums earned	(216,979)	(261,335)	(271,025)								(13,201,770)		(13,951,109)	XXX	(13,951,109)
1.10 Other adjustments due to MLR calculations - Premiums														XXX	
1.11 Risk Revenue														XXX	
1.12 Net adjusted premiums earned after reinsurance (Lines 1.8 + 1.9 + 1.10 + 1.11)	146,172,394	150,835,677	166,244,048								14,376,707	3,090,889	480,719,715	XXX	481,517,880
2. Claims:															
2.1 Incurred claims excluding prescription drugs	115,498,933	120,360,438	133,850,785								11,789,967		381,500,123	XXX	381,500,123
2.2 Prescription drugs	35,514,288	34,386,433	39,105,270								(1,018)	1,593,476	110,598,449	XXX	110,598,449
2.3 Pharmaceutical rebates	8,219,833	9,919,586	12,929,564										31,068,983	XXX	31,068,983
2.4 State stop-loss, market stabilization and claim/census based assessments (informational only)	453,680												453,680	XXX	453,680
3. Incurred medical incentive pools and bonuses														XXX	
4. Deductible Fraud and Abuse Detection/Recovery Expenses (for MLR use only)															
5.0 TOTAL Incurred Claims (Lines 2.1 + 2.2 - 2.3 + 3) (From Part 2, Line 2.15)	142,793,388	144,827,285	160,026,491								11,788,949	1,593,476	461,029,589	XXX	461,029,589
5.1 Net assumed less ceded reinsurance claims incurred	39,984	(60,780)	21,366								3,793,589		3,794,159	XXX	3,794,159
5.2 Other adjustments due to MLR calculations - Claims	1,702,000	1,200,000	264,000								(4,064,000)	389,000	(509,000)	XXX	(509,000)
5.3 Rebates Paid										XXX	XXX			XXX	
5.4 Estimated rebates unpaid prior year										XXX	XXX			XXX	
5.5 Estimated rebates unpaid current year										XXX	XXX			XXX	
5.6 Fee for service and co-pay revenue														XXX	
5.7 Net incurred claims after reinsurance (Lines 5.0 + 5.1 + 5.2 + 5.3 - 5.4 + 5.5 - 5.6)	144,535,372	145,966,505	160,311,857								11,518,538	1,982,476	464,314,748	XXX	464,314,748
6. Improving Health Care Quality Expenses Incurred:															
6.1 Improve health outcomes	201,088	242,885	341,260										785,233	1,024,461	1,809,694
6.2 Activities to prevent hospital readmissions	32,183	38,873	57,667										128,723	173,030	301,753
6.3 Improve patient safety and reduce medical errors	8,888	10,736	16,738										36,362	47,421	83,783
6.4 Wellness and health promotion activities	28,492	34,415	52,319										115,226	170,578	285,804
6.5 Health Information Technology expenses related to health improvement	47,856	57,557	82,446								4,335		192,194	312,807	505,001
6.6 TOTAL of Defined Expenses Incurred for Improving Health Care Quality (Lines 6.1 + 6.2 + 6.3 + 6.4 + 6.5)	318,507	384,466	550,430								4,335		1,257,738	1,728,297	2,986,035
7. Preliminary Medical Loss Ratio: MLR (Lines 4 + 5.0 + 6.6 - Footnote 2.0) / Line 1.8	0.978	0.961	0.964							XXX	XXX	0.516	XXX	XXX	XXX
8. Claims Adjustment Expenses:															
8.1 Cost containment expenses not included in quality of care expenses in Line 6.6	855,624	1,317,506	1,220,699								48,502	21,180	3,463,511	3,464,312	6,927,823
8.2 All other claims adjustment expenses	5,322,198	5,975,750	5,663,605								721,666	701,660	18,384,879	23,775,978	42,160,857
8.3 TOTAL Claims adjustment expenses (Lines 8.1 + 8.2)	6,177,822	7,293,256	6,884,304								770,168	722,840	21,848,390	27,240,290	49,088,680
9. Claims Adjustment Expense Ratio (Line 8.3 / Line 1.8)	0.042	0.048	0.041								0.028	0.234	XXX	XXX	XXX

SUPPLEMENTAL HEALTH CARE EXHIBIT - PART 1 (Continued)

(To Be Filed by April 1 - Not for Rebate Purposes)

	Business Subject to MLR									10	11	12	13	14	15
	Comprehensive Health Coverage			Mini-Med Plans			Expatriate Plans		9						
	1	2	3	4	5	6	7	8							
	Individual	Small Group Employer	Large Group Employer	Individual	Small Group Employer	Large Group Employer	Small Group	Large Group	Student Health Plans	Government Business (Excluded by Statute)	Other Health Business	Medicare Advantage Part C and Medicare Part D Stand-Alone Subject to ACA	Subtotal (Cols. 1 thru 12)	Uninsured Plans	Total (Cols. 13 + 14)
10. General and Administrative (G&A) Expenses:															
10.1 Direct sales salaries and benefits			88,336										88,336	88,336	176,672
10.2 Agents and brokers fees and commissions			1,019,942								4,537		1,024,479	1,651,168	2,675,647
10.3 Other taxes (excluding taxes on Lines 1.5 through 1.7 and Line 14 below)															
10.4 Other general and administrative expenses	5,178,550	3,954,195	3,955,379								460,926	343,427	13,892,477	21,171,282	35,063,759
10.4A Community Benefit Expenditures (informational only)															
10.5 TOTAL General and administrative (Lines 10.1 + 10.2 + 10.3 + 10.4)	5,178,550	3,954,195	5,063,657								465,463	343,427	15,005,292	22,910,786	37,916,078
11. Underwriting Gain/(Loss) (Lines 1.12 - 5.7 - 6.6 - 8.3 - 10.5)	(10,037,857)	(6,762,745)	(6,566,200)								1,618,203	42,146	(21,706,453)	XXX	(72,787,661)
12. Income from fees of uninsured plans	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	30,286,538	30,286,538
13. Net investment and other gain/(loss)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	21,070,818	XXX	21,070,818
14. Federal income taxes (excluding taxes on Line 1.5 above)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	1,170,230	XXX	1,170,230
15. Net gain or (loss) (Lines 11 + 12 + 13 - 14)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	(1,805,865)	XXX	(22,600,535)
16. ICD-10 Implementation Expenses (informational only; already included in general expenses and Line 10.4)															
16A. ICD-10 Implementation Expenses (informational only: already included in Line 10.4)															
OTHER INDICATORS:															
1. Number of Certificates / Policies	10,597	11,365	12,099								2,690	5,396	42,147	47,455	89,602
2. Number of Covered Lives	15,891	19,700	23,210								2,754	5,396	66,951	99,898	166,849
3. Number of Groups	XXX	2,120	46	XXX							2,557	5,396	10,119	120	10,239
4. Member Months	194,939	235,460	279,328								33,769	64,851	808,347	1,206,354	2,014,701

(a) Is run off business reported in Columns 1 through 9 or 12? Yes[ ] No[X]
(b) If yes, show the amount of premiums and claims included: Premiums $..... Claims $.....

