



State of Vermont
Department of Banking, Insurance,
Securities and Health Care Administration
89 Main Street
Montpelier, VT 05620-3101
www.bishca.state.vt.us

Consumer Assistance Only:
Insurance: 1-800-964-1784
Health Care Admin.: 1-800-631-7788
Securities: 1-877-550-3907

MEMORANDUM

TO: Jim Hester, Chair, Health Care Reform Commission
The Honorable Steven Maier, Chair, House Committee on Health Care
The Honorable Doug Racine, Chair, Senate Committee on Health and Welfare

FROM: Paulette Thabault, Commissioner of the Department of Banking, Insurance, Securities and Health Care Administration (BISHCA)

RE: Health Plan Administrative Cost Report

DATE: December 15, 2009

Pursuant to Act 49, attached is a copy of the Health Plan Administrative Cost Report (December 2009). As instructed in the law, this report is a collaborative effort between BISHCA, The Agency of Human Services, and the Department of Human Resources. The report identifies a common methodology for examining costs for private insurers, entities administering self-insured health plans, and offices or departments in the agency of human services. The report also compares administrative costs across these entities.

Please contact BISHCA at (802) 828-2900 if you have questions regarding this report.



Banking
802-828-3307

Insurance
802-828-3301

Captive Insurance
802-828-3304

Securities
802-828-3420

Health Care Admin.
802-828-2900

STATE OF VERMONT
DEPARTMENT OF BANKING, INSURANCE,
SECURITIES & HEALTH CARE ADMINISTRATION



LEGISLATIVE REPORT
DIVISION OF HEALTH CARE ADMINISTRATION

HEALTH PLAN ADMINISTRATIVE COST REPORT

TO

**THE HOUSE COMMITTEE ON HEALTH CARE, THE SENATE COMMITTEE
ON HEALTH AND WELFARE, AND THE HEALTH CARE REFORM
COMMISSION**

DECEMBER 2009

Department of Banking, Insurance, Securities & Health Care Administration

Table of Contents

	<u>Page</u>
Introduction	3
Executive Summary	5
Considerations Specific to the Makeup of Administrative Costs	9
Reporting Methodologies	11
Comparing Administrative Costs	17
Appendices	24
Appendix A: Act 49 (S.129) of 2009: An act relating to containing health care costs, Section 3: Health Plan Administrative Cost Report	
Appendix B: Annual Statement Definitions of Administrative Costs	
Appendix C: Annual Statement Definitions – Statement of Revenues and Expenses	
Appendix D: Annual Statement Definitions – Underwriting and Investment Exhibit, Analysis of Expenses (Administrative Cost Detail)	
Appendix E: Private Insurance, State Employee Medical Plan, and Medicaid Data	

The Department of Banking, Insurance, Securities & Health Care Administration would like to thank the Vermont Agency of Human Services, the Office of Vermont Health Access, and the Vermont Department of Human Resources for their commitment of time, energy, and intellect in helping prepare this report. We also appreciate the comments from Blue Cross Blue Shield of Vermont, MVP Healthcare, and CIGNA for taking time to review this report under short notice.

Introduction

Act 49 of the 2009 Legislative Session requires the Department of Banking, Insurance, Securities and Health Care Administration (the Department) to examine administrative costs for health insurance plans, the state employee health benefit plan, the Medicaid program, and health care services provided by the Agency of Human Services (AHS).¹

The report will describe the scope of the information reported and delineate key items required to consider when comparing the information. The Appendices provide detailed definitions and schedules fundamental to the report.

Scope and methodology

The data for this report was obtained from three distinct sources. First, the private insurance data was captured through the Annual Statements that are filed with the Department. These reports are developed under a reporting structure defined by the National Association of Insurance Commissioners (NAIC). Information reported is for calendar year 2008. The Department captured information for the three largest private insurers in Vermont since they account for 95% of comprehensive major medical lives covered.²

The companies are Blue Cross and Blue Shield of Vermont (BCBSVT), MVP Health Plan, and Connecticut General Life Insurance (CIGNA). BCBSVT conducts business only in Vermont, and so undergo a more comprehensive solvency review than MVP Health Plan and CIGNA, which are New York and Connecticut based companies respectively.³

¹ See Appendix A for a copy of the applicable language of Act 49.

² Calculated from 2008 Annual Statement Supplement Report (ASSR) data filed with the Department. Only comprehensive major medical lives (see below) included. These insurers may have other lines of business (like Federal or Medicare Supplement) included in other financial data in this report, but the lives associated with that business is not included in this calculation. The BCBSVT data includes The Vermont Health Plan (TVHP), a wholly owned subsidiary of BCBSVT.

Comprehensive major medical lives are defined for ASSR reporting as follows: "These policies include but are not limited to policies that provide indemnity, HMO, PPO, POS or expense based coverage including coverage for hospital, medical and surgical expenses. This category excludes limited benefit plans such as Short Term Medical Insurance, hospital only, medical only, hospital confinement indemnity, surgical, outpatient indemnity, specified disease, intensive care, and organ and tissue transplant coverage as well as any other coverage described in the other categories of this exhibit [Definitions for Completing Annual Statement Supplement for 2008 Accident & Health Lines of Business in Vermont]."

³ Note that MVP Health Plan is different than MVP Health Insurance Company, which administers some of Vermont's Catamount Health business. MVP Health Insurance Company had \$138 million in premiums for the entire company in 2008, of which \$22 million was for business in Vermont (not all of this is Catamount). In contrast, MVP Health Plan (referred to as MVP in this report) had \$923 million in premiums for the entire company, of which \$99 million was Vermont business.

Second, the state employee health plan information was obtained from the Department of Human Resources (DHR). This is also reported for calendar year 2008 and is gathered by the DHR from CIGNA, Express Scripts, and the State of Vermont accounting system.

Costs directly related to the state health care plan include the contract with CIGNA, a separate stop/loss contract (with CIGNA), and staff. Also, operating costs related to the benefit plans include the wellness program and flexible spending plan. CIGNA and Express Scripts provide claims detail as required by their respective contracts.

Indirect costs of state supported services such as payroll, building services, and data processing are charged to the state employee health plan through its operating budget. Large capital costs are typically bonded and do not run through their budget. In addition, the state employee plan differs from private companies as it operates as a non-profit entity with no reserve requirement.

Finally, the Medicaid and Agency of Human Services health care plan information comes from the Office of Vermont Health Access (OVHA). This information is from the 2009 state fiscal year (period ending June 30, 2009).

The Medicaid data has been prepared by OVHA, who were asked to follow the NAIC definitions for claims and administrative costs that are used to define the private insurance data contained in this report. As such, it includes spending for traditional comprehensive major medical services, including drug spending. It excludes spending on nursing homes and long-term care (LTC) services, as well as other non-traditional department health spending within AHS.

Like the state employee plan, indirect costs of state supported services such as payroll, building services, and data processing are charged to OVHA through its operating budget. Large capital costs are typical bonded and not run through their budget. Finally, the Medicaid health plan differs from private companies in that it is operating as a non-profit entity with no reserve requirements.

Preparation of the information included in-depth interviews with the Insurance Division of the Department, DHR, and OVHA. As unique issues emerged from those discussions, the Department compiled the information and used both footnotes and matrices to display how plans might differ. It should be noted that the reporting organizations are dissimilar, all plans are not standard, and the reporting taxonomies differ.

Finally, in arriving at findings, the Department relied on the data and information provided by all parties in the filings and in answers to subsequent information requests. While the Department did not audit the data, the Department did review it for general reasonableness. If there are significant errors or omissions in that data and information, it could affect any of these findings.

Executive Summary

Act 49 of the 2009 Legislative Session requires the Department of Banking, Insurance, Securities and Health Care Administration (the Department) to examine administrative costs for health insurance plans, the state employee health benefit plan, the Medicaid program, and health care services provided by the Agency of Human Services (AHS). It also requires the Department to determine a methodology for calculating and reporting information about administrative costs and to provide a comparison of that information.

The Department met several times with the Office of Vermont Health Access (OVHA) and the Vermont Department of Human Resources (DHR) to discuss issues critical to preparation of the report. The Department has shared a draft with commercial insurers, OVHA, and the DHR. The findings included in this report are being delivered to the Senate Committee on Health and Welfare, the House Committee on Health Care, and the Vermont Health Care Reform Commission in December 2009.

Both opportunities and limitations were identified while preparing this report. Perhaps the most compelling issue was the various reporting taxonomies⁴ that make direct and complete comparisons difficult at best. Even when plans reported in the same manner (such as defined by the National Association of Insurance Commissioners), other considerations had to be addressed when attempting to compare the information.

Nevertheless, the analysis intends to provide a better understanding of how to consider administrative costs and provides a framework that can be used to monitor and analyze those costs over time.

Findings identified during this review include:

1) Reporting issues:

- a. Health care plans have different risk-benefit designs that affect costs. An example of this is fully insured plans vs. self-insured plans. The administrative cost necessary to manage each plan differs.
- b. Much of the information that is described in this report is not readily available and requires substantive program knowledge to gather and record the information correctly.
- c. Administrative costs are different across plans since the scope of functions can be quite different. Eligibility, claims processing, case management, stop/loss costs, marketing, and corporate functions can

⁴ The Concise American Heritage Dictionary defines taxonomy as “the science, laws, or principles of classification,....”

all differ depending on the health care product. Well-defined functions may provide better analysis for comparing costs.

