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May 3, 2011

Purchasing Division
2019 Washington Street, East
Post Office Box 50130
Charleston, West Virginia 25305-0130

Re: Response to Request for Information No. INS11012

Dear Ms. Murray:

We appreciate the opportunity to submit our response to Request for Information No. INS11012 – Actuarial and Economic Modeling of West Virginia's Health Insurance Exchange. CCRC Actuaries, LLC (CCRC Actuaries) is highly qualified to perform the requested actuarial services due to our staff's experience and knowledge in performing comprehensive actuarial studies for public and private health insurance programs, our experience in providing actuarial and financial analyses to government entities, and our expertise in governmental and health care issues.

Since our formation in 2000, CCRC Actuaries' focus has been entirely on the actuarial issues in the financing of health care. We have served over 300 clients across the country including CMS, the Department of Defense and the states of Colorado and West Virginia. We are proud of and it is significant in that each of these clients has been previously served by international actuarial consulting firms and has made the decision that CCRC Actuaries will be their actuarial firm. Additionally, we have extensive experience providing testimony to the Executive and Legislative Branches of the State of West Virginia, as well as various Boards and Management Teams.

CCRC Actuaries considers our prior experience and intimate knowledge of the West Virginia Health Plans a valuable asset to the State of West Virginia. No other actuarial firm has the depth of knowledge of the West Virginia health care delivery system and no other actuarial firm has produced a comprehensive actuarial model of the West Virginia health care financing system in 2009 based on each of the State's 1.8 million residents. I would describe our relationship as professional and with trust that has been earned through experience. The experience and competence of the actuarial team led by Dave Bond has effectively analyzed and projected experience for the West Virginia Health Plans for the last twenty years. Our professional services have been provided independently with integrity and diligence, meeting all requirements in terms of insightfulness, quality and timeliness.

CCRC Actuaries has a tremendous commitment and dedication to the health care and insurance industry and has specialized in the area of health care strategic planning for government groups. We appreciate your consideration of CCRC Actuaries and look forward to the opportunity to continue our relationship with the State of West Virginia Health Plans.

Should you have any questions or comments regarding our response, please do not hesitate to contact our offices.

Respectfully,

Dave Bond

Dave Bond, F.S.A., M.A.A.A.
Managing Partner
dave.bond@ccrcactuaries.com

CCRC
Actuaries, LLC

Response to Request for Information No. INS11012

West Virginia Offices of the Insurance Commissioner

Actuarial and Economic Modeling of West Virginia's Health Insurance Exchange

May 3, 2011

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-Resumes of Key Personnel

Contact Information

CCRC Actuaries, LLC

415 Main Street, Reisterstown, Maryland 21136

Dave Bond, F.S.A., M.A.A.A., Managing Partner

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I. INTRODUCTION

Massachusetts and Utah are the two states with existing state exchanges and it is noteworthy that the two states differ fundamentally. The Massachusetts exchange is considered an "active purchaser" model, has a large organization and a sizeable budget. The state's model does not allow all licensed insurers to participate in the exchange. The Utah model, on the other hand, is an "all-comer" model that allows any licensed health insurer to participate. Utah's exchange initiative is much smaller in scope with only two full-time employees and a limited budget. Currently, the Massachusetts state exchange is suffering major cost overruns. Both models welcome the participation of brokers and general agents.

California is broadly attempting to follow the Massachusetts model and has not only implemented legislation to establish and operate a state exchange, but has authorized the creation of a state government authority that supports committees to consider the implementation of a state health insurance exchange. The members of the authority were appointed by then-Governor Arnold Schwarzenegger and members of the state legislature.

The neighboring state of Maryland has just passed legislation that would create a large-scale online health insurance exchange. This public entity will be run by government officials, and will be officially established as a public corporation and an independent unit of State government. In the future, enabling this legislation suggests that the Maryland exchange system could grow so that an online portal could report on insurer information from multiple states, meaning that individuals would have access to a wider selection of coverage for themselves and/or their small businesses.

II. QUESTIONS TO CONSIDER

What is the likely take-up of Exchange coverage among people with incomes between 139% and 400% poverty guidelines?

CCRC Actuaries developed a model of the West Virginia health care financing economy through a project working with the West Virginia Health Care Authority. The model is a cohort model which projects health care expenditures based on demographics including health care expenditures, age and gender, insurance provider and household income. This model included the likelihood that families would purchase or elect coverage, the analysis was based on the affordability of the proposed insurance coverage, as well as the availability of other forms of insurance generally through employers. The decision for families in the future will use the same

criteria as in the past with different choices. The decision will be based on the families' expectation of future health care needs and the ability for the families to finance the various options.

Should the State establish a basic health program for people up to 200% of poverty?

PPACA defines the specific levels of coverage to be offered by the state Exchanges. The minimum level is the Bronze level, which shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 60 percent of the full actuarial value of the benefits provided under the benefit plan. Our interpretation of PPACA requirements is that this is the minimum or basic health program the Exchange must offer, though benefits can be richer under the Silver or Gold or Platinum levels. While the State does have an option to provide a Basic benefit for families under 200% FPL, it is unclear.

How can the Exchange ensure continuity of care for individuals who fluctuate between the Medicaid program and private coverage through the Exchange?

CCRC Actuaries has experience in this issue with respect to families who cross the Medicaid family eligibility at the current level of 35% of the FPL. With the Medicaid expansion increasing Medicaid coverage up to 135% of FPL, the issues will be the same. The Exchange will need to coordinate with providers to assure continuity of care and assist insureds in the transition stages.

Using spreadsheet and micro-simulation consider time, financial resources, personnel, and adaptability of the model for future state modeling needs.

CCRC Actuaries developed a projection model in 2009 for the West Virginia Health Care Authority which has the ability to forecast changes in insurance coverage for the 1.8 million West Virginians. The principle insurance packages are commercial insurers, PEIA, WVRHBT, Medicaid, Medicare, WVCHIP and the uninsured. This model will need to be updated to reflect specific requirements of PPACA and the workings of the Insurance Exchange.

III. ACTUARIAL SERVICES AND ECONOMIC MODELING

In order to design and successfully implement an Exchange, the state must have a clear and comprehensive understanding of its uninsured and underinsured population. Using any existing literature, Federal surveys or data that the State has collected to this point up-date, expand or otherwise enhance this information to support the development of Exchange goals and design of the Exchange.

a) **Explain design, planning, implementation and analysis of all technical and statistical needs in these areas:**

- **Explain open enrollment strategies and what impact of such strategies could have on the insurance market, inside and outside of the exchange;**

In our opinion, there could be significant selection issues in the initial years of the Exchange due to elimination of pre-existing requirements and the question whether non-participation penalties are significant to induce the market to purchase health care through the Exchange. This anti-selection should diminish over time as the Exchange represents a more significant part of the health care financing entity.

- **Analyze Risk Adjustment methodologies and recommend best approaches to comply with state and federal goals;**

Health status based risk adjustment methodologies have been an important tool in the health insurance marketplace since the 1980s. The use of risk adjustment has significant effects on health insurance companies, healthcare providers, consumers and employers. Risk adjustment is a powerful tool in the health insurance marketplace. Risk adjusters allow health insurance programs to measure the morbidity of the members within different groups and pay participating health plans fairly. Risk adjustment is widely used in government programs including Medicare Advantage, state Medicaid and healthcare reform programs. Actuaries typically use models developed by commercial vendors or publicly available models such as CDPS, Medicaid Rx or CMS'HCC models. Concurrent models are usually used to measure morbidity when the data collection and measurement periods are the same, while prospective models are usually used if the estimation period is after the data collection period. The most appropriate model for West Virginia will depend on its use by policy makers.

- **Assess reinsurance options;**

Reinsurance may provide a tool for the Exchange to reduce the variability of initial results; in general this reduction in variability will come at a cost to the State, but a cost that should be considered.