AFFORDABLE CARE ACT (ACA) RECEIPTS, PAYMENTS, RECEIVABLES and PAYABLES

	Current Year		Prior Year	
	Comprehensive Health Coverage		Comprehensive Health Coverage	
	1 Individual Plans	2 Small Group Employer Plans	3 Individual Plans	4 Small Group Employer Plans
ACA Receivables and Payables				
1. Permanent ACA Risk Adjustment Program				
1.0 Premium adjustments receivable/(payable)	13,613,415	8,658,482	22,155,372	694,512
2. Transitional ACA Reinsurance Program				
2.0 Total amounts recoverable for claims (paid & unpaid)		XXX		XXX
3. Temporary ACA Risk Corridors Program				
3.1 Accrued retrospective premium				
3.2 Reserve for rate credits or policy experience refunds				
ACA Receipts and Payments				
4. Permanent ACA Risk Adjustment Program				
4.0 Premium adjustments receipts/(payments)	21,798,428	23,084	21,418,914	260,897
5. Transitional ACA Reinsurance Program				
5.0 Amounts received for claims		XXX		XXX
6. Temporary ACA Risk Corridors Program				
6.1 Retrospective premium received				
6.2 Rate credits or policy experience refunds paid				

SUPPLEMENTAL HEALTH CARE EXHIBIT - PART 2

(To Be Filed By April 1 - Not for Rebate Purposes)

REPORT FOR: 1. CORPORATION: BLUE CROSS AND BLUE SHIELD OF VERMONT 2. LOCATION: Berlin, VT 05602

NAIC Group Code 4745 **BUSINESS IN THE STATE OF Vermont DURING THE YEAR 2022** **NAIC Company Code 53295**

		Business Subject to MLR												
		Comprehensive Health Coverage			Mini-Med Plans			Expatriate Plans		9	10	11	12	13
		1	2	3	4	5	6	7	8					
		Individual	Small Group Employer	Large Group Employer	Individual	Small Group Employer	Large Group Employer	Small Group	Large Group	Student Health Plans	Government Business (Excluded by Statute)	Other Health Business	Medicare Advantage Part C and Medicare Part D Stand-Alone Subject to ACA	Total (a)
1.	Health Premiums Earned:													
1.1	Direct premiums written	146,500,867	151,569,127	166,502,175								27,603,393	3,113,920	495,289,482
1.2	Unearned premium prior year													
1.3	Unearned premium current year													
1.4	Change in unearned premium (Lines 1.2 - 1.3)													
1.5	Paid rate credits													
1.6	Reserve for rate credits current year			20,889,938										20,889,938
1.7	Reserve for rate credits prior year			20,411,384										20,411,384
1.8	Change in reserve for rate credits (Lines 1.6 - 1.7)			478,554										478,554
1.9	Premium balances written off													
1.10	Group conversion charges													
1.11	TOTAL Direct premiums earned (Lines 1.1 + 1.4 - 1.9 + 1.10)	146,500,867	151,569,127	166,502,175								27,603,393	3,113,920	495,289,482
1.12	Assumed premiums earned from non-affiliates													
1.13	Net assumed less ceded premiums earned from affiliates											(10,116,375)		(10,116,375)
1.14	Ceded premiums earned to non-affiliates	216,979	261,335	271,025								3,085,395		3,834,734
1.15	Other adjustments due to MLR calculation - Premiums													
1.16	Net premiums earned (Lines 1.11 - 1.5 - 1.8 + 1.12 + 1.13 - 1.14 + 1.15)	146,283,888	151,307,792	165,752,596								14,401,623	3,113,920	480,859,819
2.	Direct Claims Incurred:													
2.1	Paid claims during the year	143,381,854	142,981,146	159,689,582								3,812,405	6,290,881	456,155,868
2.2	Direct claim liability current year	9,966,900	10,824,200	4,204,100								7,586,838	1,644,717	34,226,755
2.3	Direct claim liability prior year	9,822,500	7,972,700	3,146,400								6,252,466	5,782,827	32,976,893
2.4	Direct claim reserves current year													
2.5	Direct claim reserves prior year													
2.6	Direct contract reserves current year													
2.7	Direct contract reserves prior year													
2.8	Paid rate credits													
2.9	Reserve for rate credits current year			20,889,938										20,889,938
2.10	Reserve for rate credits prior year			20,411,384										20,411,384
2.11	Incurred medical incentive pools and bonuses (Lines 2.11a + 2.11b - 2.11c)													
	2.11A Paid medical incentive pools and bonuses current year													
	2.11B Accrued medical incentive pools and bonuses current year													
	2.11C Accrued medical incentive pools and bonuses prior year													
2.12	Net healthcare receivables (Lines 2.12a - 2.12b)	732,866	1,005,361	1,199,345								(6,642,172)	559,295	(3,145,305)
	2.12A Healthcare receivables current year	6,923,645	6,712,722	4,179,388								889,753	3,995,083	22,700,591
	2.12B Healthcare receivables prior year	6,190,779	5,707,361	2,980,043								7,531,925	3,435,788	25,845,896
2.13	Group conversion charge													
2.14	Multi-option coverage blended rate adjustment													
2.15	TOTAL Incurred Claims (Lines 2.1 + 2.2 - 2.3 + 2.4 - 2.5 + 2.6 - 2.7 + 2.8 + 2.9 - 2.10 + 2.11 - 2.12 + 2.13 + 2.14)	142,793,388	144,827,285	160,026,491								11,788,949	1,593,476	461,029,589
2.16	Assumed Incurred Claims from non-affiliates													
2.17	Net Assumed less Ceded Incurred Claims from affiliates											(4,883,292)		(4,883,292)
2.18	Ceded Incurred Claims to non-affiliates	(39,984)	60,780	(21,366)								(8,676,881)		(8,677,451)
2.19	Other Adjustments due to MLR calculation - Claims	1,702,000	1,200,000	264,000								(4,064,000)	389,000	(509,000)
2.20	Net Incurred Claims (Lines 2.15 - 2.8 - 2.9 + 2.10 + 2.16 + 2.17 - 2.18 + 2.19)	144,535,372	145,966,505	159,833,303								11,518,538	1,982,476	463,836,194
3.	Fraud and Abuse Recoveries that Reduced PAID Claims in Line 2.1 above (informational only)													

(a) Column 13, Line 1.1 includes direct written premium of $..... for stand-alone dental and $..... for stand-alone vision policies.