- d. The private insurers, the state employee health plan, and OVHA each report to different entities. This results in costs being defined differently.
- 2) Administrative costs charged in self-funded plans are lower than those incurred in fully insured (risk bearing) plans. This finding is consistent with other research.⁵ This may also be due in part to self-funded plans providing some of the administrative support within its own company infrastructure (staff time, support functions, etc).
- 3) For private insurers⁶:

	Lives	Premiums & Premium Equivalents (millions)	Administrative Cost % of Premiums	Administrative Cost PMPM
BCBSVT Total	160,207	\$661.0	12.3%	\$42.30
MVP Health Plan - Vermont Only	21,090	\$98.9	11.7%	\$45.58
CIGNA - Vermont Only	42,035	\$121.3	N/A	N/A
MVP Health Plan - National Health	218,280	\$922.7	13.0%	\$45.97
CIGNA - National Accident & Health	N/A	\$6,501.5	10.2%	N/A

Notes:

PMPM means per member per month.

State premium tax, if applicable, is not included in administrative costs in this analysis.

Lives are estimated based on member months, except for CIGNA. CIGNA lives are from their Annual Statement Supplement Report (ASSR) comprehensive major medical business reporting.

- a. BCBSVT has higher administrative costs as a percent of premiums than MVP Health Plan but has lower administrative costs per member per month than MVP Health Plan.
- b. BCBSVT and CIGNA have different lines of business, which can affect comparisons of administrative costs and measures to companies with only one line of business.⁷

⁵ Kenneth E. Thorpe, “Costs and Implications of a Single Payer Healthcare Model for the State of Vermont”, prepared for the Vermont Commission on Health Care Reform, August 29, 2006 (revised draft), page 8.

⁶ MVP Health Plan’s Vermont only data in the table does not include MVP Health Insurance Company’s Vermont business. MVP Health Insurance totals \$22 million and is the program where they transact Catamount Health business.

- c. Compared to BCBSVT, which is solely a Vermont company, MVP Health Plan and CIGNA may have administrative efficiencies due to the economies of scale of their national business.
- d. CIGNA’s data is not directly comparable due to limitations in its reported administrative data.

4) For self-funded plans:

	Lives	Premiums & Premium Equivalents (millions)	Administrative Cost % of Premiums	Administrative Cost PMPM
BCBSVT Cost Plus & ASO ⁸	57,814	\$260.3	7.1%	\$26.62
Vermont State Employees Medical Plan	22,638	\$113.8	7.3%	\$30.42

PMPM means per member per month.

Lives are estimated based on member months for BCBSVT Cost Plus and ASO.

The administrative cost PMPM for BCBSVT Cost Plus & ASO is based on the amount charged, not necessarily the cost incurred.

- a. BCBSVT’s self-funded plans (Cost Plus and ASO⁹) are charged administrative cost fees similar to the Vermont State Employees Medical Plan.
- b. Differences in how the self-funded plans are structured can affect the administrative cost measures.
- c. Differences in how administrative costs are reported can affect the administrative cost measures.
- d. Admin costs for self –insured plans

⁷ Examples of different line of business are comprehensive major medical business, Federal employee plans, and Medicare Supplement plans.

⁸ “Cost Plus” includes an uninsured product where the insurer pays the claims and receives reimbursements from the employer group, who is thus self-insured. In this product the employer group bears the underwriting risk and the insurer merely processes claims and administers the plan. The insurer charges the employer group an administrative fee for the services provided. This product is frequently paired with a high deductible “stop/loss” policy issued by the insurer that serves to protect the group by placing a ceiling on how much the employer group will pay.

“ASO” (Administrative Services Only) is an arrangement in which a licensed insurer provides administrative services to an employer’s health benefits plan (such as processing claims), but doesn’t insure the risk of paying benefits to enrollees.

⁹ Ibid.

5) For Medicaid:

	Lives	Premiums & Premium Equivalents (millions)	Administrative Cost % of Premiums	Administrative Cost PMPM
Vermont Medicaid	143,474	\$444.1	8.7%	\$22.37

PMPM means per member per month.
 Lives are estimated based on member months.

- a. Comparisons of administrative costs are difficult due to the unique nature of Medicaid’s programs and the different reporting taxonomies.
- b. Recognizing “a” above, Medicaid’s administrative percent of premiums is higher than self-funded plans and lower than fully insured plans.
- c. Recognizing “a” above, Medicaid’s administrative cost per member per month is lower than both self-funded plans and fully insured plans.
- d. Catamount premium subsidies are not included in the Medicaid traditional health care spending plan. They are included in the “AHS Other” line in the non-traditional AHS health care spending table on page 23.

In summary, the Department identified the opportunities and challenges in establishing a common methodology for evaluating administrative costs of health plans. The Department obtained critical data from the Department’s Insurance Division for the three largest commercial insurance companies in Vermont. This information was collected under NAIC standards and was used as the foundation for much of the comparative work. The AHS health spending and Medicaid plan along with the Department of Human Resources State Employees Medical Plan information was then collected and was reviewed to ensure that a fair comparison could be completed.

The Department has listed its findings that explain the issues that one must consider while using the information to compare various plans, entities, and products. These findings note that whether comparing private insurance plans or government plans, there are unique considerations within each. Although direct and complete comparisons could not be made, the findings highlighted are fair and represent a reasonable approach to assess the administrative costs of the various plans reviewed.

Considerations Specific to the Makeup of Administrative Costs

Defining administrative costs

In order to accurately compare and examine administrative costs for health care plans it is necessary that those costs be clearly defined. This was noted by Abt Associates Inc. in 1993 while preparing a study of health care administrative costs on behalf of the American Medical Association.¹⁰ However, more revealing was that they went on to say that not only has a consistent definition been elusive but that most studies spend very little time on this issue.¹¹

A study by Kenneth Thorpe was one of the first to build a “systemic framework” that could categorize administrative costs.¹² He essentially grouped costs into four functions: 1) transaction related (claims processing, etc.), 2) benefits management (date and reporting, etc.), 3) selling and marketing, and 4) regulatory compliance. Thorpe said, “the range of administrative functions in the U.S. health care system is far broader and more complex than ...the literature would imply.”¹³

Adopting a pre-defined construct does not resolve all the issues when trying to compare administrative costs. For example, numerous difficulties emerge while trying to compare administrative costs across commercial insurance companies, HMOs, and government payers (Medicare and Medicaid). Abt Associates describes some of these difficulties, noting that HMOs have very different administrative costs than those of typical insurance companies.¹⁴ Further, they note that administrative labor costs are often carried out by staff who have other functions to complete.¹⁵ Accurate allocation of these costs is “...essentially an arbitrary exercise...”¹⁶ Even comparing administrative costs only across commercial payers is difficult because all health care plans have numerous different types of products that are not equivalent in administrative complexity.¹⁷ Finally, Thorpe notes that when measuring by the more sophisticated method of valuing “economic costs”, it is not clear what is being compared.¹⁸

The Department reviewed previous reports that have studied these matters and found that the classification of costs is highly subjective. A review of four distinct

¹⁰ American Medical Association, Abt Associates Inc, “Administrative Costs and the Debate about U.S. Health System Reform: A Review of the Literature”, February 1993

¹¹ Ibid

¹² Kenneth E. Thorpe, “Inside the Black Box of Administrative Costs”, Health Affairs, Vol. 11, No. 2:41-55, Summer 1992

¹³ Ibid, page 42

¹⁴ American Medical Association, Abt Associates Inc, “Administrative Costs and the Debate about U.S. Health System Reform: A Review of the Literature”, February 1993, page 4

¹⁵ Ibid, p5

¹⁶ Ibid

¹⁷ Kenneth E. Thorpe, “Inside the Black Box of Administrative Costs”, Health Affairs, Vol. 11, No. 2:41-55, Summer 1992, p. 44

¹⁸ Ibid, p.45

approaches to categorizing administrative costs illustrates that subjectivity, as noted in the chart below.

Functional groupings

NAIC ¹⁹	Kahn study ²⁰	Deloitte Consulting Study ²¹	Thorpe study ²²
Claim adjustment expense and cost containment expenses	Claims and Payment	Claim transactions, commissions, sales marketing, underwriting	Transaction related expenses
			Benefits management
	Sales, marketing, underwriting, credentialing, information systems	Medical management (QA) & advertising and promotion expenses	Selling; marketing expenses
	Utilization, quality review, case (benefit) management		
			Regulatory compliance; eligibility expenses
General administrative expenses	General administrative expenses	Corporate functions, research, Information technology expenses	

As one can see, the independent categories do not easily map to one another and unique functions (such as benefits management) can be isolated due to an author's own perspective. Any option is viable and can be used to compare costs across plans once the functional grouping is defined. But the work to gather the detail and reclassify the costs for the plans requires much additional time and effort.

Also, the commercial insurance companies include both fully insured and self-insured plans. What is problematic is that the administrative costs for the commercial insurance companies is not allocated or reported as to whether it supports fully insured or self-insured plans. Therefore, direct comparisons require analyses that identify the administrative costs more completely.

Another difficulty emerges when categorizing the administrative costs into functional groupings across commercial insurance plans and government programs. Government programs such as Medicaid are much broader in scope when it comes to

¹⁹ "Official NAIC Annual Statement Instructions: Health", for the 2007 reporting year. From Calvin Ferguson, National Association of Insurance Commissioners (NAIC), August 1, 2007.