- **Analyze various reforms and the impact such reforms, potential and actual, will likely have on premiums in different markets;**

CCRC Actuaries has developed a projection model in 2009 for the West Virginia Health Care Authority which has the ability to forecast changes in insurance coverage for the 1.8 million West Virginians. This model will need to be updated to reflect changes in the marketplace as mandated by PPACA.

- **Determine what measures should be used to define success;**

Success will ultimately be measured in the reduction of the uninsured and whether premiums have been lowered over the long-term

- **Explain the options regarding the methodologies for standardization and operationalizing the actuarial valuation of different benefit levels in the Exchange in accordance with the state and federal laws;**

The actuary is required to calculate two principle numbers: The actuarial present value of all benefits covered by the program and the actuarial present value of the cost sharing components of the program. Each of the four benefit designs allowed govern how large the latter can be as a percent of the former.

- **Recommend methodologies to standardize and enforce the new medical loss ratio requirement in federal law;**

There has been a great deal of correspondence between the Feds and the industry as represented by the NAIC and the AAA. Dave Bond participated in the initial discussions of the logistical issues represented by PPACA in its MLR requirements. These requirements continue to be a moving target, but the concept of measuring MLR is fairly simple.

- **Assess adverse selection impacts of various legislative and policy decisions.**

Our actuaries have years of experience forecasting and analyzing the consequences of legislative and policy decisions.

- **Model the impact of merging small and non-group markets, including the impact on premiums for individual consumers and for small employers and their workers.**

From a conceptual standpoint the impact on premiums is a simple calculation. It will depend on who is covered in the Exchange and who is not. Clearly, premiums will be going up for most Small Group insureds and premiums will be going down for Individual insureds. The extent will be based on knowledge of current insured statuses and an accurate forecast of future migration.

- **Modeling the impact on premiums and access to coverage of increasing the definition of small group market to include employers with up to 100 employees before 2016 and starting in 2016;**

CCRC Actuaries models can be used to determine the impact. In general, larger small groups have better health insurance premiums due to market considerations. The expansion of the small group definition will help stabilize the market due to the larger numbers of insureds.

- **Make recommendations to ensure that insurers' pooling practices maximize the benefits of shared risk, including positive impacts for consumers on rates.**

Insurer's pooling practices will have to be reviewed to determine the appropriate designs.

- **Model likely behavior in non-group, small group and large group market in response to specified market changes and policy decisions;**

CCRC Actuaries has developed a projection model in 2009 for the West Virginia Health Care Authority which has the ability to forecast changes in insurance coverages for the 1.8 million West Virginians. This model will need to be updated to reflect changes in the marketplace as mandated by PPACA.

- **Model the impact of the self-insured market on the Exchange and recommend various approaches to mitigate adverse impact;**

CCRC Actuaries has developed a projection model in 2009 for the West Virginia Health Care Authority which has the ability to forecast changes in insurance coverages for the 1.8 million West Virginians. This model will need to be updated to reflect changes in the marketplace as mandated by PPACA.

- **Model the cost of state-mandated benefits to assess the financial impact of non-public and public funding insurance coverage for induced terminations (abortions);**

CCRC Actuaries has annually provided fiscal note evaluation for PEIA, WVCHIP and AccessWV to cost out various benefit changes. In addition, we have developed a projection model in 2009 for the West Virginia Health Care Authority which has the ability to forecast changes in insurance coverages for the 1.8 million West Virginians. This model will need to be updated to reflect changes in the marketplace as mandated by PPACA.

- **Discuss the impact of migration between public health, public sector and commercial health insurance plans and programs based on price, tax benefits, benefit and plan designs and the effects on state insurance and tax laws;**

CCRC Actuaries has developed a projection model in 2009 for the West Virginia Health Care Authority which has the ability to forecast changes in insurance coverages for the 1.8 million West Virginians. This model will need to be updated to reflect changes in the marketplace as mandated by PPACA. This model was specifically designed to analyze and project migration between the principal payors of health care in West Virginia under health care reform.

- **Develop methodologies to measure the cost of state-mandated benefits, including estimations of the net costs of mandates (taking into account the effect of savings resulting from coverage and proper delivery of mandated services), marginal costs (taking into account coverage for mandated benefits that insurance plans already provide), and estimations of out-of-pocket costs to consumers if coverage for mandated benefits is not provided;**

CCRC Actuaries has annually provided fiscal note evaluation for PEIA, WVCHIP and AccessWV to cost out various benefit changes. Most recently these analyses included the cost of providing Autistic services under these programs. In addition, we have developed a projection model in 2009 for the West Virginia Health Care Authority which has the ability to forecast changes in insurance coverages for the 1.8 million West Virginians. This model will need to be updated to reflect changes in the marketplace as mandated by PPACA.

- **Analyze the potential benefits or detriments of standardized benefit plans.**

Standardized benefit plans will be easier to understand by consumers who are often misled by health care benefits which have limited actuarial value. Medicare first structured such an approach with 10 standardized Medicare Supplement plans so that insureds could easily make comparative choices. A negative includes the fact that benefits will not be richer than the defined standards.

b) The Exchange must be financially sustainable by January 2015 and the State must determine the best way to meet this requirement. Provide recommendations and analysis on the following:

- **What will the estimated annual costs of exchange operations be, starting in 2015?**

The estimated costs of exchange operations will depend on the extent that West Virginia analyzes, oversees and reports on operations. While PPACA sets certain standards, it is a certainty that there will be variability in each States approach to managing the Exchanges. The costs will include the management team, operations including accounting, audtiting and actuarial functions. One view of administrative expenses is that Medicare and PEIA have comparable administrative loads, averaging 4% of premium costs. The Exchange could ultimately be managing $2-4 billion dollars, assuming 1$ override, the costs would be between $20 million to $40 million of annual costs based on PPACA requirements.

- **Develop and analyze various models for maintaining necessary funding for the exchange starting in 2015, including through assessments on insurers.**

Funding options include premium tax override to health care insurers, to all insurance providers, health care providers or general revenue appropriations. Insurance premiums are somewhat elementary to model as are any potential assessments to health care providers.

c) Provide a qualitative discussion of the existing financial, physical, cultural and other socio-economic barriers for individuals, employers and carriers in West Virginia as a whole and regionally to identify, purchase, enroll and maintain enrollment in health insurance coverage and how these issues may impact the Exchange and the sustainability of the Exchange.

- **Evaluate and discuss the impact of the Exchange on Medicaid, Medicare and other government programs and how to accommodate those impacts.**

The exchange is given the responsibility of identifying and managing membership. Among these responsibilities is identifying which individuals are required to purchase through the exchange and if they

qualify for some level of subsidy. This task can be more challenging in identifying which product options are available for the individual relative to Medicaid, WVCHIP, and PEIA.

Some argue that the Exchange will ultimately result in a leveling of the playing field in terms of provider reimbursement. In 2011, the public programs are heavily subsidized by low reimbursements to providers in comparison to private payers. It would be my expectation that the Exchange will serve to reduce the number of uninsured, assuming that employers and employees can afford the costs.

- **Evaluate and discuss the potential solutions for the financial burden of obtaining health coverage - specifically, how federal subsidies and cost sharing will impact Medicaid, CHIP and other government program eligibles and enrollees.**

Clearly the federal subsidies which are based on the FPL of the family seeking coverage are designed to result in more families making the decision that they can afford health care coverage. Coverage will not be universal, largely due to society issues and individual issues. In 2013, roughly half of WVCHIP, children will move to Medicaid based on the expansion to 135%. Both programs should expect expansion, beyond this initial migration, due to the relatively rich benefit packages of Medicaid and WVCHIP.