SUPPLEMENTAL HEALTH CARE EXHIBIT - PART 3

(To Be Filed By April 1 - Not for Rebate Purposes)

REPORT FOR: 1. CORPORATION: BLUE CROSS AND BLUE SHIELD OF VERMONT 2. LOCATION: Berlin, VT 05602

NAIC Group Code 4745 BUSINESS IN THE STATE OF Vermont DURING THE YEAR 2022 NAIC Company Code 53295

All Expenses	Improving Health Care Quality Expenses						Claims Adjustment Expenses		9	10
	1 Improve Health Outcomes	2 Activities to Prevent Hospital Readmissions	3 Improve Patient Safety and Reduce Medical Errors	4 Wellness & Health Promotion Activities	5 HIT Expenses	6 Total (1 to 5)	7 Cost Containment Expenses	8 Other Claims Adjustment Expenses	General Administrative Expenses	Total Expenses (6 to 9)
1. Individual Comprehensive Coverage Expenses:										
1.1 Salaries (including $..... for affiliated services)	119,709	21,523	8,870	18,818	30,576	199,496	855,624	1,695,238	2,608,096	5,358,454
1.2 Outsourced services	56,053	10,648				66,701		777,505	818,990	1,663,196
1.3 EDP Equipment and Software (incl $..... for affiliated services)	11,928			9,663	17,218	38,809		1,696,763	178,335	1,913,907
1.4 Other Equipment (excluding EDP) (incl $..... for affiliated services)										
1.5 Accreditation and Certification (incl $..... for affiliated services)		XXX	XXX	XXX	XXX					
1.6 Other Expenses (incl $..... for affiliated services)	13,398	12	18	11	62	13,501		1,152,692	1,573,129	2,739,322
1.7 Subtotal before reimbursements and taxes (Lines 1.1 to 1.6)	201,088	32,183	8,888	28,492	47,856	318,507	855,624	5,322,198	5,178,550	11,674,879
1.8 Reimbursements by uninsured plans and fiscal intermediaries										
1.9 Taxes, licenses and fees (in total, for tying purposes)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	1,124,760	1,124,760
1.10 TOTAL (Lines 1.7 to 1.9)	201,088	32,183	8,888	28,492	47,856	318,507	855,624	5,322,198	6,303,310	12,799,639
1.11 TOTAL fraud and abuse detection/recovery expenses included in Column 7 (informational only)										
2. Small Group Comprehensive Coverage Expenses:										
2.1 Salaries (including $..... for affiliated services)	144,591	25,997	10,714	22,730	36,685	240,717	972,908	2,066,050	2,325,034	5,604,709
2.2 Outsourced services	67,704	12,861				80,565	344,598	895,645	579,283	1,900,091
2.3 EDP Equipment and Software (incl $..... for affiliated services)	14,409			11,671	20,797	46,877		1,799,355	176,742	2,022,974
2.4 Other Equipment (excluding EDP) (incl $..... for affiliated services)										
2.5 Accreditation and Certification (incl $..... for affiliated services)		XXX	XXX	XXX	XXX					
2.6 Other Expenses (incl $..... for affiliated services)	16,181	15	22	14	75	16,307		1,214,700	873,136	2,104,143
2.7 Subtotal before reimbursements and taxes (Lines 2.1 to 2.6)	242,885	38,873	10,736	34,415	57,557	384,466	1,317,506	5,975,750	3,954,195	11,631,917
2.8 Reimbursements by uninsured plans and fiscal intermediaries										
2.9 Taxes, licenses and fees (in total, for tying purposes)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	1,154,783	1,154,783
2.10 TOTAL (Lines 2.7 to 2.9)	242,885	38,873	10,736	34,415	57,557	384,466	1,317,506	5,975,750	5,108,978	12,786,700
2.11 TOTAL fraud and abuse detection/recovery expenses included in Column 7 (informational only)										
3. Large Group Comprehensive Coverage Expenses:										
3.1 Salaries (including $..... for affiliated services)	223,097	42,392	16,712	29,355	57,762	369,318	906,292	1,997,410	2,545,015	5,818,035
3.2 Outsourced services	76,063	15,257		9,102		100,422	314,407	1,040,200	592,422	2,047,451
3.3 EDP Equipment and Software (incl $..... for affiliated services)	16,976			13,846	24,595	55,417		1,700,284	193,173	1,948,874
3.4 Other Equipment (excluding EDP) (incl $..... for affiliated services)										
3.5 Accreditation and Certification (incl $..... for affiliated services)		XXX	XXX	XXX	XXX					
3.6 Other Expenses (incl $..... for affiliated services)	25,124	18	26	16	89	25,273		925,711	1,733,047	2,684,031
3.7 Subtotal before reimbursements and taxes (Lines 3.1 to 3.6)	341,260	57,667	16,738	52,319	82,446	550,430	1,220,699	5,663,605	5,063,657	12,498,391
3.8 Reimbursements by uninsured plans and fiscal intermediaries										
3.9 Taxes, licenses and fees (in total, for tying purposes)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	649,922	649,922
3.10 TOTAL (Lines 3.7 to 3.9)	341,260	57,667	16,738	52,319	82,446	550,430	1,220,699	5,663,605	5,713,579	13,148,313
3.11 TOTAL fraud and abuse detection/recovery expenses included in Column 7 (informational only)										

SUPPLEMENTAL HEALTH CARE EXHIBIT - PART 3 (Continued)

(To Be Filed By April 1 - Not for Rebate Purposes)

All Expenses	Improving Health Care Quality Expenses						Claims Adjustment Expenses		9	10
	1 Improve Health Outcomes	2 Activities to Prevent Hospital Readmissions	3 Improve Patient Safety and Reduce Medical Errors	4 Wellness & Health Promotion Activities	5 HIT Expenses	6 Total (1 to 5)	7 Cost Containment Expenses	8 Other Claims Adjustment Expenses	General Administrative Expenses	Total Expenses (6 to 9)
4. Individual Mini-Med Plans Expenses										
4.1 Salaries (including $..... for affiliated services)										
4.2 Outsourced services										
4.3 EDP equipment and software (including $..... for affiliated services)										
4.4 Other equipment (excluding EDP) (including $..... for affiliated services)										
4.5 Accreditation and certification (including $..... for affiliated services)		XXX	XXX	XXX	XXX					
4.6 Other expenses (including $..... for affiliated services)										
4.7 Subtotal before reimbursements and taxes (Lines 4.1 to 4.6)										
4.8 Reimbursements by uninsured plans and fiscal intermediaries										
4.9 Taxes, licenses and fees (in total, for tying purposes)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		
4.10 TOTAL (Lines 4.7 to 4.9)										
4.11 TOTAL fraud and abuse detection/recovery expenses included in Column 7 (informational only)										
5. Small Group Mini-Med Plans Expenses										
5.1 Salaries (including $..... for affiliated services)										
5.2 Outsourced services										
5.3 EDP Equipment and Software (including $..... for affiliated services)										
5.4 Other equipment (excluding EDP) (including $..... for affiliated services)										
5.5 Accreditation and certification (including $..... for affiliated services)		XXX	NONE	X	XXX					
5.6 Other expenses (including $..... for affiliated services)										
5.7 Subtotal before reimbursements and taxes (Lines 5.1 to 5.6)										
5.8 Reimbursements by uninsured plans and fiscal intermediaries										
5.9 Taxes, licenses and fees (in total, for tying purposes)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		
5.10 TOTAL (Lines 5.7 to 5.9)										
5.11 TOTAL fraud and abuse detection/recovery expenses included in Column 7 (informational only)										
6. Large Group Mini-Med Plans Expenses										
6.1 Salaries (including $..... for affiliated services)										
6.2 Outsourced services										
6.3 EDP equipment and software (including $..... for affiliated services)										
6.4 Other equipment (excluding EDP) (including $..... for affiliated services)										
6.5 Accreditation and certification (including $..... for affiliated services)		XXX	XXX	XXX	XXX					
6.6 Other expenses (including $..... for affiliated services)										
6.7 Subtotal before reimbursements and taxes (Lines 6.1 to 6.6)										
6.8 Reimbursements by uninsured plans and fiscal intermediaries										
6.9 Taxes, licenses and fees (in total, for tying purposes)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		
6.10 TOTAL (Lines 6.7 to 6.9)										
6.11 TOTAL fraud and abuse detection/recovery expenses included in Column 7 (informational only)										