²⁰ Kahn, et al., "The Cost of Health Insurance Administration in California: Estimates For Insurers, Physicians, and Hospitals", Health Affairs, 24, no. 6 (2005): 1629-1639.
doi: 10.1377/hlthaff.24.6.1629

²¹ Deloitte Consulting LLP report to the Department, September 2007, Section I, Executive Summary.

²² Kenneth E. Thorpe, "Inside the Black Box of Administrative Costs", Health Affairs, Vol. 11, No. 2:41-55, Summer 1992.

providing health care services. As a result, allocating administrative costs requires careful deliberation to provide a fair comparison against commercial health care plans.

Reporting Methodologies

Private Insurance Reporting

In accordance with Title 8 V.S.A. § 3561, all companies transacting insurance business in Vermont must file detailed financial statements with the Department that are prepared in accordance with Statutory Accounting Principles. These Principles are promulgated in the Accounting Practices and Procedures Manual (APPM) and are presented in a uniform format prescribed by the National Association of Insurance Commissioners (NAIC), the organization of insurance regulators from all 50 states, the District of Columbia, and the five U.S. territories.

The APPM provides a set of definitions intending to capture all costs of a given entity and to provide a standard across jurisdictions. Insurance companies are required to report the costs and revenues across their lines of business in a manner that is consistent. Also, insurance companies are operating in a for-profit environment, whereby capital costs are depreciated and reserve requirements are mandated under state statute. Both the reporting standard and the for-profit business model include a reporting structure that differs for the State employee health care plan and the Agency of Human Services and Medicaid health care plan.

The Department performs in depth quarterly financial analysis of Vermont's Domestic entities in order to monitor their risk of insolvency. In addition to routine surveillance, and also in compliance with NAIC standards and Vermont Statute, the Department performs routine examinations of the financial condition of our domestic insurers. Both the analysis and examination functions include monitoring of loss ratios, underwriting results, and administrative expenses as they relate to the company's financial health.

The private insurers' financial reports filed with the Department are called the Annual Statements. Because they are filed under the same reporting standards, this allows for comparisons among insurers and among states using the same definitions. However, despite this common reporting, there are issues with making comparisons among insurers due to whether or not they do business in multiple states, the complex nature of the types of plans and lines of business they offer, and various accounting rules that may affect how they report data, even within the construct of the common NAIC definitions. (See Considerations when Comparing Insurance Companies below.)

The Annual Statements contain revenue, claims, and expense data. Revenue consists primarily of premiums, plus possibly some other relatively minor revenue adjustments. Claims are expenses incurred for providing health care services to covered

individuals.²³ Premiums are designed to cover claims, administrative expenses, other miscellaneous expenses or adjustments, and contributions to a company's surplus.

The common definitions and methodologies in the Annual Statements under Statutory Accounting Principles provide a common taxonomy for beginning to evaluate insurers' administrative expenses. Given these reporting considerations, the Department presents these insurers on the same playing field for comparison purposes in this report. See Appendices B and C for detail.

Administrative costs defined by NAIC

The NAIC reporting format for the Annual Statements breaks down administrative costs into claim adjustment expenses (which include cost containment expenses and other claim adjustment expenses) and general administrative expenses.

Claim adjustment expenses are the transactional level costs associated with the adjustment, recording, and payment of claims. **General administrative expenses** are all other administrative expenses such as rent, commissions, and legal fees. Both types of expenses include salaries, consulting services, travel, etc.

For purposes of this report, **administrative expenses include only claim adjustment expenses and general administrative expenses**, not investment or other miscellaneous expense adjustments such as aggregate write-ins for other income or expenses, change in premium deficiency reserves, federal and foreign income taxes incurred, and Vermont premium tax.

The Annual Statements also provide detail within the above administrative expense categories. Line items include rent, salaries, commissions, legal fees, auditing and other consulting services, marketing, and depreciation as defined in the NAIC reporting instructions. See Appendix D for detail.

Considerations when Comparing Insurance Companies

As previously mentioned, the Annual Statements are based upon common definitions defined by the NAIC. Nevertheless, there are considerations when trying to compare data among Vermont's three largest insurers, the Vermont State Employees Medical Plan, Medicaid, and non-traditional AHS health care spending. The table below highlights these issues.

²³ The private insurers report "incurred claims" in the Annual Statements. In this report, the Vermont State Employee Medical Plan and Medicaid/AHS report "paid claims".

Vermont Reported Data

	Private Insurance			Self-Insured		Vermont Agency of Human Services
	BCBSVT Total	MVP Health Plan (VT Only)	CIGNA (VT Only)	Private BCBSVT Cost Plus & ASO	Government Vermont State Employees Medical Plan	
Vermont based	Yes	No	No	Yes	Yes	Yes
Takes on the risk of claims	Yes (no for Cost Plus & ASO)	Yes	Yes	No	Yes	Yes
Stop/loss included in reported data	Yes	N/A	Yes	Yes	Yes	Yes
Has different lines of health insurance business in VT	Yes	No	Yes	No	No	Yes
Reports different lines of business for VT	Yes	No	No	No	No	By Department
Reports Vermont only administrative costs	Yes	Yes	No	Yes	Yes	Yes
Reports detailed administrative costs for VT	Yes (no for Cost Plus & ASO)	No	No	No	No	By Department only
Reports claims detail for VT	Yes (no for Cost Plus & ASO)	Yes	No	No	Minimal	Yes
Reports Vermont member months	Yes	Yes	In ASSR only	Yes	Reports lives	In some cases
Can have underwriting gain or loss	Yes	Yes	Yes	Yes	No	No
Vermont premium tax assessed	No	No	Yes	No	No	No

* BCBSVT Total includes The Vermont Health Plan (TVHP), Cost Plus & Administrative Services Only (ASO) business.

Annual Statements include detailed financial statements for the entire company's business, but may provide only limited detail by state if that company does business in multiple states. For example, BCBSVT only does business in Vermont so the data available for the entire company reflects only Vermont business. CIGNA, on the other hand, does business in many states so detail is available for their entire national business, but their Vermont-specific data is minimal.

Blue Cross Blue Shield of Vermont (BCBSVT)

Total BCBSVT business includes their fully insured business, The Vermont Health Plan (TVHP), and Cost Plus & Administrative Services Only (ASO) business. This total business was about \$661 million in 2008.

Data reported in the Annual Statement for BCBSVT's fully insured business includes their comprehensive major medical plans, Federal Employees Health Benefit

Plan, Medicare Supplement²⁴, and Other Health lines of business. These different lines of business have different administrative costs as allocated by the insurer. A separate Annual Statement is filed for TVHP, a wholly owned subsidiary of BCBSVT.

Data for BCBSVT's Cost Plus and ASO business is more limited. For example, a detailed administrative cost breakdown is not included in the Cost Plus and ASO data like it is in the Annual Statements.

Due to the lack of availability of data, we have not included BCBSVT's CBA Blue business, a third party administrator (TPA). BCBSVT also has a Blue Card program, a national Blue Cross Blue Shield program that enables members in one BCBS plan to obtain health care services while traveling or living in another BCBS plan's service area. Blue Card fees paid to other BCBS plans are included in BCBSVT's administrative costs reflected in their Annual Statement (about \$3 million in 2008). The Department adjusted for these costs for comparative purposes.

MVP Health Plan

MVP Health Plan Inc. is a New York Health Maintenance Organization (HMO) and files data with the Department in a format similar to insurers who only have Vermont business such as BCBSVT. However, there is not the same level of detail on administrative costs as with BCBSVT because MVP Health Plan does business in multiple states and their Annual Statement aggregates data for the entire company. The Department receives only some data for MVP Health Plan's Vermont business because the State of New York requires the company to file the same data for each state it does business in, but not to the level of detail required for the entire company, which includes many states.

Note that MVP Health Plan is different than MVP Health Insurance Company, which administers some of Vermont's Catamount Health business. MVP Health Insurance Company had \$138 million in premiums for the entire company in 2008, of which \$22 million was for business in Vermont (not all of this is Catamount). In contrast, MVP Health Plan had \$923 million in premiums for the entire company, of which \$99 million was Vermont business.

CIGNA Health Plans

CIGNA is also an out-of-state company and conducts business from Connecticut. The entire company's national accident and health business was over \$6.5 billion in 2008. Vermont's portion of their business was \$121 million.

The Vermont data in the Annual Statement filed with the Department is even less robust than MVP Health Plan because Connecticut does not require that level of detail to be reported by state. For example, the Department receives total revenue data for

²⁴ This coverage supplements Medicare coverage for those over the age of 65. Other private insurance plans may include some retirees and/or those over 65, but data is not available.

CIGNA's Vermont business but no associated administrative cost data. Administrative cost data can be estimated based upon CIGNA's entire national business. However, that data is limited and is not directly comparable to other private insurers because it includes both accident and health insurance lines of business.

Catamount Health

Both BCBSVT and the MVP Health Insurance Company offer Catamount Health, which is an individual health insurance product created for uninsured Vermonters who do not have access to employer (group) insurance and do not qualify for other state subsidized health programs such as the Vermont Health Access Program (VHAP) and Dr. Dynasaur. It includes a comprehensive benefit package that covers primary care, chronic care, acute care, hospital services, and prescription drugs.