IV. CCRC Actuaries, LLC Corporate Experience

CCRC Actuaries was founded by Dave Bond, F.S.A., M.A.A.A. and Brad Paulis in December 2000. Since our formation, our actuaries have worked with a significant number of public and private self-insured health insurance programs. The nucleus of the CCRC Actuaries staff was previously the Baltimore Office for Health Care Actuarial Services of Ernst & Young LLP (Ernst & Young). While at Ernst & Young, the Baltimore office consulted with numerous health care organizations. Ernst & Young subsequently ceased the separate operations of Health Care under Actuarial Services. In addition to the long term care entities which we currently have as clients, we have performed actuarial work for a handful of Federal and State entities, including CMS, the Department of Defense, and the states of West Virginia and Colorado, as well as managed care and health insurance clients. We are proud of and it is significant that each of these clients were previously served by international actuarial consulting firms and have made the decision that CCRC Actuaries will be their actuarial firm.

Currently, CCRC Actuaries has over 300 clients including the following major clients: United Mine Workers of America Health and Retirement Funds (UMWA), the West Virginia Public Employees Insurance Agency (West Virginia PEIA), the West Virginia Retiree Health Benefit Trust (WV RHBT), the West Virginia Children's Health Insurance Program (West Virginia CHIP), The Robert C. Byrd Health Policy Institute, and the West Virginia Department of Insurance - AccessWV. Additionally, CCRC Actuaries is the primary actuary for engagements with the Centers for Medicare & Medicaid Services (CMS) and the Department of Defense (DoD) through a subcontract with Kearney & Company, P.C.

CCRC Actuaries currently staffs eight actuarial consultants and provides the full gamut of health care actuarial services with our focus being long-term care and government programs.

Some of CCRC Actuaries recent self-funded clients include:

West Virginia Public Employees Insurance Agency
Ted Cheatham, Executive Director
304-558-7850 x 52634

Dave Bond of CCRC Actuaries has been the lead actuary for PEIA since 1995, noting that this was originally through an Ernst & Young contract through 2000. From January 2001 to date, CCRC Actuaries has served as the

actuaries for the plan. During the time from 1990 through 2011, the plan has gone from great financial and public perception difficulties to a program that is both financially sound and well thought of by the participants. Additionally, the State of West Virginia was the first state to provide Medicare coverage through the Medicare Advantage Prescription Drug program effective July 1, 2007. CCRC Actuaries assisted the management decision which ultimately resulted in the State of West Virginia saving approximately $140,000,000.

Our actuarial services to PEIA have included financial projections, pricing of benefit options, evaluating the impact of fee schedule changes and contribution level changes, benefit design recommendations, projection of retiree liabilities and options, analysis of a state prescription drug initiative, evaluation of the selection impact and pricing issues of managed care options, claim liability projections and general advice and council to PEIA, the PEIA Finance Board, and the West Virginia Retiree Health Benefit Trust Fund Board (WVRHBT). On an annual basis this includes the development of actuarial assumptions to reflect the degree of demographic differences between the self-funded fee-for-service option and the managed care options. The actuarial value of each managed care plan's benefit design is benchmarked to the PPB and the fee-for-service option. In addition, CCRC Actuaries is annually engaged to analyze the financial viability of managed care entities for PEIA and the WVRHBT. Further, at the request of management, CCRC Actuaries has testified at numerous public hearings and legislative meetings.

CCRC Actuaries is responsible for providing quarterly updates to the Five Year Financial Plan. The Financial Reports include plan revenues and expenses based on projected enrollment, utilization and cost trends observed by the Plan and in the industry, and expected changes in provider reimbursement and benefit design. On an annual basis, CCRC Actuaries performs a detailed medical and prescription drug trend analysis at the beginning of the process of developing the annual revised Financial Plan in December. The medical trend analysis focuses on emerging utilization and unit cost trends for services provided in-state and out-of-state for approximately forty-five categories of Inpatient, Outpatient, Physician and other services. The prescription drug trend analysis focuses on the emerging utilization and unit costs of both established drugs and new products on the market, including specialty drugs. Our analysis assists Management in developing changes in the prescription drug formulary to minimize plan costs while maintaining a highly medically effective formulary.

As part of the assignment, we have developed a methodology that allowed an analytical comparison of a state prescription drug initiative proposal based on PEIA and West Virginia Children's Health Insurance Program (CHIP) experience, including formulary and generic pricing adjustments. It is noteworthy that other participating prescription drug initiative States, represented by international actuarial and accounting firms, ultimately relied

on our projections. Additionally, we identified a miscalculation in the development of managed care employee contribution rates that has resulted in increased revenue to the State of West Virginia of approximately $2.5 million in Fiscal Year 2003.

In 2000, we were engaged as the actuarial consultants for RXIS, a multi-state prescription drug initiative that was led by the State of West Virginia. Most recently we have performed analysis of West Virginia's participation in the CMS RDS program and the MAPD Program.

In developing all actuarial work, the actuaries employ methodologies consistent with the actuarial standards. Claim data is analyzed for validity and credibility is established based on statistical laws of numbers. CCRC Actuaries obtains data from a variety of sources to cross check singular sources of information and cross references claim reports to general ledger information to assure a greater quality.

West Virginia Retiree Health Benefit Trust (RHBT)
Ted Cheatham, Executive Director
304-558-7850 x 52634

The West Virginia Retiree Health Benefit Trust Fund was created by the West Virginia Legislature in 2006 in an effort to pre-fund retiree health care benefits. Prior to the creation of the Trust, retiree health care expenditures and revenues were operated as a separate fund of PEIA. The Trust Fund provides health care coverage to approximately 14,000 Non-Medicare beneficiaries and 38,000 Medicare beneficiaries. CCRC Actuaries was appointed as the plan actuary in 2006 and continues to serve the Board in a consulting capacity.

Our actuarial services to the Trust Fund include analysis of medical and prescription drug claim and capitation data, development of benefit structures, projection of baseline program costs, and financial projections for Medicare and Non-Medicare retirees. Under this contract, CCRC Actuaries has developed GASB 43 and GASB 45 liabilities on multiple occasions as requested by the State based on current benefit structure and alternatives under consideration.

Both before and after the implementation of GASB 43 and 45, CCRC Actuaries has assisted the State in the evaluation of retiree health care liabilities based on the Sick and Annual Leave program and the subsidization of retiree health care. CCRC Actuaries was engaged to develop the Actuarial Accrued Liability (AAL), the Annual Required Contribution (ARC), the Annual Other Postemployment Benefits (OPEB) Cost, and the Net OPEB

Obligation (NOO) for active employee and retiree health care and life insurance liabilities for Other Postemployment Benefits for the State of West Virginia's (the State) defined benefit and defined contribution cost sharing multi-employer plans. OPEB are benefits that are provided to retired employees beyond those provided by their pension plans. The OPEB for the WVRHBT includes subsidies for medical, prescription drug and life insurance benefits. These calculations include the OPEB liability of state agencies, state colleges and universities, West Virginia county school boards and non-state employers. This analysis has been performed in 2006 through 2009 and is currently being developed for 2010.

Governmental Accounting Standards Board (GASB) 43 and 45 address the liabilities associated with the rising cost of health care. Health costs continue to grow faster than national income and, despite research indicating that the employees receive good value for the increased spending; it is questionable whether governments and private employers can continue to finance the current benefit levels. Most recently, CCRC Actuaries has assisted Governor Tomlin and Senator McCabe in exploring multiple alternative scenarios which will result in both adequate funding of the liability at acceptable benefit levels for retirees.