SUPPLEMENTAL HEALTH CARE EXHIBIT - PART 3 (Continued)

(To Be Filed By April 1 - Not for Rebate Purposes)

All Expenses	Improving Health Care Quality Expenses						Claims Adjustment Expenses		9	10
	1 Improve Health Outcomes	2 Activities to Prevent Hospital Readmissions	3 Improve Patient Safety and Reduce Medical Errors	4 Wellness & Health Promotion Activities	5 HIT Expenses	6 Total (1 to 5)	7 Cost Containment Expenses	8 Other Claims Adjustment Expenses	General Administrative Expenses	Total Expenses (Cols. 6 to 9)
7. Small Group Expatriate Plans Expenses										
7.1 Salaries (including $..... for affiliated services)										
7.2 Outsourced services										
7.3 EDP equipment and software (including $..... for affiliated services)										
7.4 Other equipment (excluding EDP) (including $..... for affiliated services)										
7.5 Accreditation and certification (including $..... for affiliated services)		XXX	XXX	XXX	XXX					
7.6 Other expenses (including $..... for affiliated services)										
7.7 Subtotal before reimbursements and taxes (Lines 7.1 to 7.6)										
7.8 Reimbursements by uninsured plans and fiscal intermediaries										
7.9 Taxes, licenses and fees (in total, for tying purposes)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		
7.10 TOTAL (Lines 7.7 to 7.9)										
7.11 TOTAL fraud and abuse detection/recovery expenses included in Column 7 (informational only)										
8. Large Group Expatriate Plans Expenses										
8.1 Salaries (including $..... for affiliated services)										
8.2 Outsourced services										
8.3 EDP equipment and software (including $..... for affiliated services)										
8.4 Other equipment (excluding EDP) (including $..... for affiliated services)										
8.5 Accreditation and certification (including $..... for affiliated services)		XXX	NONE	X	XXX					
8.6 Other expenses (including $..... for affiliated services)										
8.7 Subtotal before reimbursements and taxes (Lines 8.1 to 8.6)										
8.8 Reimbursements by uninsured plans and fiscal intermediaries										
8.9 Taxes, licenses and fees (in total, for tying purposes)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		
8.10 TOTAL (Lines 8.7 to 8.9)										
8.11 TOTAL fraud and abuse detection/recovery expenses included in Column 7 (informational only)										
9. Student Health Plans Expenses										
9.1 Salaries (including $..... for affiliated services)										
9.2 Outsourced services										
9.3 EDP equipment and software (including $..... for affiliated services)										
9.4 Other equipment (excluding EDP) (including $..... for affiliated services)										
9.5 Accreditation and certification (including $..... for affiliated services)		XXX	XXX	XXX	XXX					
9.6 Other expenses (including $..... for affiliated services)										
9.7 Subtotal before reimbursements and taxes (Lines 9.1 to 9.6)										
9.8 Reimbursements by uninsured plans and fiscal intermediaries										
9.9 Taxes, licenses and fees (in total, for tying purposes)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		
9.10 TOTAL (Lines 9.7 to 9.9)										
9.11 TOTAL fraud and abuse detection/recovery expenses included in Column 7 (informational only)										

SUPPLEMENTAL HEALTH CARE EXHIBIT - PART 1

53295202221659100 2022 Document Code: 216

(To Be Filed by April 1 - Not for Rebate Purposes - See Cautionary Statement at https://content.naic.org/sites/default/files/inline-files/committees_e_app_blanks_related_shce_cautionary_statement.pdf)

REPORT FOR: 1. CORPORATION: BLUE CROSS AND BLUE SHIELD OF VERMONT 2. LOCATION: Berlin, VT 05602

NAIC Group Code 4745 BUSINESS IN THE STATE OF Grand Total DURING THE YEAR 2022 NAIC Company Code 53295