Premium subsidies are provided by the state on a sliding scale for individuals with income at or below 300% of the federal poverty level. The cost of the subsidies are reflected in the OVHA expenditure reports and are reflected in the "unique program" area of their health care costs. The actual detail related to enrollment, claims, and other costs are captured by BCBSVT and the MVP Health Insurance Company.

The reader should be aware how the Catamount Plan information is recorded in the report. The administrative costs and revenue for the BCBSVT Catamount Plan are captured in the BCBSVT plan analysis. Since the MVP Health Plan does not administer the Catamount Plan (it is administered by MVP Health Insurance Co.), no Catamount data is included in their data. Finally, the subsidies paid by OVHA for the Catamount Plan are accounted for under AHS Other in the non-traditional AHS health spending data.

Considerations when Comparing Private Insurance Companies to the Vermont State Employees Medical Plan and the Vermont Agency of Human Services Health Spending

There are also considerations when trying to compare private insurance data to the Vermont State Employees Medical Plan, Vermont Medicaid, and non-traditional AHS health care spending.

It is important to note the differences between fully insured plans and self-funded plans. They differ primarily by who assumes the insurance risk.

- In a **fully insured plan**, the employer generally pays a premium to an insurance company based on the number and nature of the policies issued, and the insurance company assumes the risk of providing health coverage for insured events. Premiums can vary across employers based on employer size, employee population characteristics, and health care use. However, employers are charged the same premium for each employee.²⁵

²⁵ Employee Benefit Research Institute, Fast Facts, "Health Plan Differences: Fully-Insured vs. Self-Insured", February 11, 2009, #114. (<http://www.ebri.org/pdf/FFE114.11Feb09.Final.pdf>)

- In a **self-insured plan**, instead of purchasing health insurance from an insurance company and paying the insurer a per-employee premium to bear the risk, the employer acts as its own insurer and retains the risk. In the simplest form, the employer uses the money that it would have paid the insurance company and instead directly pays health care claims to providers. Self-insured plans often contract with an insurance company or other third party administrator (TPA) to administer the plan, but the employer bears the risk associated with offering health benefits.²⁶ Most self-insured plans are accompanied by a stop/loss insurance contract.²⁷

Vermont State Employees Medical Plan

The Vermont State Employees Medical Plan is a self-insured plan administered by CIGNA. The information reported for the State Employee Plan is not included in the other CIGNA data reported under the commercial insurance plans. Being self-funded, the State Plan pays for claims and administrative costs. There is no underwriting gain/loss or profit. This is the same for Medicaid and other AHS departments. However, for both the State Plan and AHS health care spending, there is a relatively small part of the business that has a stop/loss component. This caps the amount of claims to be paid given certain circumstances, thereby capping the risk to the plans under those circumstances. For the State Plan, this stop/loss is included in the administrative costs.

The prescription drug program is administered by Express Scripts. Express Scripts processes employee health care claims and assists in the provision of services related to the plan. The Department of Human Resources collects premiums from employees. Along with the employer share of premiums, the revenues are recorded in the medical internal services fund. This information is reviewed and reported as part of the State of Vermont's Comprehensive Annual Financial Report.²⁸

Medicaid and the Agency of Human Services

Medicaid and non-traditional AHS health spending have their own considerations when comparing administrative costs to other plans in this report. First, Medicaid pays for long-term care, unique program services, and comprehensive medical health care services. In order to examine the question of administrative costs under a common

²⁶ Employee Benefit Research Institute, Fast Facts, "Health Plan Differences: Fully-Insured vs. Self-Insured", February 11, 2009, #114. (<http://www.ebri.org/pdf/FFE114.11Feb09.Final.pdf>)

²⁷ A stop/loss insurance contract provides protection in the event of high cost, unexpected claims by providing either a ceiling or limit to the employer's claim costs, after which the stop/loss insurer covers all or a portion of costs in excess of that level.

²⁸ The Basic Financial Statements were prepared in conformity with generally accepted accounting principles (GAAP) as prescribed by the Governmental Accounting Standards Board (GASB). They contain government-wide statements that present the State's financial activities in a manner similar to that of a private corporation; fund statements that report governmental, proprietary, fiduciary fund financial activity; component unit financial activity; and note disclosures that explain and enhance the basic financial statements. – Letter of Transmittal, James B. Reardon, CPA, Commissioner, December 23, 2008.

methodology, it was first necessary to determine which health care services are comparable to those paid for in other health plans. The Office of Vermont Health Access (OVHA) reviewed their program costs and the information presented in this report reflects their interpretation of health care costs that are typically provided in a commercial insurance product (as defined by NAIC) as well as the respective administrative costs. Included in the administrative costs are claims processing and costs associated with determining eligibility.

Medicaid also has “unique programs” designed to support or enhance existing health care services as part of the global commitment waiver agreement. These programs are included in different departments across AHS and both administrative and program costs have been identified. OVHA determined these costs in accordance with “waiver” reporting requirements and these costs are considered separate and apart from traditional health care costs. Examples include programs such as nursing home care, disproportionate share, Legal Aid, personal care services, and community care services.

Comparing Administrative Costs

There are a few ways to evaluate the relative magnitude of administrative costs for an insurance plan. One method is to simply compare the percent of administrative costs against the overall premiums of the product being sold. Accordingly, if one plan “A” (or plans) shows that administrative costs are 12% of its business, and another plan “B” shows 11%, then all things being equal, plan B is more efficient. This method is used frequently in the insurance industry because it is consistent with other ratios that allow you to analyze all costs as the portion of a given premium dollar. For instance, in health insurance, a “medical loss ratio” is the percent of premium spent on medical expenditures or claims. By combining this loss ratio and the administrative ratio, you have a measure of how much of the original premium dollar remains to contribute to the insurers profitability.

Another method that can add some depth to the analysis of administrative expenses is to compare administrative costs per covered individual, per month (referred to as “per member months”, or PMPM). This is done by dividing administrative expenses by total enrollees or “member months”. This method is used to help convey the relative cost for administrative services to the individual that has to pay premiums. Since plan members are often billed on a monthly basis, the analysis helps the member evaluate costs in real terms.

Analysis of Data

In the following tables, the two industry methods noted above for looking at administrative costs are reflected in the two columns to the right. The other columns in the table show the data behind those calculations, and indicate the scope of the plans by showing financial data and member months.

It is important to note that demographic data can affect comparisons among companies and plans. These include benefit mix, age (such as the number of retirees in a given plan), members' share of costs, gender, and occupations. These variables can affect not only claims, but administrative costs as well.

Findings - Private Insurance Comparison

	Member months	Premiums (premium equivalents, revenues)	Administrative Costs	Administrative cost percent of premiums	Administrative cost per member per month
BCBSVT Total	1,922,487	\$660,980,574	\$81,330,764	12.3%	\$42.30
MVP Health Plan - Vermont Only	253,077	\$98,945,087	\$11,535,023	11.7%	\$45.58
CIGNA - Vermont Only	514,856	\$121,303,715	N/A	N/A	N/A
MVP Health Plan - National Health	2,619,359	\$922,702,540	\$120,410,364	13.0%	\$45.97
CIGNA - National Accident & Health	N/A	\$6,501,545,805	\$663,406,710	10.2%	N/A

Notes:

Administrative costs do not include state premium taxes.

N/A stands for not available based on current Annual Statement reporting.

BCBSVT Total includes their fully insured business, TVHP, Cost Plus, and ASO.

CIGNA's Vermont only member months are from their Annual Statement Supplement Report (ASSR) comprehensive major medical business reporting.

- BCBSVT and MVP Health Plan's Vermont business have administrative costs as a percent of premiums that are within 0.6% of each other.
- The data for CIGNA's Vermont business is limited. However, their national accident and health business has a lower administrative ratio than BCBSVT or MVP Health Plan's Vermont business. This may be due to CIGNA's national business having efficiencies due to economies of scale. Also, the inclusion of their accident insurance business can impact their administrative costs and measures.
- BCBSVT and CIGNA have different lines of business in Vermont, and MVP Health Plan has just one line of business. The different lines of business can have different relative administrative costs, but are aggregated in the table above.

- The Deloitte Consulting report on BCBSVT administrative costs filed with the Department in September 2007 found administrative costs reasonable for the service levels and programs provided by BCBSVT.²⁹
- MVP Health Plan's Vermont business is an HMO, and MVP Health Plan is also an out-of-state company that does not have as detailed administrative expense reporting for Vermont as a company like BCBSVT, which only has Vermont business. Thorpe states, "On average, administrative (non-medical) expenses in HMOs are lower (9.4 percent) relative to the average conventional plan."³⁰ The Department has not been able to determine whether the fact that MVP Health Plan's Vermont business is an HMO would account for this lower administrative percent of premiums.
- Compared to BCBSVT, which is solely a Vermont company, MVP Health Plan and CIGNA may have administrative efficiencies due to the economies of scale of their national business.
- BCBSVT and MVP Health Plan's Vermont business have an administrative PMPM difference of \$3.28, which is a 7.8% difference.