In addition to the retiree health care liability, CCRC Actuaries performed an analysis of the current liability of the Sick and Annual Leave (SAL) Program, a subset of OPEB, offered to public employees of the State as of June 30, 2008. OPEB plans are subject to compliance requirements as described in Statements 43 and 45 of the GASB. The SAL analysis was conducted for employees covered under the State's Public Employees' Retirement System (PERS), Teachers' Retirement System (TRS), Teachers' Defined Contribution Retirement System (TDC), Teachers' Insurance and Annuity Association and College Retirement Equities Fund (TIAA-CREF), County Teachers (Plan C), Great West (Plan G), West Virginia Death, Disability and Retirement Fund (Plan A) and West Virginia State Police Retirement System (Plan B).

In developing all actuarial work, the actuaries employ methodologies consistent with the actuarial standards. Claim data is analyzed for validity and credibility is established based on statistical laws of numbers. CCRC Actuaries obtains data from a variety of sources to cross check singular sources of information and cross references claim reports to general ledger information to assure a greater quality.

West Virginia Children's Health Insurance Program (CHIP)
Sharon Carte, Director
(304) 558-2732

CCRC Actuaries were selected by the West Virginia CHIP management team and the West Virginia CHIP Board to replace the prior provider of actuarial services in 2000. We replaced a large international actuarial firm in providing actuarial services to the West Virginia CHIP program at significant professional fee savings over the prior vender. The Board initially hired us on a temporary basis and subsequently extended our involvement based on our command of the risk issues faced by the program.

Our involvement has included the development of program costs on an incurred basis for state reporting purposes and a cash basis for federal reporting purposes. We have been responsible for monthly claim reserve numbers to be reported to the Board. In addition, we have developed both the quarterly reports to the West Virginia Legislature, as mandated in the enabling act, as well as federal reporting requirements. Our analysis has included the monitoring and reporting of significant trend developments under the medical, dental and prescription drug benefit programs. Additionally, we developed an analysis on health care expenditures comparing Phase II children and Phase III, as well as expenditures by enrollment duration. We quantified the expected savings from both the implementation of a state prescription drug initiative and developed expected savings of the recently introduced three-tier formulary of the prescription drug program administered by Express Scripts.

Most recently we have completed and certified a proposed expansion of the program to CMS. Under this work we developed various benefit designs that resulted in expected costs for the Federal government, the State and the participants based on the request of the Board.

AccessWV / West Virginia Health Insurance Plan
Nancy Malecek, Director
(304) 558-6279 – Extension 1175

Legislation to establish the West Virginia Health Insurance Plan was approved and signed into law on April 2, 2004. The plan largely follows the risk pool model legislation of the National Association of Insurance Commissioners.

The program offers coverage to residents of the state who have been turned down for individual insurance in the private market, or who can only get coverage at rates higher than the plan or who have a recognized chronic illness condition. The program serves as the state's alternative mechanism for portability under the federal Health Insurance Portability and Accountability Act (HIPAA). Under the legislation, the plan also accepts Health Care Tax Credit (HCTC) premium subsidy payments from the federal government for eligible trade

displaced workers and Pension Benefit Guarantee Corporation recipients. Funding to cover plan deficits, beyond what will be covered by premium income, is covered by an assessment of hospitals.

Organization of the program is overseen by the West Virginia Insurance Commission. The program became operational in July 2005 and currently covers approximately 900 individuals. CCRC Actuaries was engaged to develop all benefit design considerations, develop the standard risk rate, and to develop financial projections to assist the Access WV Board. On a semi-annual basis CCRC Actuaries performs a market assessment analysis to determine what percent of the Individual Health Market its premiums represent. In addition, we produce quarterly reports that include results of the current fiscal year as well as a five-year projection.

Recently, CCRC Actuaries was engaged by the West Virginia Insurance Commissioner to consult on the State's development of the temporary high risk pool under the Patient Protection and Affordable Care Act. CCRC Actuaries projected the anticipated enrollment levels, premium revenue, and claims costs for the West Virginia Qualified High Risk Pool based on the proposed program structure and operating procedures.

United Mine Workers of America Health Plans
Mr. David Richards, Assistant Director
Managed Care Program and Development & Research
(202) 521-2298

CCRC Actuaries has been engaged by UMWA Health and Retirement Funds to provide actuarial services for the Combined Benefit Fund, the 1992 Benefit Fund and the 1993 Benefit Fund since 2001. These services include long-term actuarial projections for each fund, development of pre-funding premiums and, most recently, the impact of the Medicare Modernization Act under each of the available options for each fund.

The Combined Benefit Fund

CCRC Actuaries was engaged to perform the actuarial projection of long-term revenue and expenses for the Combined Benefit Fund. The Combined Benefit Fund provides primary health care benefits to retirees and survivors of UMWA. This fund is financed by several different acts of Congress and by the coal industry. In the fiscal year of 2009, The Combined Benefit Fund has annual revenue of $283 million and approximately 25,000 members. The greatest concentrations of covered insureds are in West Virginia, Kentucky and Pennsylvania.

The operation of the fund is governed by the provisions of the Coal Industry Retiree Health Benefit Act of 1992, and is the result of a merger of the 1950 UMWA Benefit Plan and the 1974 UMWA Benefit Plan.

Covered benefits include primary health care benefits and death benefits. In 2010, health care benefits are projected to be 89% of plan costs, death benefits approximately 1% of plan costs and administrative expenses are approximately 10% of plan costs. Development of health care costs and death benefits required the construction of a demographic based model on the closed group of covered individuals based on expected mortality and morbidity. The Combined Benefit Fund Board required a 10-year projection for its review and adoption of the projection.

1992 Benefit Plan, 1993 Benefit Plan, and Prefunded Plan

The UMWA Health & Retirement Plans engaged CCRC Actuaries in 2010 to perform similar analysis for the 1992 Benefit Plan Fund and the 1993 Benefit Plan Fund. Additionally, CCRC Actuaries began performing work for the Prefunded Benefit Plan in 2008. We have combined these three funds since both have the same Board of Directors, though each fund operates separately.

The 1992 Benefit Plan Fund has approximately 8,700 covered individuals with annual expenditures of approximately $102,000,000. The 1993 Benefit Plan Fund has approximately 8,300 covered individuals with annual expenditures of approximately $85,000,000. The Prefunded Benefit Plan is small plan, with approximately 40 covered individuals with annual expenditures of approximately $363,000. These engagements include analysis of historical claim expenditures for medical and prescription drugs, analysis of past trends, projections of future trends and demographic transfers into and out of each program.

West Virginia Affordable Insurance Workgroup Institute for Health Policy Research
Thomas Heywood
(304) 347-1702

In 2002, the State of West Virginia Planning Grant began to study individual's motivations in purchasing health insurance, with the ultimate goal of developing health care products that appeal to these motivations. The State Planning Grant had completed surveys, focus groups and reviewed work of other states to help with strategies to reduce the number of uninsured. The group consisted of over 120 members with input from the healthcare system, business, industry, consumers and lawmakers.

Original recommendations were compiled in October 2003 and the goal of the WVAIW was to cover 50% of uninsured adults' ages 19 to 64 within five years, which was approximately 120,000 people. Two primary benefit packages were initially developed to provide the coverage to the uninsured. The Individual Health Access plan was similar to an Arkansas package and provides limited numbers of hospital stays, outpatient visits and prescriptions. The Adult Basic Package was developed to be offered to employers with 2 to 50 employees. CCRC Actuaries, based on these recommendations, developed the product as a major medical plan with a relatively low annual benefit amount.

The West Virginia Affordable Insurance Workgroup reconvened under the direction of Governor Joe Manchin in 2005. The Workgroup was co-chaired by Tom Heywood and Sonia Chambers and included a cross-section of the West Virginia health care economy including hospitals, physicians, private and governmental insurers and other professionals. The Workgroup proposed various insurance mechanisms to provide health care coverage including clinic models, self-insurance, group and individual models. Several of the initiatives were introduced in the marketplace. For you reference, we have included a copy of the Affordable Insurance Workgroup's Report and Recommendations.