Supp216.1 Grand Total

	Business Subject to MLR									10	11	12	13	14	15
	Comprehensive Health Coverage			Mini-Med Plans			Expatriate Plans		9						
	1 Individual	2 Small Group Employer	3 Large Group Employer	4 Individual	5 Small Group Employer	6 Large Group Employer	7 Small Group	8 Large Group	Student Health Plans	Government Business (Excluded by Statute)	Other Health Business	Medicare Advantage Part C and Medicare Part D Stand-Alone Subject to ACA	Subtotal (Cols. 1 thru 12)	Uninsured Plans	Total (Cols. 13 + 14)
1. Premium:															
1.1 Health premiums earned (From Part 2, Line 1.11)	146,500,867	151,569,127	166,502,175								27,603,393	3,113,920	495,289,482	XXX	495,289,482
1.2 Federal high risk pools														XXX	
1.3 State high risk pools														XXX	
1.4 Premiums earned including state and federal high risk programs (Lines 1.1 + 1.2 + 1.3)	146,500,867	151,569,127	166,502,175								27,603,393	3,113,920	495,289,482	XXX	495,289,482
1.5 Federal taxes and federal assessments	(660,286)	(295,947)	(325,649)								2,599	21,828	(1,257,455)	(880,072)	(2,137,527)
1.6 State insurance, premium and other taxes (Similar local taxes of $.....)	15,284	16,174	16,357								1,848	1,013	50,676	63,788	114,464
1.6A Community Benefit Expenditures (informational only)															
1.7 Regulatory authority licenses and fees	756,496	751,888	296,394								20,469	190	1,825,437	18,119	1,843,556
1.8 Adjusted Premiums Earned (Lines 1.4 - 1.5 - 1.6 - 1.7)	146,389,373	151,097,012	166,515,073								27,578,477	3,090,889	494,670,824	XXX	495,468,989
1.9 Net assumed less ceded reinsurance premiums earned	(216,979)	(261,335)	(271,025)								(13,201,770)		(13,951,109)	XXX	(13,951,109)
1.10 Other adjustments due to MLR calculations - Premiums														XXX	
1.11 Risk Revenue														XXX	
1.12 Net adjusted premiums earned after reinsurance (Lines 1.8 + 1.9 + 1.10 + 1.11)	146,172,394	150,835,677	166,244,048								14,376,707	3,090,889	480,719,715	XXX	481,517,880
2. Claims:															
2.1 Incurred claims excluding prescription drugs	115,498,933	120,360,438	133,850,785								11,789,967		381,500,123	XXX	381,500,123
2.2 Prescription drugs	35,514,288	34,386,433	39,105,270								(1,018)	1,593,476	110,598,449	XXX	110,598,449
2.3 Pharmaceutical rebates	8,219,833	9,919,586	12,929,564										31,068,983	XXX	31,068,983
2.4 State stop-loss, market stabilization and claim/census based assessments (informational only)	453,680												453,680	XXX	453,680
3. Incurred medical incentive pools and bonuses														XXX	
4. Deductible Fraud and Abuse Detection/Recovery Expenses (for MLR use only)															
5.0 TOTAL Incurred Claims (Lines 2.1 + 2.2 - 2.3 + 3) (From Part 2, Line 2.15)	142,793,388	144,827,285	160,026,491								11,788,949	1,593,476	461,029,589	XXX	461,029,589
5.1 Net assumed less ceded reinsurance claims incurred	39,984	(60,780)	21,366								3,793,589		3,794,159	XXX	3,794,159
5.2 Other adjustments due to MLR calculations - Claims	1,702,000	1,200,000	264,000								(4,064,000)	389,000	(509,000)	XXX	(509,000)
5.3 Rebates Paid										XXX	XXX			XXX	
5.4 Estimated rebates unpaid prior year										XXX	XXX			XXX	
5.5 Estimated rebates unpaid current year										XXX	XXX			XXX	
5.6 Fee for service and co-pay revenue														XXX	
5.7 Net incurred claims after reinsurance (Lines 5.0 + 5.1 + 5.2 + 5.3 - 5.4 + 5.5 - 5.6)	144,535,372	145,966,505	160,311,857								11,518,538	1,982,476	464,314,748	XXX	464,314,748
6. Improving Health Care Quality Expenses Incurred:															
6.1 Improve health outcomes	201,088	242,885	341,260										785,233	1,024,461	1,809,694
6.2 Activities to prevent hospital readmissions	32,183	38,873	57,667										128,723	173,030	301,753
6.3 Improve patient safety and reduce medical errors	8,888	10,736	16,738										36,362	47,421	83,783
6.4 Wellness and health promotion activities	28,492	34,415	52,319										115,226	170,578	285,804
6.5 Health Information Technology expenses related to health improvement	47,856	57,557	82,446								4,335		192,194	312,807	505,001
6.6 TOTAL of Defined Expenses Incurred for Improving Health Care Quality (Lines 6.1 + 6.2 + 6.3 + 6.4 + 6.5)	318,507	384,466	550,430								4,335		1,257,738	1,728,297	2,986,035
7. Preliminary Medical Loss Ratio: MLR (Lines 4 + 5.0 + 6.6 - Footnote 2.0) / Line 1.8	0.978	0.961	0.964							XXX	XXX	0.516	XXX	XXX	XXX
8. Claims Adjustment Expenses:															
8.1 Cost containment expenses not included in quality of care expenses in Line 6.6	855,624	1,317,506	1,220,699								48,502	21,180	3,463,511	3,464,312	6,927,823
8.2 All other claims adjustment expenses	5,322,198	5,975,750	5,663,605								721,666	701,660	18,384,879	23,775,978	42,160,857
8.3 TOTAL Claims adjustment expenses (Lines 8.1 + 8.2)	6,177,822	7,293,256	6,884,304								770,168	722,840	21,848,390	27,240,290	49,088,680
9. Claims Adjustment Expense Ratio (Line 8.3 / Line 1.8)	0.042	0.048	0.041								0.028	0.234	XXX	XXX	XXX

SUPPLEMENTAL HEALTH CARE EXHIBIT - PART 1 (Continued)

(To Be Filed by April 1 - Not for Rebate Purposes)

	Business Subject to MLR									10	11	12	13	14	15
	Comprehensive Health Coverage			Mini-Med Plans			Expatriate Plans		9						
	1	2	3	4	5	6	7	8							
	Individual	Small Group Employer	Large Group Employer	Individual	Small Group Employer	Large Group Employer	Small Group	Large Group	Student Health Plans	Government Business (Excluded by Statute)	Other Health Business	Medicare Advantage Part C and Medicare Part D Stand-Alone Subject to ACA	Subtotal (Cols. 1 thru 12)	Uninsured Plans	Total (Cols. 13 + 14)
10. General and Administrative (G&A) Expenses:															
10.1 Direct sales salaries and benefits			88,336										88,336	88,336	176,672
10.2 Agents and brokers fees and commissions			1,019,942								4,537		1,024,479	1,651,168	2,675,647
10.3 Other taxes (excluding taxes on Lines 1.5 through 1.7 and Line 14 below)															
10.4 Other general and administrative expenses	5,178,550	3,954,195	3,955,379								460,926	343,427	13,892,477	21,171,282	35,063,759
10.4A Community Benefit Expenditures (informational only)															
10.5 TOTAL General and administrative (Lines 10.1 + 10.2 + 10.3 + 10.4)	5,178,550	3,954,195	5,063,657								465,463	343,427	15,005,292	22,910,786	37,916,078
11. Underwriting Gain/(Loss) (Lines 1.12 - 5.7 - 6.6 - 8.3 - 10.5)	(10,037,857)	(6,762,745)	(6,566,200)								1,618,203	42,146	(21,706,453)	XXX	(72,787,661)
12. Income from fees of uninsured plans	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	30,286,538	30,286,538
13. Net investment and other gain/(loss)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	21,070,818	XXX	21,070,818
14. Federal income taxes (excluding taxes on Line 1.5 above)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	1,170,230	XXX	1,170,230
15. Net gain or (loss) (Lines 11 + 12 + 13 - 14)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	(1,805,865)	XXX	(22,600,535)
16. ICD-10 Implementation Expenses (informational only; already included in general expenses and Line 10.4)															
16A. ICD-10 Implementation Expenses (informational only: already included in Line 10.4)															
OTHER INDICATORS:															
1. Number of Certificates / Policies	10,597	11,365	12,099								2,690	5,396	42,147	47,455	89,602
2. Number of Covered Lives	15,891	19,700	23,210								2,754	5,396	66,951	99,898	166,849
3. Number of Groups	XXX	2,120	46	XXX							2,557	5,396	10,119	120	10,239
4. Member Months	194,939	235,460	279,328								33,769	64,851	808,347	1,206,354	2,014,701

(a) Is run off business reported in Columns 1 through 9 or 12? Yes[ ] No[X]
(b) If yes, show the amount of premiums and claims included: Premiums $..... Claims $.....