²⁹ The Deloitte Consulting report on BCBSVT administrative costs filed with the Department in September 2007 notes that their administrative costs were higher than comparable industry benchmarks, but that about half of the difference was related to spending towards a major information technology system and offering its Medical Management program to its entire membership, rather than a subset of its enrollment which is more typical of other health plans. Furthermore, the report notes, "When consideration is given to the relatively small size of the BCBSVT membership, as well as other unique aspects of the Vermont marketplace, we conclude that a cost performance that is 9% above the industry mean is reasonable for the service levels and programs provided by BCBSVT." Note that the report is comparing BCBSVT administrative costs to industry benchmarks and not directly to the other large private insurance companies covering Vermonters in this report. Please see the Deloitte report for more information on BCBSVT's administrative costs. – Deloitte Consulting LLP report to the Department, September 2007, Section I, page I-10, I-22.

³⁰ Kenneth E. Thorpe, "Inside the Black Box of Administrative Costs", Health Affairs, Summer 1992; 11(2): page 49.

Self-Insured Comparison

Self-funded plans are products whereby the employer takes the risk for costs in order to have lower premiums. Often, these products include a stop/loss insurance product that provides protection in the event of high cost, unexpected claims by providing either a ceiling or limit to the employers claim costs, after which the stop/loss insurer covers all or a portion of costs in excess of that level.

	Member months	Premiums (premium equivalents, revenues)	Administrative Costs	Administrative Cost % of Premiums	Administrative Cost per Member per Month
BCBSVT Cost Plus & ASO	693,766	\$260,256,986	\$18,470,256	7.1%	\$26.62
Vermont State Employees Medical Plan	271,656	\$113,816,175	\$8,264,678	7.3%	\$30.42
State Plan without \$670K Stop/Loss	271,656	\$113,146,718	\$7,595,221	6.7%	\$27.96
State Plan without \$3.2 million Behavioral Health	271,656	\$110,609,065	\$8,264,678	7.5%	\$30.42

- The BCBSVT Cost Plus & ASO business and the Vermont State Employee Medical Plan are both in the self-insured business. However, one major difference is that BCBSVT is the processor of other companies' self-insured health plans vs. the State Plan, which is roughly equivalent to a company having a self-insured health plan that gets processed by an insurer. For the State, the insurer that processes the Plan is CIGNA (not to be confused with the CIGNA private insurance data discussed separately). Despite this major difference, administrative costs can be compared because both have premiums, claims, and administrative data for their self-insured business.
- The administrative percent of premiums is similar, with 7.1% for BCBSVT and 7.3% for the State Plan.
- BCBSVT charges its average employer groups a lower administrative PMPM than the State Plan by \$3.80.
- The administrative data reported for the State Plan includes close to \$670,000 in stop/loss payments, which is a type of insurance to cap the risk to the plan. Some of these dollars could be considered claims and some could be considered administrative costs. If these dollars were not included in the administrative costs in this analysis, then the State Plan's administrative percent of premiums would be 6.7% and the administrative PMPM would be \$27.96. These adjusted measures may be more comparable to BCBSVT's Cost Plus and ASO business.

- An outside vendor administers the prescription drug plan for the State, and claims and administrative costs for this spending cannot be specifically identified. Therefore, the administrative component of this drug spending is included in claims in this analysis. BCBSVT’s self-funded business accounts for its drug program similarly.
- CIGNA is responsible for the behavioral health component of the State Plan, and has primary liability for the cost of this component of the State Plan. Since this \$3.2 million is primarily an “insured” part of the Plan, comparisons to purely self-insured business should acknowledge that part of the State Plan is insured. BCBSVT’s self-funded business accounts for its behavioral health program similarly.

Vermont Medicaid and Non-traditional AHS Health Care Spending

The Medicaid data in the table below has been categorized to be comparable to the private insurance data defined previously. The data follows the NAIC definitions for claims and administrative costs that were used to define the private insurance data contained in this report. As such, it includes spending for comprehensive major medical services, including drug spending. It excludes spending on nursing homes and long-term care (LTC) services, as well as other non-OVHA departments within AHS, which are included in the Non-traditional AHS Health Spending line below.

	Member months	Premiums (premium equivalents, revenues)	Administrative Costs	Administrative Cost % of premiums	Administrative Cost per Member per Month
Medicaid	1,721,684	\$444,076,333	\$38,505,947	8.7%	\$22.37
Non-traditional AHS Health Spending	N/A	\$775,640,200	\$46,204,088	6.0%	N/A
Total Medicaid & Non-traditional AHS Health Spending	N/A	\$1,219,716,533	\$84,710,035	6.9%	N/A

- Comparisons of administrative costs are difficult due to the unique nature of Medicaid’s programs and the different reporting taxonomies.
- The Medicaid administrative percent of premiums of 8.7% is lower than the private insurers and slightly higher than the self-insured businesses.
- Medicaid’s administrative cost per member per month is lower than both self-funded plans and fully insured plans.

- One difference that Medicaid has compared to the other insurance plans is that dental spending is included in the claims and administrative costs. Due to the lack of detail for dental administrative costs at this time, the Department could not do a direct comparison to other insurers by removing these dental claims and administrative expenses from the analysis.
- The non-traditional AHS health care spending is not directly comparable to the other insurers in this report due to the unique nature of the various AHS departments and programs. It is shown here to aggregate all AHS health care spending for contextual purposes.

The table below summarizes data for non-traditional AHS health care spending. These data are not comparable to more traditional comprehensive major medical data, like shown for Medicaid, due to the unique nature of AHS department program services. Comparisons across different AHS departments for non-traditional health care costs simply will not make sense. For example, AHS Other includes administrative costs that could be allocated to other programs. A much better understanding of existing reporting and accounting taxonomies under global commitment is necessary to understand and compare other AHS department spending.

Non-traditional AHS Health Spending	Premiums (premium equivalents, revenues)	Administrative Costs	Administrative Cost % of premiums
AHS OVHA Nursing Home	\$124,158,905	\$4,797,325	3.9%
AHS OVHA Other Long-Term Care	\$56,974,751	\$2,201,424	3.9%
AHS OVHA Premium Payments (Part B, Catamount, ESI., etc.)	\$60,892,830	\$0	0.0%
AHS OVHA Other (DSH, Clawback, Legal Aid, Transp., PCS, ACCS etc.)	\$105,019,440	\$0	0.0%
AHS Dept. of Mental Health	\$109,083,799	\$3,550,704	3.3%
AHS Dept. of Health Substance Abuse	\$14,371,615	\$1,363,067	9.5%
AHS Dept. of Children & Families	\$37,061,675	\$6,147,845	16.6%
AHS Dept. of Disabilities, Aging, & Independent Living	\$142,804,766	\$6,003,957	4.2%
Dept. of Education	\$39,701,915	\$335,051	0.8%
AHS Other (MCO investments, Dept. of Health, Other AHS Administrative costs)	\$85,570,503	\$21,804,714	25.5%
Total LTC & Other AHS	\$775,640,200	\$46,204,088	6.0%

Member months and administrative cost per member per month are not available for these programs and departments.

Appendix A

Act 49 (S.129) of 2009 An act relating to containing health care costs.

Sec. 3. HEALTH PLAN ADMINISTRATIVE COST REPORT

(a) No later than December 15, 2009, the commissioner of banking, insurance, securities, and health care administration, in collaboration with the secretary of human services and the commissioner of human resources, shall provide a health plan administrative cost report to the health care reform commission, the house committee on health care, and the senate committee on health and welfare.

(b) The report shall:

(1) identify a common methodology based on the current rules for insurer reports to the department of banking, insurance, securities, and health care administration for calculating costs of administering a health plan in order to provide useful comparisons between the administrative costs of:

(A) private insurers;

(B) entities administering self-insured health plans, including the state employees' and retirees' health benefit plans; and

(C) offices or departments in the agency of human services; and

(2) compare administrative costs across the entities in Vermont providing health benefit plans.

Appendix B

Annual Statement Definitions of Administrative Costs

The National Association of Insurance Commissioners (NAIC), the organization of insurance regulators from all 50 states, provides a manual for the accounting and reporting of data from insurance companies in accordance with Statutory Accounting Principles. This Accounting Practices and Procedures Manual (APPM) provides principles and guidelines for consistent accounting and reporting across states and insurance companies. The Annual Statements filed with the Department by the insurance companies follow the accounting practices and principles in the APPM.

APPM Preamble, III, 22.

“This document states the fundamental concepts on which statutory financial accounting and reporting standards are based. These concepts provide a framework to guide the National Association of Insurance Commissioners (“NAIC”) in the continued development and maintenance of statutory accounting principles (“SAP” or “statutory basis”) and, as such, these concepts and principles constitute an accounting basis for the preparation and issuance of statutory financial statements by insurance companies in the absence of state statutes and/or regulations.”³¹

The Annual Statements contain revenue, claims, and expense data. Revenue consists primarily of premiums, plus possibly some other relatively minor revenue adjustments. Claims are expenses incurred for providing health care services to covered individuals. Premiums are designed to cover claims, administrative expenses, and other miscellaneous expenses or adjustments such as a change in premium deficiency reserves. In other words, premiums are expected to contribute sufficient revenues to provide for the following:

1. Claims
2. Administrative expenses (see below)
 - a. Claim adjustment expenses
 - i. Cost containment expenses
 - ii. Other claim adjustment expenses
 - b. General administrative expenses
3. Misc. expenses and adjustments
4. Contribution to a company’s surplus / retained earnings

Note that administrative expenses can be broken down into more detail (see below). Also note that non-operating revenues and expenses are not included above or in this analysis. Non-operating activity includes things such as investment activity.