West Virginia Health Care Authority
Sonia Chambers, Chair of the Board
(304) 558-7000 ext. 214

Under direction from the West Virginia Health Care Authority the State initiated the development of a financial model to facilitate the redesign of financing health care in West Virginia. This study analyzed the impact that various proposals will have on employers, employees, the uninsured, private and public payors, and providers.

The model will provide projections for the cost of implementing several cost containment measures and the range of potential future cost savings from wellness initiatives, such as statewide patient-centered medical homes, e-prescribing pilot, electronic medical records pilot, assessment of the cost effectiveness and appropriate utilization of technology and procedures, budgeting process, implementation of preventive services, initiative to promote personal health responsibility, and initiative to promote end-of-life care.

In addition, the model will provide projections of the cost to extend health insurance under various options, such as a Medicaid expansion, company and individual insurance mandates, and increasing Medicaid reimbursement

rates to match Medicare reimbursement rates. These projections will include the number of uninsured who will be covered and the cost to the government, employers and/or individuals.

West Virginians for Affordable Health Care
Perry Bryant, Executive Director
(304) 344-1673

West Virginians for Affordable Health Care is a tax-exempt, nonprofit organization under IRC 501(c)(4) organized in November, 2005 by a diverse group of individuals concerned about the rising cost of health care and health care insurance coverage. CCRC Actuaries developed a report that analyzed the projected costs and savings of implementing various health care options. This report was ultimately published by national news services, including the Washington Post, New York Times and USA Today.

IV. STATE AND REGIONAL HEALTH CARE MARKETS

We can assert with great confidence that no other actuarial firm has a better understanding of the West Virginia health care environment than CCRC Actuaries. CCRC Actuaries has been the primary health actuary for West Virginia's government payers, and has completed additional projects for the multiple entities. In 2009, CCRC Actuaries completed a comprehensive actuarial study on West Virginia's health care financing for the West Virginia Health Care Authority and West Virginians for Affordable Health Care. This study included an examination of the then current system, and various potential transformations of the system. The potential transformations included expansion of Medicaid eligibility for adults, "pay or play" insurance mandates for individuals and employers, implementation of a medical home initiative, e-prescribing expansion, and the development and improvement of health information technology. Implementation costs and claim reduction estimates were computed for PEIA, West Virginia CHIP, Medicaid, Commercially Insured, Uninsured, Medicare and Medicaid Dual Eligibles, and PEIA and Commercial Medicare. CCRC Actuaries also assisted the Department of Health and Human Resources (DHHR) by reviewing the models that DHHR developed to estimate the effect of Medicaid expansion for proposed Senate Bills for health care reform. CCRC Actuaries provided DHHR independent estimates and assisted with improving DHHR assumptions and techniques to most accurately reflect the effect the bill would have on Medicaid expenditures and enrollment. CCRC Actuaries has also met with the Governor of West Virginia to discuss, among other state health care topics, possible solutions to reducing the OPEB liability of the West Virginia Retiree Health Benefit Trust.

Dave Bond has also served as the Chairperson of the Financial Matters Subcommittee of the State of Maryland Department of Aging's Continuing Care Advisory Committee. As Chairperson, Dave has helped develop effective regulatory structures to ensure financial adequacy of health care systems in the State of Maryland.

In evaluating the regional health care delivery system for West Virginia, it is clear that in general the health care markets of Maryland, Virginia and Pennsylvania are very different from West Virginia due to differences in metropolitan population. On the other hand, similarities can be found in western Maryland, southeastern Ohio, Kentucky and Tennessee.

West Virginia, with a median age of 40.5, has the distinction of being recognized as one of the states with the highest median age in the United States compared to 36.8 nationally. This has increased from 38.9 ten years ago. This has significant ramifications for PEIA, as it has watched the growing number of retirees in the program compared to the number of actives.

According to the CDC, the percent of West Virginia residents with a body mass index (BMI) greater than thirty was less than 15% in 1990. This has increased to over 30% by 2009. Consequently, obesity has contributed to West Virginia having a lower life expectancy for a new born of 75.1, compared to 77.9 nationally. West Virginia's child overweight and obesity rate stands at 35.5%, about 4% higher than the national average.

In combination with its rural character, these three observations define the challenges of financing health care in West Virginia. Whereas other areas and other states have been able to negotiate with providers to change practice protocols and receive substantial unit discounts, West Virginia's rural makeup has hampered the development of these basic managed care precepts. Finally, the fact that retiree coverage is heavily subsidized by active employee premiums makes the growth of retiree coverage more alarming for PEIA management.

The management of PEIA has addressed some of these concerns by eliminating subsidized retiree health benefits for new hires and attempting to restrict the growth of the active employee subsidy for current retirees.

While PEIA management has been understandably concerned about the recent high rates of increase of the cost of providing health care coverage of active employees and retirees, the State Medicaid program has experienced an average 9.8% annual growth from Federal Fiscal Year 1990 to Federal Fiscal Year 2009 according to State Health Facts. In the period of 2007 to 2009, the State Medicaid program experienced lowers trends; however, due to the passage of PPACA, medical and drug trends have started to accelerate, and are expected to continue to

rise due to the expansion of eligibility, restriction of coverage limits, and elimination of pre-existing condition clauses.

Let's take a moment and compare West Virginia health statistics to the United States:

- Age 65+ population is 15.8% in West Virginia and only 12.9% nationally based on 2009 projected census figures.
- Low birth weight babies index is 9.5 for West Virginia in 2007 compared to 8.2 nationally.
- Smokers among adults is 26.5% for West Virginia in 2007 compared to 18.3% nationally.
- The overweight and obesity rate for West Virginia was 65% in 2007 compared to 61% nationally.
- Cancer deaths per 100,000 population was 207.6 for West Virginia in 2007 compared to 178.4 nationally.
- Heart disease deaths per 100,000 population was 229.4 for West Virginia in 2007 compared to 190.9 nationally.
- Diabetes deaths per 100,000 population was 35.5 in West Virginia compared to 22.5 nationally.

What do these statistics mean in terms of utilization of services and mortality?

- Hospital admits of 155 per 1,000 in West Virginia compared to 117 nationally in 2008.
- Emergency unit visits of 652 per 1,000 population in West Virginia compared to 404 nationally in 2008.
- Hospital outpatient visits of 3,645 per 1,000 population in West Virginia compared to 2,050 nationally in 2008.
- The infant death rate of 7.6 per 1,000 of births in West Virginia compared to 6.8 nationally.
- The number of deaths of 952 per 100,000 population in West Virginia compared to 760 per 100,000 population nationally, principally through higher death rates from Heart Disease, Cancer, Stroke, and Diabetes.

These statistics frame the challenge for PEIA, RHBT, CHIP and AccessWV management and their respective Boards in structuring a financial plan for delivering health care services to insureds, active employees, retirees and children. Compounding the health challenges are the relatively limited growth in state revenues due to economic challenges. PEIA and RHBT must balance the expense needs of a program that is growing at 9% each year on average with State of West Virginia revenues that typically grow on average 2% or 3% each year.

West Virginia health delivery systems are relatively limited by geographical areas in the state and bordering out-of-state providers. The rural nature of the state is summarized in that only 55% of West Virginia's population lives in metropolitan areas compared to 80% nationally. There are few areas with multiple and competing hospital systems. In many counties, there are few choices between primary care providers and specialty care providers. The number of physicians and RNs per 100,000 population in West Virginia fall short of national

averages and many counties have access problems. Due to the rural nature of the State and the relatively low number of physicians in the State, many rural physician providers basically have a monopoly where the insured has no other convenient choice for medical care. Subsequently, a substantial number of PEIA and CHIP participants travel across state lines to get health care services. Since PEIA's legislative mandate does not apply to out of state providers, this currently tends to frustrate both the PEIA Finance Board and the CHIP Board's desire to control costs.