Supp216.2 Grand Total

AFFORDABLE CARE ACT (ACA) RECEIPTS, PAYMENTS, RECEIVABLES and PAYABLES

	Current Year		Prior Year	
	Comprehensive Health Coverage		Comprehensive Health Coverage	
	1 Individual Plans	2 Small Group Employer Plans	3 Individual Plans	4 Small Group Employer Plans
ACA Receivables and Payables				
1. Permanent ACA Risk Adjustment Program				
1.0 Premium adjustments receivable/(payable)	13,613,415	8,658,482	22,155,372	694,512
2. Transitional ACA Reinsurance Program				
2.0 Total amounts recoverable for claims (paid & unpaid)		XXX		XXX
3. Temporary ACA Risk Corridors Program				
3.1 Accrued retrospective premium				
3.2 Reserve for rate credits or policy experience refunds				
ACA Receipts and Payments				
4. Permanent ACA Risk Adjustment Program				
4.0 Premium adjustments receipts/(payments)	21,798,428	23,084	21,418,914	260,897
5. Transitional ACA Reinsurance Program				
5.0 Amounts received for claims		XXX		XXX
6. Temporary ACA Risk Corridors Program				
6.1 Retrospective premium received				
6.2 Rate credits or policy experience refunds paid				

SUPPLEMENTAL HEALTH CARE EXHIBIT - PART 2

(To Be Filed By April 1 - Not for Rebate Purposes)

REPORT FOR: 1. CORPORATION: BLUE CROSS AND BLUE SHIELD OF VERMONT 2. LOCATION: Berlin, VT 05602

NAIC Group Code 4745 **BUSINESS IN THE STATE OF Grand Total DURING THE YEAR 2022** **NAIC Company Code 53295**

Supp216.3 Grand Total

		Business Subject to MLR												
		Comprehensive Health Coverage			Mini-Med Plans			Expatriate Plans		9	10	11	12	13
		1	2	3	4	5	6	7	8					
		Individual	Small Group Employer	Large Group Employer	Individual	Small Group Employer	Large Group Employer	Small Group	Large Group	Student Health Plans	Government Business (Excluded by Statute)	Other Health Business	Medicare Advantage Part C and Medicare Part D Stand-Alone Subject to ACA	Total (a)
1.	Health Premiums Earned:													
1.1	Direct premiums written	146,500,867	151,569,127	166,502,175								27,603,393	3,113,920	495,289,482
1.2	Unearned premium prior year													
1.3	Unearned premium current year													
1.4	Change in unearned premium (Lines 1.2 - 1.3)													
1.5	Paid rate credits													
1.6	Reserve for rate credits current year			20,889,938										20,889,938
1.7	Reserve for rate credits prior year			20,411,384										20,411,384
1.8	Change in reserve for rate credits (Lines 1.6 - 1.7)			478,554										478,554
1.9	Premium balances written off													
1.10	Group conversion charges													
1.11	TOTAL Direct premiums earned (Lines 1.1 + 1.4 - 1.9 + 1.10)	146,500,867	151,569,127	166,502,175								27,603,393	3,113,920	495,289,482
1.12	Assumed premiums earned from non-affiliates													
1.13	Net assumed less ceded premiums earned from affiliates											(10,116,375)		(10,116,375)
1.14	Ceded premiums earned to non-affiliates	216,979	261,335	271,025								3,085,395		3,834,734
1.15	Other adjustments due to MLR calculation - Premiums													
1.16	Net premiums earned (Lines 1.11 - 1.5 - 1.8 + 1.12 + 1.13 - 1.14 + 1.15)	146,283,888	151,307,792	165,752,596								14,401,623	3,113,920	480,859,819
2.	Direct Claims Incurred:													
2.1	Paid claims during the year	143,381,854	142,981,146	159,689,582								3,812,405	6,290,881	456,155,868
2.2	Direct claim liability current year	9,966,900	10,824,200	4,204,100								7,586,838	1,644,717	34,226,755
2.3	Direct claim liability prior year	9,822,500	7,972,700	3,146,400								6,252,466	5,782,827	32,976,893
2.4	Direct claim reserves current year													
2.5	Direct claim reserves prior year													
2.6	Direct contract reserves current year													
2.7	Direct contract reserves prior year													
2.8	Paid rate credits													
2.9	Reserve for rate credits current year			20,889,938										20,889,938
2.10	Reserve for rate credits prior year			20,411,384										20,411,384
2.11	Incurred medical incentive pools and bonuses (Lines 2.11a + 2.11b - 2.11c)													
	2.11A Paid medical incentive pools and bonuses current year													
	2.11B Accrued medical incentive pools and bonuses current year													
	2.11C Accrued medical incentive pools and bonuses prior year													
2.12	Net healthcare receivables (Lines 2.12a - 2.12b)	732,866	1,005,361	1,199,345								(6,642,172)	559,295	(3,145,305)
	2.12A Healthcare receivables current year	6,923,645	6,712,722	4,179,388								889,753	3,995,083	22,700,591
	2.12B Healthcare receivables prior year	6,190,779	5,707,361	2,980,043								7,531,925	3,435,788	25,845,896
2.13	Group conversion charge													
2.14	Multi-option coverage blended rate adjustment													
2.15	TOTAL Incurred Claims (Lines 2.1 + 2.2 - 2.3 + 2.4 - 2.5 + 2.6 - 2.7 + 2.8 + 2.9 - 2.10 + 2.11 - 2.12 + 2.13 + 2.14)	142,793,388	144,827,285	160,026,491								11,788,949	1,593,476	461,029,589
2.16	Assumed Incurred Claims from non-affiliates													
2.17	Net Assumed less Ceded Incurred Claims from affiliates											(4,883,292)		(4,883,292)
2.18	Ceded Incurred Claims to non-affiliates	(39,984)	60,780	(21,366)								(8,676,881)		(8,677,451)
2.19	Other Adjustments due to MLR calculation - Claims	1,702,000	1,200,000	264,000								(4,064,000)	389,000	(509,000)
2.20	Net Incurred Claims (Lines 2.15 - 2.8 - 2.9 + 2.10 + 2.16 + 2.17 - 2.18 + 2.19)	144,535,372	145,966,505	159,833,303								11,518,538	1,982,476	463,836,194
3.	Fraud and Abuse Recoveries that Reduced PAID Claims in Line 2.1 above (informational only)													

(a) Column 13, Line 1.1 includes direct written premium of $..... for stand-alone dental and $..... for stand-alone vision policies.

SUPPLEMENTAL HEALTH CARE EXHIBIT - PART 3

(To Be Filed By April 1 - Not for Rebate Purposes)

REPORT FOR: 1. CORPORATION: BLUE CROSS AND BLUE SHIELD OF VERMONT 2. LOCATION: Berlin, VT 05602

NAIC Group Code 4745 BUSINESS IN THE STATE OF Grand Total DURING THE YEAR 2022 NAIC Company Code 53295