³¹ NAIC Accounting Practices and Procedures Manual, Volume I, March 2007, Preamble, III, 22, page P-5.

Administrative Expenses

The APPM defines claim adjustment expenses as “those costs expected to be incurred in connection with the adjustment and recording of accident and health claims...”³² These expenses are (1a) either cost containment expenses or (1b) other claim adjustment expenses.

Cost containment expenses are “expenses that actually serve to reduce the number of health services provided or the cost of such services.” These expenses must result in reduced levels of costs or services. Examples are case management activities, utilization review, consumer education relating to health improvement, network access fees and other provider contracting costs, and expenses for internal and external appeals processes.³³

Other claim adjustment expenses are those claim adjustment expenses that do not fall under cost containment. Examples are estimating the amounts of losses and distributing loss payments, maintaining records, general clerical and secretarial costs, office maintenance, occupancy, and utilities costs, supervisory and executive duties, and supplies. These expenses are incurred in connection with the adjustment and recording of accident and health claims.³⁴

General administrative expenses are all other administrative expenses such as rent, commissions, legal fees, etc.

Both claims adjustment expenses and general administrative expenses include categories such as salaries, consulting services, travel, etc. See Appendix F for detailed categories included in the Annual Statements.

³² NAIC Accounting Practices and Procedures Manual, Volume I, March 2007, SSAP No. 85 subparagraph 3, page 85-3.

³³ NAIC Accounting Practices and Procedures Manual, Volume I, March 2007, SSAP No. 85 subparagraph 4a, page 85-3.

³⁴ NAIC Accounting Practices and Procedures Manual, Volume I, March 2007, SSAP No. 85 subparagraph 4b, pages 85-3, 85-4.

APPENDIX C
Annual Statement Definitions

STATEMENT OF REVENUE AND EXPENSES

Report fully accrued revenue and expenses as defined below, for the period. Report uncovered expenses appropriately for medical, hospital and administration. Lines 9 through 13 should be reported gross of withholds and net of applicable coordination of benefits, deductibles, co-payments, risk share, and provider discounts.

Column 1 – Uncovered Expenses

Costs discussed previously in defining uncovered liabilities.

Line 1 – Member Months

Column 2 should equal Exhibit 1, Enrollment by Product Type, Line 7, Column 6.

Line 2 – Net Premium Income (including \$ ____ non-health premium income)

Should equal the total premiums reported in the Underwriting and Investment Exhibit, Part 1, Line 12, Column 4, direct written premiums plus reinsurance assumed less reinsurance ceded.

Written premium is defined as the contractually determined amount charged by the reporting entity to the policyholder for the effective period of the contract based on the expectation of risk, policy benefits, and expenses associated with the coverage provided by the terms of the insurance contract. For health contracts without fixed contract periods, premiums written will be equal to the amount collected during the reporting period plus uncollected premiums at the end of the period less uncollected premiums at the beginning of the period.

Line 3 – Change in Unearned Premium Reserves and Reserve for Rate Credits

Exclude: Reserves relating to uninsured plans and the uninsured portion of partially insured plans.

Line 4 – Fee-for-Service (net of \$ ____ medical expenses)

Include: Revenue recognized by the reporting entity for provision of health services to non-members by reporting entity providers and to members through provision of health services excluded from their prepaid benefit packages. Include in the inside amount, the medical expenses associated with fee-for-service business.

Line 5 – Risk Revenue

Include: Amounts charged by the reporting entity as a provider or intermediary for specified medical services (e.g. full professional, dental, radiology, etc.) provided to the policyholders or members of another insurer or reporting entity.

Unlike premiums that are collected from an employer group or individual member, risk revenue is the prepaid (usually on a capitated basis) payment, made by another insurer or reporting entity to the reporting entity in exchange for services to be provided or offered by such organization.

Line 6 – Aggregate Write-ins for Other Health Care Related Revenues

Enter the total of the write-ins listed in schedule Details of Write-ins Aggregated at Line 6 for Other Health Care Related Revenues.

Line 7 – Aggregate Write-ins for Other Non-health Revenues

Enter the total of the write-ins in schedule Details of Write-ins Aggregate at Line 7 for Other Non-health Revenues.

Line 9 – Hospital/Medical Benefits

Include: Expenses for physician services provided under contractual arrangement to the reporting entity.

Salaries, including fringe benefits, paid to physicians for delivery of medical services. Capitation payments by the reporting entity to physicians for delivery of medical services to reporting entity subscribers.

Fees paid by the reporting entity to physicians on a fee-for-service basis for delivery of medical services to reporting entity subscribers. This includes capitated referrals.

Inpatient hospital costs of routine and ancillary services for reporting entity members while confined to an acute care hospital.

Charges for non-reporting entity physician services provided in a hospital are included in this line item only if included as an undefined portion of charges by a hospital to the reporting entity. (If separately itemized or billed, physician charges should be included in outside referrals, below.)

The cost of utilizing skilled nursing and intermediate care facilities.

Routine hospital service includes regular room and board (including intensive care units, coronary care units, and other special inpatient hospital units), dietary and nursing services, medical surgical supplies, medical social services, and the use of certain equipment and facilities for which the provider does not customarily make a separate charge.

Ancillary services may also include laboratory, radiology, drugs, delivery room, physical therapy services, other special items and services for which charges are customarily made in addition to a routine service charge.

Skilled nursing facilities are primarily engaged in providing skilled nursing care and related services for patients who require medical or nursing care or rehabilitation service.

Intermediate care facilities are for individuals who do not require the degree of care and treatment that a hospital or skilled nursing-care facility provides, but that do require care and services above the level of room and board.

Report gross of reinsurance. Report net of coordination of benefits, co-payments and subrogation.

Exclude: Expenses for medical personnel time devoted to administrative tasks.

Emergency room and out-of-area hospitalization.

All items meeting the definition of Cost Containment Expenses found in SSAP No. 85, Claim Adjustment Expenses, Amendments to SSAP No. 55, Unpaid Claims, Losses and Loss Adjustment Expenses.

- Line 10 – Other Professional Services
- Include: Expenses for other professional providers under contractual arrangement to the reporting entity.
- Salaries, as well as fringe benefits, paid by the reporting entity to non-physician providers licensed, accredited or certified to perform specified health services, consistent with state law, engaged in the delivery of medical services.
- Compensation to personnel engaged in activities in direct support of the provision of medical services. For example, include compensation to pharmacists, dentists, psychologists, optometrists, podiatrists, extenders, nurses, clinical personnel such as ambulance drivers and technicians.
- Exclude: Professional services not meeting this definition. Report these services as administrative expenses. For example, exclude compensation to paraprofessionals, janitors, quality assurance analysts, administrative supervisors, secretaries to medical personnel, and medical record clerks.
- Prescription drugs.
- All items meeting the definition of Cost Containment Expenses found in SSAP No. 85, Claim Adjustment Expenses, and Amendments to SSAP No. 55, Unpaid claims, Losses and Loss Adjustment Expenses.
- Line 11 – Outside Referrals
- Include: Expenses for providers not under arrangement with the reporting entity to provide services, such as consultations, or out-of-network providers.
- Line 12 – Emergency Room and Out-of-Area
- Include: Expenses for other health delivery services including emergency room costs incurred by members for which the reporting entity is responsible and out-of-area service costs for emergency physician and hospital.
- In the event a member is admitted to the health care facility immediately after seeking emergency room service, emergency service expenses are reported in this line, the expenses after admission are reported in the hospital/medical line, provided the member is seeking services in the service area. Out-of-area expenses incurred, whether emergency or hospital, are reported in this line.
- Line 13 – Prescription Drugs
- Include: Expenses for Prescription Drugs and other pharmacy benefits covered by the reporting entity.
- Deduct: Pharmaceutical rebates relating to insured plans.
- Exclude: Prescription drug charges that are included in a hospital billing which should be classified as Hospital/Medical Benefits on Line 9.
- Line 14 – Aggregate Write-ins for Other Hospital and Medical
- Enter the total of the write-ins listed in schedule Details of Write-ins Aggregated at Line 14 for Other Medical and Hospital.

- Line 15 – Incentive Pool, Withhold Adjustments and Bonus Amounts
- This category is for adjusting the full medical expenses reported by means of both debit and credit entries. For example, report physician withholds forfeited to the reporting entity as a credit entry. Report amounts incurred due to an arrangement whereby the reporting entity agrees to utilization savings with a provider as a debit entry.
- Line 17 – Net Reinsurance Recoveries
- Amounts recovered and recoverable from reinsurers on paid losses.
- Include: Amounts related to assumed and ceded business.
- Line 19 – Non-Health Claims (net)
- Include: Claims for life or property/casualty insurance, net of reinsurance.
- Line 20 – Claims Adjustment Expenses, Including \$___ Cost Containment Expenses
- All expenses incurred in connection with the recording, adjustment and settlement of claims. This includes the total of the expense classification “Other Claim Adjustment Expenses” and all “Cost Containment Expenses” in the Underwriting and Investment Exhibit, Part 3, Analysis of Expenses.
- Cost Containment Expenses and Other Claim Adjustment Expenses have been defined in SSAP No. 85. Refer to SSAP No. 85 for accounting guidance.
- Prior to 2004, companies might have classified certain expenses, such as network access fees and consumer education costs, within General Administrative Expenses. In accordance with SSAP No. 85, these amounts are now considered Cost Containment Expenses and should be classified as such.
- Line 21 – General Administrative Expenses
- Equals the amount reported in Underwriting and Investment Exhibit, Part 3, Column 3, Line 26. Refer to SSAP No. 70, Allocation of Expenses, for accounting guidance.
- Exclude: All expenses related to cost containment activities in accordance with SSAP No 85.
- Line 22 – Increase in Reserves for Life and Accident and Health Contracts (including \$___ increase in reserves for life only)
- Include: Increase in policy reserves.
- Change in premium deficiency reserve.
- Line 25 – Net Investment Income Earned
- Include: Investment income earned from all forms of investments, including investment fees earned relating to uninsured plans.
- Dividends from Subsidiary Controlled and Affiliated (SCA) entities, joint ventures, partnerships and limited liability companies, less investment expenses, taxes (excluding federal income taxes), licenses, fees, depreciation on real estate and other invested assets.
- Investment income credited to uninsured plans.
- Interest on borrowed money.