While managed care was introduced to the State of West Virginia in January 1995 through PEIA, the industry is relatively immature and has not grown successfully. The rural nature of health care delivery in West Virginia has remained undeveloped compared to other areas of the country. The Henry Kaiser Foundation reported that West Virginia had 38% enrollment in Fee-For-Service plans compared to the South regional average of only 25% and the U.S. national average of 26.8%. Medicaid managed care enrollees as a percent of total enrollment was 44% for West Virginia compared to 57% nationally in 2000. Even this percentage is somewhat overstated since only 39% of West Virginia managed care Medicaid enrollees are enrolled in full risk plans, whereas the number is 82% nationally in 2000. Preliminary analysis of HMO results in West Virginia has indicated that administrative expenses are high and health care utilization exceeds expected benchmarks. There are academic studies which question whether managed care can succeed in rural areas, due to the lack of competition between providers. To date, the verdict is unclear in West Virginia with respect to the future of managed care and currently remains as a potentially critical part of the financial puzzle of PEIA, Medicaid, and perhaps CHIP as well.

A key issue that the CHIP Board and management team remains focused on is its outreach efforts to insure children eligible for the program. The WVU Institute for Health Policy Research recently issued a publication in March 2002, "Health Insurance in West Virginia, The Children's Report" that estimated that 93.4% of all children in West Virginia have health coverage with either private insurance, WV Medicaid or WV CHIP. The study further estimated that there are approximately 23,000 children uninsured in households with estimated incomes at or below 250% of the Federal Poverty Level. The counties with the largest number of insureds are Cabell, Wayne, Wood, Raleigh, Mercer, Monongalia and Berkeley, with each having over 1,000 children uninsured.

State of West Virginia
Department of Administration
Purchasing Division
2019 Washington Street East
Post Office Box 50130
Charleston, WV 25305-0130

Request for Quotation

RFQ NUMBER	PAGE
INS11012	1

ADDRESS CORRESPONDENCE TO ATTENTION OF:
SHELLY MURRAY
304-558-8801

VENDOR
Dave Bond
CCRC Actuaries, LLC
415 Main Street
Reisterstown, MD 21136

SHIP TO
INSURANCE COMMISSION

1124 SMITH STREET
CHARLESTON, WV
25305-0540 304-558-3707

DATE PRINTED	TERMS OF SALE	SHIP VIA	F.O.B.	FREIGHT TERMS
04/20/2011				

BID OPENING DATE: 05/04/2011 BID OPENING TIME 01:30PM

LINE	QUANTITY	UOP	CAT NO	ITEM NUMBER	UNIT PRICE	AMOUNT

---------- ADDENDUM NO. 1 ----------

THIS ADDENDUM IS ISSUED TO ADDRESS THE QUESTIONS RECEIVED PRIOR TO THE QUESTION SUBMISSION DEADLINE OF 04/11/2011.

BID OPENING DATE IS EXTENDED:

FROM: 04/27/2011
TO : 05/04/2011

001 1 LS 220-34

REQUEST FOR INFORMATION

EXHIBIT 10

REQUISITION NO.: INS11012

ADDENDUM ACKNOWLEDGEMENT

I HEREBY ACKNOWLEDGE RECEIPT OF THE FOLLOWING CHECKED ADDENDUM(S) AND HAVE MADE THE NECESSARY REVISIONS TO MY PROPOSAL, PLANS AND/OR SPECIFICATION, ETC.

ADDENDUM NO.'S:

SEE REVERSE SIDE FOR TERMS AND CONDITIONS

SIGNATURE	TELEPHONE	DATE

TLE	FEIN	ADDRESS CHANGES TO BE NOTED ABOVE

WHEN RESPONDING TO RFQ, INSERT NAME AND ADDRESS IN SPACE ABOVE LABELED 'VENDOR'

GENERAL TERMS & CONDITIONS
REQUEST FOR QUOTATION (RFQ) AND REQUEST FOR PROPOSAL (RFP)

1. Awards will be made in the best interest of the State of West Virginia.

2. The State may accept or reject in part, or in whole, any bid.

3. Prior to any award, the apparent successful vendor must be properly registered with the Purchasing Division and have paid the required $125 fee.

4. All services performed or goods delivered under State Purchase Order/Contracts are to be continued for the term of the Purchase Order/Contracts, contingent upon funds being appropriated by the Legislature or otherwise being made available. In the event funds are not appropriated or otherwise available for these services or goods this Purchase Order/Contract becomes void and of no effect after June 30.

5. Payment may only be made after the delivery and acceptance of goods or services.

6. Interest may be paid for late payment in accordance with the ***West Virginia Code***.

7. Vendor preference will be granted upon written request in accordance with the ***West Virginia Code***.

8. The State of West Virginia is exempt from federal and state taxes and will not pay or reimburse such taxes.

9. The Director of Purchasing may cancel any Purchase Order/Contract upon 30 days written notice to the seller.

10. The laws of the State of West Virginia and the ***Legislative Rules*** of the Purchasing Division shall govern the purchasing process.

11. Any reference to automatic renewal is hereby deleted. The Contract may be renewed only upon mutual written agreement of the parties.

12. BANKRUPTCY: In the event the vendor/contractor files for bankruptcy protection, the State may deem this contract null and void, and terminate such contract without further order.

13. HIPAA BUSINESS ASSOCIATE ADDENDUM: The West Virginia State Government HIPAA Business Associate Addendum (BAA), approved by the Attorney General, is available online at **www.state.wv.us/admin/purchase/vrc/hipaa.htm** and is hereby made part of the agreement. Provided that the Agency meets the definition of a Cover Entity (45 CFR §160.103) and will be disclosing Protected Health Information (45 CFR §160.103) to the vendor.

14. CONFIDENTIALITY: The vendor agrees that he or she will not disclose to anyone, directly or indirectly, any such personally identifiable information or other confidential information gained from the agency, unless the individual who is the subject of the information consents to the disclosure in writing or the disclosure is made pursuant to the agency's policies, procedures, and rules. Vendor further agrees to comply with the Confidentiality Policies and Information Security Accountability Requirements, set forth in http://www.state.wv.us/admin/purchase/privacy/noticeConfidentiality.pdf.

15. LICENSING: Vendors must be licensed and in good standing in accordance with any and all state and local laws and requirements by any state or local agency of West Virginia, including, but not limited to, the West Virginia Secretary of State's Office, the West Virginia Tax Department, and the West Virginia Insurance Commission. The vendor must provide all necessary releases to obtain information to enable the director or spending unit to verify that the vendor is licensed and in good standing with the above entities.

16. ANTITRUST: In submitting a bid to any agency for the State of West Virginia, the bidder offers and agrees that if the bid is accepted the bidder will convey, sell, assign or transfer to the State of West Virginia all rights, title and interest in and to all causes of action it may now or hereafter acquire under the antitrust laws of the United States and the State of West Virginia for price fixing and/or unreasonable restraints of trade relating to the particular commodities or services purchased or acquired by the State of West Virginia. Such assignment shall be made and become effective at the time the purchasing agency tenders the initial payment to the bidder.

I certify that this bid is made without prior understanding, agreement, or connection with any corporation, firm, limited liability company, partnership, or person or entity submitting a bid for the same material, supplies, equipment or services and is in all respects fair and without collusion or Fraud. I further certify that I am authorized to sign the certification on behalf of the bidder or this bid.

INSTRUCTIONS TO BIDDERS

1. Use the quotation forms provided by the Purchasing Division. Complete all sections of the quotation form.

2. Items offered must be in compliance with the specifications. Any deviation from the specifications must be clearly indicated by the bidder. Alternates offered by the bidder as **EQUAL** to the specifications must be clearly defined. A bidder offering an alternate should attach complete specifications and literature to the bid. The Purchasing Division may waive minor deviations to specifications.