Supp216.4 Grand Total

All Expenses		Improving Health Care Quality Expenses						Claims Adjustment Expenses		9	10
		1 Improve Health Outcomes	2 Activities to Prevent Hospital Readmissions	3 Improve Patient Safety and Reduce Medical Errors	4 Wellness & Health Promotion Activities	5 HIT Expenses	6 Total (1 to 5)	7 Cost Containment Expenses	8 Other Claims Adjustment Expenses	General Administrative Expenses	Total Expenses (6 to 9)
1.	Individual Comprehensive Coverage Expenses:										
1.1	Salaries (including $..... for affiliated services)	119,709	21,523	8,870	18,818	30,576	199,496	855,624	1,695,238	2,608,096	5,358,454
1.2	Outsourced services	56,053	10,648				66,701		777,505	818,990	1,663,196
1.3	EDP Equipment and Software (incl $..... for affiliated services)	11,928			9,663	17,218	38,809		1,696,763	178,335	1,913,907
1.4	Other Equipment (excluding EDP) (incl $..... for affiliated services)										
1.5	Accreditation and Certification (incl $..... for affiliated services)		XXX	XXX	XXX	XXX					
1.6	Other Expenses (incl $..... for affiliated services)	13,398	12	18	11	62	13,501		1,152,692	1,573,129	2,739,322
1.7	Subtotal before reimbursements and taxes (Lines 1.1 to 1.6)	201,088	32,183	8,888	28,492	47,856	318,507	855,624	5,322,198	5,178,550	11,674,879
1.8	Reimbursements by uninsured plans and fiscal intermediaries										
1.9	Taxes, licenses and fees (in total, for tying purposes)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	1,124,760	1,124,760
1.10	TOTAL (Lines 1.7 to 1.9)	201,088	32,183	8,888	28,492	47,856	318,507	855,624	5,322,198	6,303,310	12,799,639
1.11	TOTAL fraud and abuse detection/recovery expenses included in Column 7 (informational only)										
2.	Small Group Comprehensive Coverage Expenses:										
2.1	Salaries (including $..... for affiliated services)	144,591	25,997	10,714	22,730	36,685	240,717	972,908	2,066,050	2,325,034	5,604,709
2.2	Outsourced services	67,704	12,861				80,565	344,598	895,645	579,283	1,900,091
2.3	EDP Equipment and Software (incl $..... for affiliated services)	14,409			11,671	20,797	46,877		1,799,355	176,742	2,022,974
2.4	Other Equipment (excluding EDP) (incl $..... for affiliated services)										
2.5	Accreditation and Certification (incl $..... for affiliated services)		XXX	XXX	XXX	XXX					
2.6	Other Expenses (incl $..... for affiliated services)	16,181	15	22	14	75	16,307		1,214,700	873,136	2,104,143
2.7	Subtotal before reimbursements and taxes (Lines 2.1 to 2.6)	242,885	38,873	10,736	34,415	57,557	384,466	1,317,506	5,975,750	3,954,195	11,631,917
2.8	Reimbursements by uninsured plans and fiscal intermediaries										
2.9	Taxes, licenses and fees (in total, for tying purposes)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	1,154,783	1,154,783
2.10	TOTAL (Lines 2.7 to 2.9)	242,885	38,873	10,736	34,415	57,557	384,466	1,317,506	5,975,750	5,108,978	12,786,700
2.11	TOTAL fraud and abuse detection/recovery expenses included in Column 7 (informational only)										
3.	Large Group Comprehensive Coverage Expenses:										
3.1	Salaries (including $..... for affiliated services)	223,097	42,392	16,712	29,355	57,762	369,318	906,292	1,997,410	2,545,015	5,818,035
3.2	Outsourced services	76,063	15,257		9,102		100,422	314,407	1,040,200	592,422	2,047,451
3.3	EDP Equipment and Software (incl $..... for affiliated services)	16,976			13,846	24,595	55,417		1,700,284	193,173	1,948,874
3.4	Other Equipment (excluding EDP) (incl $..... for affiliated services)										
3.5	Accreditation and Certification (incl $..... for affiliated services)		XXX	XXX	XXX	XXX					
3.6	Other Expenses (incl $..... for affiliated services)	25,124	18	26	16	89	25,273		925,711	1,733,047	2,684,031
3.7	Subtotal before reimbursements and taxes (Lines 3.1 to 3.6)	341,260	57,667	16,738	52,319	82,446	550,430	1,220,699	5,663,605	5,063,657	12,498,391
3.8	Reimbursements by uninsured plans and fiscal intermediaries										
3.9	Taxes, licenses and fees (in total, for tying purposes)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	649,922	649,922
3.10	TOTAL (Lines 3.7 to 3.9)	341,260	57,667	16,738	52,319	82,446	550,430	1,220,699	5,663,605	5,713,579	13,148,313
3.11	TOTAL fraud and abuse detection/recovery expenses included in Column 7 (informational only)										

SUPPLEMENTAL HEALTH CARE EXHIBIT - PART 3 (Continued)

(To Be Filed By April 1 - Not for Rebate Purposes)

Supp216.5 Grand Total

All Expenses	Improving Health Care Quality Expenses						Claims Adjustment Expenses		9	10
	1 Improve Health Outcomes	2 Activities to Prevent Hospital Readmissions	3 Improve Patient Safety and Reduce Medical Errors	4 Wellness & Health Promotion Activities	5 HIT Expenses	6 Total (1 to 5)	7 Cost Containment Expenses	8 Other Claims Adjustment Expenses	General Administrative Expenses	Total Expenses (6 to 9)
4. Individual Mini-Med Plans Expenses										
4.1 Salaries (including $..... for affiliated services)										
4.2 Outsourced services										
4.3 EDP equipment and software (including $..... for affiliated services)										
4.4 Other equipment (excluding EDP) (including $..... for affiliated services)										
4.5 Accreditation and certification (including $..... for affiliated services)		XXX	XXX	XXX	XXX					
4.6 Other expenses (including $..... for affiliated services)										
4.7 Subtotal before reimbursements and taxes (Lines 4.1 to 4.6)										
4.8 Reimbursements by uninsured plans and fiscal intermediaries										
4.9 Taxes, licenses and fees (in total, for tying purposes)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		
4.10 TOTAL (Lines 4.7 to 4.9)										
4.11 TOTAL fraud and abuse detection/recovery expenses included in Column 7 (informational only)										
5. Small Group Mini-Med Plans Expenses										
5.1 Salaries (including $..... for affiliated services)										
5.2 Outsourced services										
5.3 EDP Equipment and Software (including $..... for affiliated services)										
5.4 Other equipment (excluding EDP) (including $..... for affiliated services)										
5.5 Accreditation and certification (including $..... for affiliated services)		XXX	NONE	X	XXX					
5.6 Other expenses (including $..... for affiliated services)										
5.7 Subtotal before reimbursements and taxes (Lines 5.1 to 5.6)										
5.8 Reimbursements by uninsured plans and fiscal intermediaries										
5.9 Taxes, licenses and fees (in total, for tying purposes)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		
5.10 TOTAL (Lines 5.7 to 5.9)										
5.11 TOTAL fraud and abuse detection/recovery expenses included in Column 7 (informational only)										
6. Large Group Mini-Med Plans Expenses										
6.1 Salaries (including $..... for affiliated services)										
6.2 Outsourced services										
6.3 EDP equipment and software (including $..... for affiliated services)										
6.4 Other equipment (excluding EDP) (including $..... for affiliated services)										
6.5 Accreditation and certification (including $..... for affiliated services)		XXX	XXX	XXX	XXX					
6.6 Other expenses (including $..... for affiliated services)										
6.7 Subtotal before reimbursements and taxes (Lines 6.1 to 6.6)										
6.8 Reimbursements by uninsured plans and fiscal intermediaries										
6.9 Taxes, licenses and fees (in total, for tying purposes)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		
6.10 TOTAL (Lines 6.7 to 6.9)										
6.11 TOTAL fraud and abuse detection/recovery expenses included in Column 7 (informational only)										