Exclude: Capital gains and losses on investments.
Equity in undistributed income or loss of SCA entities, joint ventures, partnerships and limited liability companies.

Line 26 – Net Realized Capital Gains (Losses) Less Capital Gains Tax of \$ _____

Include: Realized investment related foreign exchange gains/losses.

Exclude: Unrealized capital gains/losses.

Line 28 – Net Gain or (Loss) from Agents' or Premium Balances Charged Off

Enter the amount recovered from balances previously written-off as uncollectible.

Line 29 – Aggregate Write-ins for Other Income or Expenses

Enter the total of the write-ins listed in schedule Details of Write-ins Aggregated at Line 29 for Other Income or Expenses.

Line 31 – Federal and Foreign Income Taxes Incurred

Include: Current year provisions for federal and foreign income taxes, and federal and foreign income taxes incurred or refunded during the year relating to prior periods.

Line 32 – Net Income (Loss)

Excess or deficiency of total revenues over total expenses adjusted for extraordinary items and less federal taxes for period.

Detail of Write-ins Aggregated at Line 6 for Other Health Care Related Revenues

Include: Revenue from sources not covered in the other revenue accounts.

Detail of Write-ins at Line 7 for Other Non-Health Revenues

Include: Revenue from life and property/casualty business.

Gains losses on fixed assets.

Details of Write-ins Aggregated at Line 14 for Other Hospital and Medical

Include: Other hospital and medical expenses not covered in the other claims accounts.

Details of Write-ins Aggregated at Line 29 for Other Income or Expenses

Include: As income, interest due from ceding reinsurers on funds held by the ceding company on behalf of the reporting insurer (assuming entity).

As an offset to expense, interest due from ceding reinsurers on funds held by the ceding company on behalf of the reporting insurer.

Income or expense items not covered in any other account.

Net realized foreign exchange capital gains and losses not related to investments. Refer to SSAP No. 23, Foreign Currency Transactions and Translations, for accounting guidance.

Fines and penalties of regulatory authorities.

APPENDIX D
Annual Statement Definitions
UNDERWRITING AND INVESTMENT EXHIBIT

PART 3 – ANALYSIS OF EXPENSES

Administrative Services Contracts (ASC) and Administrative Services Only (ASO) commissions, expenses and taxes paid by the administrator to the administrator such plan shall be reported on a gross basis by type of expense. General expense items must be itemized and entered in sufficient detail to indicate their precise nature. Expenses are not reported on a functional basis, except to the extent specifically permitted herein and only if: (1) services are independently organized, (2) rent, salaries and wages, and other major items of expense directly incident thereto, but not necessarily including the cost of employee benefit plans and Social Security taxes, are charged to function, and (3) adequate accounting thereof is maintained. Whenever personnel or facilities are used in common by two or more companies, or whenever the personnel or facilities of one company are used in the activities of two or more companies, each company shall assign its share of the expense to the same expense classification as if it had incurred the entire expense. This latter requirement shall not apply to activities such as administration of jointly underwritten group contracts and joint mortality and morbidity studies.

Costs for managed care activities must be allocated between claim adjustment expenses and general administrative expenses. Claim adjustment expenses should be allocated to either cost containment expenses or other claim adjustment expenses, in accordance with SSAP No. 85, Claim Adjustment Expenses, Amendments to SSAP No. 55, Unpaid Claims, Losses and Loss Adjustment Expenses. Allocate claim adjustment expenses to (either in cost containment expenses, Column 1 or other claim adjustment expenses, Column 2.)

Other costs such as network development costs, provider contracting costs and other similarly related costs should be allocated to Columns 1 through 3 as appropriate, in accordance with SSAP No. 85.

Prior to 2004, companies might have classified certain expenses, such as network access fees and consumer education costs, within General Administrative Expenses. In accordance with SSAP No. 85, these amounts are now considered Cost Containment Expenses and should be classified as such.

A reporting entity that pays any affiliated entity (including a managing general agent) for the management, administration, or service of all or part of its business or operations shall allocate these costs to the appropriate expense classification item (salaries, rent, postage, etc.) as if these costs had been borne directly by the company. Do not report management, administration, or similar fees as one-line expenses. The reporting entity may estimate these expense allocations based on a formula or other reasonable basis.

A reporting entity that pays any non-affiliated entity (including a managing general agent) for the management, administration, or service of all or part of its business or operations shall allocate these costs to the appropriate expense classification items as follows:

- a. If the total payments for claims handling or adjustment services equals or exceeds 10 percent of the "Total Claim Adjustment Expenses Incurred," allocate these costs to the appropriate expense classification items as if these costs had been borne directly by the reporting entity.
- b. Allocate payments for services other than claims handling or adjustment services to the appropriate expense classifications as if these costs had been borne directly by the company, if the total of such fees paid to the non-affiliate(s) equals or exceeds 10 percent of Column 3, Line 26. If the total is less than 10 percent, the company may report the payments on Line 14.

The total management and service fees incurred attributable to affiliates and non-affiliates shall be reported in the footnote to Underwriting and Investment Exhibit – Part 3, and the method(s) used for allocation shall be disclosed in the Notes to Financial Statements. The reporting entity shall use the same method(s) on a consistent basis. Refer to SSAP No. 70, Allocation of Expenses, for accounting guidance.

Line 1 – Rent

Include: Rent for all premises occupied by the reporting entity, including any adequate rent for occupancy of its own buildings, in whole or in part, except to the extent that allocation to other expense classifications on a functional basis is permitted and used.

Expenses incurred as tenant for light, heat, water, fuel, interest, taxes, building maintenance, alterations and service, etc.

Deduct: Rent under sublease.

Exclude: These items for health care delivery.

Line 2 – Salaries, Wages and Other Benefits

Include: Salaries and wages, bonuses and incentive compensation to employees, overtime payments, continuation of salary during temporary short-term absences, dismissal allowances, payments to employees while in training and other compensation to employees not specifically designated herein, except to the extent that allocation to other expense classifications is permitted and used.

Fees and other compensation to directors for attendance at board or committee meetings and any other fees and compensation paid to them in their capacities as directors or committee members.

Agency compensation other than commissions.

Payments by reporting entity under a program for pension, stock options, purchases, and award plans (including change in quoted market value) and total and permanent disability benefits, life insurance benefits, accident, health, hospitalization, medical, surgical, or other temporary disability benefits under a self-administered or trustee plan or for the purchase of annuity or insurance contracts.

Appropriation or any other assignment of funds by company in connection with any benefit plan of the types enumerated herein, e.g., the net periodic postretirement benefit cost, whether it be defined in terms of specified benefits or in terms of monetary amounts.

Payments by reporting entity under a program for pension, stock options, purchases and award plans (including change in quoted market price), total and permanent disability benefits, death benefits, accident, health, hospitalization, medical, surgical, or other temporary disability benefits, where no contribution or appropriation is made prior to the payment of the benefit.

Meals to employees.

Contributions to employee associations or clubs.

Expense and maintenance of recreation grounds.

Payments to employees and agents in military service.

Expense of periodical medical or dental examinations, or of medical dispensary, convalescent home or sanitarium for employees and agents.

Earned amounts related to employee stock ownership plans. Refer to SSAP No. 12, Employee Stock Ownership Plans and SSAP No. 13, Stock Options and Stock Purchase.

Exclude: Contributions or appropriations for past service if reported in Capital and Surplus Account.

Benefit payments. (To be reported in the appropriate item of the Statement of Revenue and Expenses.)

Line 3 – Commissions

Include: Collection or service fees, policy fees, membership fees and other fees, Commuted renewal commissions.

Line 4 – Legal Fees and Expenses

Include: Court costs, penalties and all fees or retainers for legal services or expenses in connection with matters before administrative or legislative bodies.

Exclude: Salaries and expenses of company personnel.

Legal expenses associated with investigation, litigation and settlement of policy claims.

Legal fees specifically associated with real estate transactions.

Line 5 – Certifications and Accreditation Fees

Include: Fees associated with the certification and accreditation of a health plan, including but not limited to, fees paid to Joint Commission on Accreditation of Healthcare Organizations (JCAHO); National Commission on Quality Assurance (NCQA); American Association for Health Care Certification (Utilization Review Accreditation Commission (URAC)).

Exclude: Rating agencies and other similar organizations.

Line 6 – Auditing, Actuarial and Other Consulting Services

Exclude: Fees for examinations made by State Departments.