3. Unit prices shall prevail in case of discrepancy. All quotations are considered F.O.B. destination unless alternate shipping terms are clearly identified in the quotation.

4. All quotations must be delivered by the bidder to the office listed below prior to the date and time of the bid opening. Failure of the bidder to deliver the quotations on time will result in bid disqualifications: Department of Administration, Purchasing Division, 2019 Washington Street East, P.O. Box 50130, Charleston, WV 25305-0130

5. Communication during the solicitation, bid, evaluation or award periods, except through the Purchasing Division, is strictly prohibited (W.Va. C.S.R. §148-1-6.6).

State of West Virginia
Department of Administration
Purchasing Division
2019 Washington Street East
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Charleston, WV 25305-0130

Request for Quotation

RFQ NUMBER	PAGE
INS11012	2

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VENDOR
RFQ COPY
TYPE NAME/ADDRESS HERE

SHIP TO
INSURANCE COMMISSION

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CHARLESTON, WV
25305-0540 304-558-3707

DATE PRINTED	TERMS OF SALE	SHIP VIA	F.O.B.	FREIGHT TERMS
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BID OPENING DATE: 05/04/2011 BID OPENING TIME 01:30PM

LINE	QUANTITY	UOP	CAT. NO.	ITEM NUMBER	UNIT PRICE	AMOUNT

NO. 1 ..✓..

NO. 2 .....

NO. 3 .....

NO. 4 .....

NO. 5 .....

I UNDERSTAND THAT FAILURE TO CONFIRM THE RECEIPT OF THE ADDENDUM(S) MAY BE CAUSE FOR REJECTION OF BIDS.

VENDOR MUST CLEARLY UNDERSTAND THAT ANY VERBAL REPRESENTATION MADE OR ASSUMED TO BE MADE DURING ANY ORAL DISCUSSION HELD BETWEEN VENDOR'S REPRESENTATIVES AND ANY STATE PERSONNEL IS NOT BINDING. ONLY THE INFORMATION ISSUED IN WRITING AND ADDED TO THE SPECIFICATIONS BY AN OFFICIAL ADDENDUM IS BINDING.

Eugene Davis Board Jr.
SIGNATURE

CCRC ACTUARIES, LLC
COMPANY

4-29-2011
DATE

NOTE: THIS ADDENDUM ACKNOWLEDGEMENT SHOULD BE SUBMITTED WITH THE BID.

---------- END OF ADDENDUM NO. 1 ----------

SEE REVERSE SIDE FOR TERMS AND CONDITIONS

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TITLE	FEIN	ADDRESS CHANGES TO BE NOTED ABOVE

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I certify that this bid is made without prior understanding, agreement, or connection with any corporation, firm, limited liability company, partnership, or person or entity submitting a bid for the same material, supplies, equipment or services and is in all respects fair and without collusion or Fraud. I further certify that I am authorized to sign the certification on behalf of the bidder or this bid.

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RFI # INS11012

Addendum #1

1. Page 3, Section 1.1 - In the event the State elects to proceed with a solicitation based on the RFI responses; would only those respondents to the RFI be eligible for subsequent solicitations?

   Answer: No. However, submissions will be used in crafting subsequent solicitations for baseline research.

2. Page 4, Section 1.4 - Are there any current reports or papers (e.g., results/findings) available to prospective RFI respondents in advance of the RFI response submission deadline? If so, where can the information be found?

   Answer: The OIC has made available to the public a number of Exchange research documents. These documents can be found at http://www.wvinsurance.gov/healthcareexchange/HealthCareExchange.aspx

3. Page 5, Section 1.4.2 - Are there any current reports or papers (e.g., results/findings) available to prospective RFI respondents in advance of the RFI response submission deadline? If so, where can the information be found?

   Answer: http://www.wvinsurance.gov/healthcareexchange/HealthCareExchange.aspx

4. Does the RFQ require a detailed response to all the questions in sections 1.4.3 and 1.4.4? Or are those questions more of sample of issues that will need to be addressed in a future RFP and are being shown here for informational purposes?

   Answer: This is a Request for Information or RFI, not a Request for Quotation or RFQ. Section 1.4.3 and 1.4.4 are areas that need to be addressed in determining how best to fulfill the new Patent Protection and Affordable Care Act requirements. These questions represent the current issues identified for further research and we ask that vendors respond to all questions if possible.

5. The RFQ is a little sketchy as to its purpose. Can you be a bit more explicit regarding the goals of this RFQ?

   Answer: This is a Request for Information or RFI, not a Request for Quotation or RFQ. The purpose of this Request for Information (RFI) is to determine the focus, structure, and content of future baseline research procurements.

6. Will the State be facilitating face-to-face meetings with potential vendors prior to releasing an RFP? There would be beneficial one on one communication regarding the solution capabilities that cannot be conveyed in an RFI response.

   Answer: This is not envisioned at this time. Vendors should attempt to convey strategies for baseline research methods/solutions that are both reflected and not reflected in this RFI.

7. Will the responding vendors be able to mark certain areas of the RFI response confidential?

   Answer: All documents submitted to the State Purchasing Division related to purchase orders or contracts are considered public records. All bids, proposals, or offers submitted by Vendors shall become public information and are available for inspection during normal official business hours in the Purchasing Division Records and Distribution center after the bid opening. However, the only exemptions to disclosure of information are listed in *West Virginia Code* §29B-1-4. Any information considered a trade secret must be separated from the Vendor submission and clearly labeled as such. Primarily, only trade secrets, as submitted by a bidder, are exempt from public disclosure. The submission of any information to the State by a Vendor puts the risk of disclosure on the Vendor. The State does not guarantee non-disclosure of any information to the public.

8. Will this RFI response and the subsequent RFP response preclude the responding vendors from any other future work with the State?

   Answer: No. RFI respondents are encouraged to apply for future baseline research procurements.

9. Is the State considering allowing Medicaid eligible residents to enroll through the Exchange?

Answer: No option is being ruled out at this time.

10. Is Exchange governance to be addressed as part of this project?

Answer: West Virginia's Exchange governance was outlined in State Code via SB 408, which passed on March 12, 2011.

11. Does the scope of the project include the role of the producer (broker) in the Exchange?

Answer: Yes. Researching the role of the insurance producer is a fundamental research component of this project.

12. Is there or will there be data available as to numbers of insured, uninsured or underinsured individuals or small groups at some point, such as 12-31-2010?

Answer: As part of future baseline research procurements, basic market research data as those listed in this question need to be answered. Where data already exists on basic market research questions, the information needs to be evaluated and verified where appropriate.

13. Does the state have data available as to income distributions of residents versus the various percents of the FPL?

Answer: Use the best and most relevant data available from the best and most relevant resources with justification regarding your findings in relation to the data and resources selected.

14. Does the state have data available as to levels and types of insurance coverage for small employers?

Answer: Same as #13.

15. Will the state provide data as to residents covered under Medicaid, Medicare and public sector or public employee plans? For the public sector, what is the level of coverage? Are other public entities covered with the state employee plan?

Answer: Such data does exist. All baseline research information needs to be evaluated and where appropriate, verified.

16. Is data available for the state as to distribution of physicians and hospitals by state regions on a per capita basis?

    Answer: Such data exists in various forms but all baseline research information needs to be evaluated and where appropriate, verified.

17. How many health insurance companies, HMOs currently operate within the state? What is the enrollment for each company?

    Answer: Same as #13

18. Does the state have data available as to number of employers who are self insured in the state? By region? By group size?

    Answer: Same as #13.