SUPPLEMENTAL HEALTH CARE EXHIBIT - PART 3 (Continued)

(To Be Filed By April 1 - Not for Rebate Purposes)

Supp216.6 Grand Total

All Expenses	Improving Health Care Quality Expenses						Claims Adjustment Expenses		9	10
	1 Improve Health Outcomes	2 Activities to Prevent Hospital Readmissions	3 Improve Patient Safety and Reduce Medical Errors	4 Wellness & Health Promotion Activities	5 HIT Expenses	6 Total (1 to 5)	7 Cost Containment Expenses	8 Other Claims Adjustment Expenses	General Administrative Expenses	Total Expenses (Cols. 6 to 9)
7. Small Group Expatriate Plans Expenses										
7.1 Salaries (including $..... for affiliated services)										
7.2 Outsourced services										
7.3 EDP equipment and software (including $..... for affiliated services)										
7.4 Other equipment (excluding EDP) (including $..... for affiliated services)										
7.5 Accreditation and certification (including $..... for affiliated services)		XXX	XXX	XXX	XXX					
7.6 Other expenses (including $..... for affiliated services)										
7.7 Subtotal before reimbursements and taxes (Lines 7.1 to 7.6)										
7.8 Reimbursements by uninsured plans and fiscal intermediaries										
7.9 Taxes, licenses and fees (in total, for tying purposes)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		
7.10 TOTAL (Lines 7.7 to 7.9)										
7.11 TOTAL fraud and abuse detection/recovery expenses included in Column 7 (informational only)										
8. Large Group Expatriate Plans Expenses										
8.1 Salaries (including $..... for affiliated services)										
8.2 Outsourced services										
8.3 EDP equipment and software (including $..... for affiliated services)										
8.4 Other equipment (excluding EDP) (including $..... for affiliated services)										
8.5 Accreditation and certification (including $..... for affiliated services)		XXX	NONE	X	XXX					
8.6 Other expenses (including $..... for affiliated services)										
8.7 Subtotal before reimbursements and taxes (Lines 8.1 to 8.6)										
8.8 Reimbursements by uninsured plans and fiscal intermediaries										
8.9 Taxes, licenses and fees (in total, for tying purposes)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		
8.10 TOTAL (Lines 8.7 to 8.9)										
8.11 TOTAL fraud and abuse detection/recovery expenses included in Column 7 (informational only)										
9. Student Health Plans Expenses										
9.1 Salaries (including $..... for affiliated services)										
9.2 Outsourced services										
9.3 EDP equipment and software (including $..... for affiliated services)										
9.4 Other equipment (excluding EDP) (including $..... for affiliated services)										
9.5 Accreditation and certification (including $..... for affiliated services)		XXX	XXX	XXX	XXX					
9.6 Other expenses (including $..... for affiliated services)										
9.7 Subtotal before reimbursements and taxes (Lines 9.1 to 9.6)										
9.8 Reimbursements by uninsured plans and fiscal intermediaries										
9.9 Taxes, licenses and fees (in total, for tying purposes)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		
9.10 TOTAL (Lines 9.7 to 9.9)										
9.11 TOTAL fraud and abuse detection/recovery expenses included in Column 7 (informational only)										

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SUPPLEMENTAL HEALTH CARE EXHIBIT'S EXPENSE ALLOCATION REPORT

(To Be Filed by April 1)

NAIC Group Code: 4745 NAIC Company Code: 53295

Description of allocation methodology:

The expense allocations utilized in preparing the Supplemental Health Care Exhibit were built from the Plan's previously existing cost allocations used in the completion of the Analysis of Operations by Line of Business (page 7) and the Underwriting & Investment Exhibit - Part 3 (page 14). The existing system already allocated expenses by LOB and between the CAE, CCE, and GAE categories, by expense line and by cost center/department. For purposes of completing the Supplemental Health Care Exhibit, the Plan first identified all incurred QI expenses that were determined to meet the definitions developed by the NAIC. These expenses were allocated between the 5 QI categories by specifically identifying the costs associated with performing the QI activities, by department and by expense line, and aligning them based on our interpretation of the definitions and examples provided for each of the 5 categories in the instructions. As the QI expenses are a subset of the Plan's overall administrative costs, the QI items were allocated by LOB and CAE/CCE/GAE category in proportion to how the applicable expense line within the particular department was allocated in the overall cost accounting system. As the Plan's operations are confined to the State of Vermont, there was no allocation of expenses between states/jurisdictions.

Detailed Description of Quality Improvement Expenses:

1 Expense Type from Part 3	2 New	3 Detailed Description of Expense
Improve Health Outcomes:		
Disease management		Through the Plan and an external vendor, members can access disease management services for specific diseases/conditions, which includes assessment, care planning, coaching/support toward goal achievement and condition self-management, communication and coordination across providers/settings, medicaiton management, benefits/health system navigation, and linkage to community resources. The vendor guarantees a minimum ROI.
Case management / care coordination		The Plan maintains a staff of nurses, mental helath clinicians, pharmacists and physicians who work with members to manage and coordinate their medical and MHSUD care to improve overall health outcomes. These activities include assessment, care planning, coaching/support toward goal achievement, communication and coordination across providers/settings, medicaiton management, benefits/health system navigation across settings, and linkage to community resources.
Pharmacy management		Through an external vendor, BCBSVT works with members and providers to encourage the most appropriate drug usage that will limit potential risk to the member while maximizing the benefit.
NCQA accreditation activities		The Plan is NCQA accredited, and performs many activities related to maintaining its accreditation. These include direct outreach to members and providers, educational initiatives, and review of utilization management and complex case management in accordance with NCQA standards.
Better Beginnings program		The Plan provides a specialized program for pregnant members to support health and wellness through pregnancy and postpartum. The program is open to all members, regardless of pregnancy risk.
Activities to Prevent Hospital Readmission:		
Case management		As part of the overall case management program, the Plan's clinical team actively works with members post discharge support to reduce the likelihood of future readmission.
Improve Patient Safety and Reduce Medical Errors:		
Prospective drug utilization review		Through an external vendor, BCBSVT monitors prescription usage for potential adverse drug interactions, and advises on step therapy treatments.
Medical management review		The Plan's Quality Improvement department reviews data and works with providers on the identification and use of best clinical practices and to encourage evidence based medicine in addressing clinical errors and safety concerns.
Wellness & Health Promotion Activities:		
Worksite wellness assessments		Wellness assessments and biometric screenings are performed at employer worksites.
Public health education events in conjunction with state health department		BCBSVT provides an online wellness platform where individuals can take a wellness assessment and get recommendations on how to improve their health and wellbeing and track progress on wellness-related goals. The Plan sponsors various events in conjunction with state and local health departments in order to encourage healthy lifestyles and physical activity.
HIT Expenses for Health Care Quality Improvements:		
HEDIS reporting		BCBSVT completes various reporting of HEDIS measures for public reporting mandated by VT law.
NCQA accreditation		As part of the NCQA accreditation process, the Plan performs many activities related to reporting and analysis of clinical effectiveness and related measures.