DAVE BOND, F.S.A., M.A.A.A.
Managing Partner
dave.bond@ccrcactuaries.com

EDUCATION/CERTIFICATION

B.S., Mathematics, Temple University 1980
Fellow of the Society of Actuaries 1991
Member of the American Academy of Actuaries 1985

EXPERIENCE SUMMARY

Mr. Bond is the Managing Partner of CCRC Actuaries, LLC. He has over thirty years of experience in actuarial issues in the self-funded health and the commercial health insurance industries. His experience has been primarily in the actuarial area and encompasses a broad range of specialized skills. He has directed the product development section of an Actuarial Department with responsibilities, which included all rate filings and underwriting decisions. He has specialized in health care strategic planning for Continuing Care Retirement Communities ("CCRCs"), employers, and government groups, the product development and financial reporting for both group and individual lines of insurance, in actuarial issues relating to Long Term Care ("LTC") and CCRCs, as well as the product development, financial reporting, and underwriting of insurance operations.

Mr. Bond's Society of Actuary activities include: Participation in the American Academy of Actuaries response to the Health Care Reform Act, Chairperson of the Financial Matters Subcommittee of the State of Maryland Department of Aging's Continuing Care Advisory Committee, Membership in the Financial Advisory Panel for the CARF-CCAC, Membership in the Health Care Reform Examination Committee and the Financial Reporting Examination Committee, Membership in the Managed Care Pricing Examination Committee and Long Term Care Examination Committee, Co-chairing a Medicare Supplement SOA Workshop, Participation in the SOA Long Term Care Experience Committee, Participation in the American Academy of Actuaries Committee on CCRCs, and Editor of the Health Section News publication. Mr. Bond also served as a member of the Financial Advisory Board for the Continuing Care Commission of AAHSA.

Prior to founding CCRC Actuaries, Dave managed and directed the actuarial activities of the Baltimore Office of Ernst & Young and previous to this position directed the group product development and group underwriting activities of an insurance company.

RELEVANT EXPERIENCE

As Managing Partner of CCRC Actuaries, Mr. Bond has primary responsibility for various actuarial functions of several major group carriers. Mr. Bond's experience includes oversight of the following projects:

West Virginia Public Employees Insurance Agency (PEIA). CCRC Actuaries annually receives claim and administrative expense information from participating Managed care organizations for PEIA. Our actuaries review the information for accuracy and reasonableness. We attest to PEIA on the requested MCO capitation level by each coverage tier which includes family, single and member plus children coverages and by type of managed care benefit structure. Mr. Bond has served the State of West Virginia in this capacity for since 1991 under an initial Ernst & Young contact which has continued under a CCRC Actuaries, LLC contract.

ACR Work. Mr. Bond and his staff reviewed the information submitted to CMS for participation as a managed care provider to Medicare eligible individuals. Information was screened for accuracy and for reasonability. MCOs were contacted and requested to send follow-up information as necessary. An analysis was completed by managed care organization that detailed whether CMS should or should not accept the provider as a participant.

Maryland Physicians Care (2006). Mr. Bond and his staff conducted a feasibility study for a provider group to participate in the Medicare Advantage program to cover both medical and prescription drugs to Medicare eligible members.

Providers

- Assisted a PHO in evaluating its experience under a capitated arrangement.
- Provided hospitals and physician groups with assistance in evaluating a global capitation proposal and construction of appropriate risk absorption models.
- Developed a risk analysis model for a PHO capitated contract.
- Performed projections of physician practice income streams under a capitated contract.

HMOs

- Conducted a review of budget and utilization levels.
- Audited ACR submissions to HCFA to determine compliance with HCFA regulations.
- Performed projections of future income streams.
- Performed claim liability analysis and prepared statutory opinion.
- Developed rate filings.
- Evaluated capital requirements including comparison to RBC standards.
- Constructed APR filings for Medicare Risk Contracts.

Indemnity (Insurer, Blue Cross/Blue Shield, and Self-funded)

- Audit of ACR submissions to CMS to determine compliance with CMS regulations.
- Evaluated and audited the actuarial liability for the Medicare Eligible Retiree Health Care Fund.
- Evaluated and audited the actuarial liability for Contract Resource Management.
- Performed numerous OPEB calculations as defined by GASB 43 and GASB 45.
- Performed rating review and recommended plan design and underwriting modifications.
- Analyzed claim liability and prepared statutory opinions.

- Performed strategic assessment of group division of major carrier.
- Reviewed strategic response to small group reform legislation.
- Providing clients with actuarial support relating to plan design and financial reporting of health care plans.
- Valuation and modeling of blocks of self-insured and insured business.

BRADLEY D. PAULIS

Partner

brad.paulis@ccrcactuaries.com

Brad has over twenty years of experience in providing actuarial consulting services for the health care industry, with an emphasis in Continuing Care Retirement Communities and Long Term Care. Brad is currently pursuing his Associateship to the Society of Actuaries. Brad serves on a volunteer basis on the Board of a local CCRC in Baltimore, and recently was appointed as an alternate member of the Financial Advisory Panel for CARF-CCAC.

Brad's experience includes:

- Audit of ACR submissions to CMS to determine compliance with CMS regulations.
- Evaluated and audited the actuarial liability for the Medicare Eligible Retiree Health Care Fund.
- Evaluated and audited the actuarial liability for Contract Resource Management.
- Performed numerous OPEB calculations as defined by GASB 43 and GASB 45.
- Development of a financial forecasting model for new and existing CCRCs.
- Former member of the financial review committee for CCRCs for the State of Maryland.
- Development of a resident data collection system, which tracks resident movement in a CCRC through various levels of care.
- Development of a computer program, which provides a demographic analysis from the data collection system.
- Development of a computer program, which assists CCRCs in evaluating the financial risk of prospective residents.
- Providing state agencies with assistance in evaluating feasibility submissions for new and expanding CCRCs.
- Testing the adequacy of entrance and monthly fees for new and existing CCRCs.
- Long-term care insurance product development and analysis.
- Providing actuarial consulting services to over 300 communities.

CHRISTOPHER BORCIK, A.S.A., M.A.A.A.
Senior Actuarial Consultant
chris.borcik@ccrcactuaries.com

Chris has over six years of experience in providing actuarial consulting services for the health care industry, with an emphasis in Continuing Care Retirement Communities and Long Term Care. Chris is an Associate of the Society of Actuaries and a Member of the American Academy of Actuaries. Chris is currently pursuing his Fellowship to the Society of Actuaries. Chris graduated Magna Cum Laude from Gettysburg College with a Bachelor of Arts in Mathematics.

Mr. Borcik's experience includes:

- Audit of ACR submissions to CMS to determine compliance with CMS regulations.
- Evaluated and audited the actuarial liability for the Medicare Eligible Retiree Health Care Fund.
- Evaluated and audited the actuarial liability for Contract Resource Management.
- Performed numerous OPEB calculations as defined by GASB 43 and GASB 45.
- Developed benefit structures for a state high risk pool.
- Development of claim reserves and analysis of product design and evaluating benefit changes for governmental clients.
- Market Area and Pricing Analysis of competitors for CCRCs.
- Development and program design of financial underwriting software to determine if potential residents of a CCRC have sufficient funds.
- Analysis of resident movement in a CCRC through various levels of care. Projecting future population flows including morbidity and mortality.
- Client support for LifeCalc CCRC software program.
- Health Care insurance trend analysis and claim reserve development.
- Providing state agencies with assistance in evaluating feasibility submissions for new and expanding CCRCs.
- Assisting CCRCs in calculating future health care liabilities in compliance with AICPA guidelines.
- Testing the adequacy of entrance and monthly fees for new and existing CCRCs.
- Calculated sample sizes and confidence intervals from Prescription Drug Event data.
- Successful completion of the Society of Actuaries' exams P, FM, MLC, MFE, C, and DP-GH. Exam topics weigh heavily on economics, probability, and statistics.
- Academic studies included intense analysis of Severity and Frequency Models, Construction of Empirical Models, Construction and Selection of Parametric Models, Risk Measures, Ruin Theory, Parametric Models, Credibility, and Simulation.