Expense of internal audits by company employees.

Line 7 – Traveling Expenses

Include: Traveling expense of officers, other employees, directors and agents, including hotel, meals, telephone, telegraph and postage charges incurred while traveling.

Amounts allowed employees for use of their own cars on company business.

The cost of, or depreciation on, and maintenance and running expenses of company-owned automobiles.

Exclude: Such expenses properly allocated to Real Estate Expenses (Line 21).

Line 8 – Marketing and Advertising

- Include:** Newspaper, magazine and trade journal advertising for the purpose of solicitation and conservation of business.
- Billboard, sign and directory advertising.
- Television, radio broadcasting and motion picture advertising, excluding subjects dealing wholly with health and welfare.
- All canvassing or other literature, such as pamphlets, circulars, leaflets, policy illustration forms and other sales aids, printed material, etc., prepared for distribution to the public by agents or through the mail for purposes of solicitation and conservation of business.
- All calendars, blotters, wallets, advertising novelties, etc., for distribution to the public.
- Printing, paper stock, etc., in connection with advertising.
- Prospect and mailing lists when used for advertising purposes.
- Fees and expenses of advertising agencies related to advertising.
- Exclude:** Pamphlets on health, welfare and educational subjects.
- Advertising required by law, regulation or ruling except to the extent that it substantially exceeds the space required for compliance.
- Salaries and expenses of advertising department.
- Help wanted advertisements.
- Advertising in connection with investments.

Line 9 – Postage, Express, and Telephone

- Include:** Freight and cartage, cables, radiograms and teletype.
- Charges for use, installation and maintenance of related equipment if not included elsewhere.

Line 10 – Printing and Office Supplies

Expenses included in this line may be reported on a functional basis.

- Include:** Policy forms, riders, supplementary contracts, applications, etc., rate books, instruction manuals, punch-cards, house organs, and all other printed material that is not required to be included in any other expense classification.
- Office supplies, pamphlets on health, welfare and educational subjects, annual reports to policyholders and stockholders if not included in Line 8.
- Books, newspapers, periodicals, etc., including investment tax and legal publications and information services, and including all such material for company's law department and libraries.

- Line 11 – Occupancy, Depreciation and Amortization
- Include: The amount of depreciation and amortization expense that is directly associated with administrative services. Expenses associated with administrative services include the costs of occupancy to the health entity that are directly associated with health administration. These include the costs of using a facility, fire and theft insurance, utilities, maintenance, lease, etc.
- Exclude: The cost or depreciation of equipment used by employees handling maintenance and repair work on company-occupied property.
- Line 12 – Equipment
- Include: Rental of all office equipment except for such charges as may be reported in Line 9.
- Line 13 – Cost or Depreciation of EDP Equipment and Software
- Include: Depreciation and amortization expense for electronic data processing equipment, operating software and non-operating software.
- Refer to SSAP No. 16, Electronic Data Processing Equipment and Software for accounting guidance.
- Line 14 – Outsourced Services Including EDP, Claims, and Other Services
- Include: Expenses for administrative services, claim management services, new programming, membership services, and other similar services.
- Exclude: Services provided by affiliates under management agreements.
- Line 15 – Boards, Bureaus and Association Fees
- Include: All dues and assessments of organizations of which the reporting entity is a member.
- All dues for employees' and agents' memberships on the reporting entity's behalf.
- Exclude: Contributions associated with scientific research, disease prevention, or other activity directly pertaining to the welfare of subscribers and the public.
- Line 16 – Insurance, Except on Real Estate
- Include: Premiums for Workers' Compensation, burglary, holdup, forgery and public liability insurance, fidelity or surety bonds, insurance on contents of company-occupied buildings and all other insurance or bonds not included elsewhere.
- Line 17 – Collection and Bank Service Charges
- Include: Collection charges on checks and drafts and charges for checking accounts and money orders.
- Line 18 – Group Service and Administration Fees
- Include: Administration fees, service fees, or any other form of allowance, reimbursement of expenses, or compensation (other than commissions) to agents, brokers, applicants, policyholders or third parties in connection with the solicitation, sale, issuance, service and administration of group business.

Line 19 – Reimbursements by Uninsured Plans

Report as a negative amount, pharmaceutical rebates of uninsured plans that are received or change in due and uncollected by the reporting entity, to the extent that they are in excess of amounts to be remitted to the uninsured plan, administrative fees, direct reimbursement of expenses, or other similar receipts or credits attributable to uninsured health plans and the uninsured portion of partially insured accident and health plans. Deduct administrative fees and related reimbursements from general administrative expenses or claim adjustment expenses if the administrative services provided include services for claim adjustment expenses as defined in SSAP No. 55, Unpaid Claims, Losses and Loss Adjustment Expenses.

Refer to SSAP 84, Certain Health Care Receivables and Receivables Under Government Insured Plans, for accounting guidance.

Line 20 – Reimbursements from Fiscal Intermediaries

Report as a negative amount, administrative fees, direct reimbursement of expenses, or other similar receipts or credits attributable to Medicare, CHAMPUS and other federal and local governmental agencies.

Line 21 – Real Estate Expenses

Include: The cost of insurance, repairs, maintenance, service, and operation of all real estate properties, whether occupied by the company or not.

Expenses incurred in the rental of real estate properties.

Salaries and other compensation of real estate managing agents and their employees.

Legal fees specifically associated with real estate transactions other than sale; rent, salaries and wages, and other direct expenses of any branch or home office unit engaged solely in real estate work (not real estate and mortgages combined).

Salaries or wages of janitors, caretakers, maintenance workers and agents in connection with owned real estate.

Exclude: Salaries and wages of any other home office, general branch office, or investment branch-office employees. Charge these amounts to salaries and wages, where they will automatically be subject to allocation as “insurance” or “investment.” The same rule applies to other expenses or charges associated with the activities of such employees.

Line 22 – Real Estate Taxes

Include: Those taxes directly assessed against property owned by the company. Canadian and other foreign taxes should be included appropriately.

- Line 23.1 – State and Local Insurance Taxes
- Include: Assessments of state industrial boards or other boards for operating expenses or for benefits to sick unemployed persons in connection with disability benefit laws or similar taxes levied by states. Canadian and other foreign taxes are to be included appropriately.
- Advertising required by law, regulation or ruling, except advertising associated with investments.
- State sales taxes, if company does not exercise option of including such taxes with the cost of goods and services purchased.
- State income taxes.
- Line 23.2 – State Premium Taxes
- Include: State taxes based on policy reserves, if in lieu of premium taxes. Canadian and other foreign taxes should be included appropriately.
- Any portion of commissions or allowances on reinsurance assumed that represents specific reimbursement of premium taxes.
- Deduct: Any portion of commissions or allowances on reinsurance ceded that represents specific reimbursement of premium taxes.
- Line 23.3 – Regulatory Authority Licenses and Fees
- Include: Assessments to defray operating expenses of any state insurance department. Canadian and other foreign taxes should be included appropriately.
- Fees for examinations by state departments.
- Exclude: Fines and penalties of regulatory authorities. Report these fines and penalties as a separate item on Page 4, Details of Write-ins Aggregated at Line 29 for Other Income or Expenses.
- Line 23.4 – Payroll Taxes
- Include: Accrued payroll tax including FICA, FUTA, and other federal, state and local payroll taxes.
- Line 23.5 – Other
- Include: Guaranty fund assessments and taxes of Canada or of any other foreign country not specifically provided for elsewhere.
- Sales taxes, other than state sales taxes, if company does not exercise option of including such taxes with the cost of goods and services purchased.

Line 24 – Investment Expenses Not Included Elsewhere

Include: Only items for which no specific provision has been made elsewhere, e.g., contributions or assessments for bondholders' protective committees, fees of investment counsel, custodian and trustee fees.

All other costs, including internal costs or costs paid to an affiliated company, related to origination, purchase or commitment to purchase bonds.

Exclude: Home office salaries and expenses on account of investment work, salaries and expenses of mortgage loan branch offices.

Legal fees and expenses.

Real Estate expenses properly chargeable to Line 21.

Interest expense incurred for experience rated refunds.

Brokerage and other related fees, to the extent that these are included in the actual cost of a bond upon acquisition. Refer to SSAP No. 26, Bonds, Excluding Loan-backed and Structured Securities for accounting guidance.

Line 25 – Aggregate Write-ins for Expenses

Enter the total of the write-ins listed in schedule Details of Write-ins Aggregated at Line 25 for Expenses.

Line 26 – Total Expenses Incurred

Column 1 + Column 2 should agree with Statement of Revenue and Expenses, Line 20. Column 3 should agree with Statement of Revenue and Expenses, Line 21. Column 4 should agree with the Exhibit of Net Investment Income, Line 11 plus 12.

Details of Write-ins Aggregated on Line 25 for Expenses

List separately all expenses for which there is no pre-printed line.

Enter in Column 3 interest incurred for experience rated refunds.

Appendix E

Private Insurance, State Employee Medical Plan, and Medicaid Data

Shaded rows are administrative costs. Data for the private insurers are from the Annual Statements submitted to the Department. The Vermont Department of Human Resources submitted data for the Vermont State Employees Medical Plan and the Office of Vermont Health Access (OVHA) submitted data for Medicaid. Lives and member months for CIGNA are comprehensive major medical lives from the Annual Statement Supplement Report (ASSR). Data may have been adjusted or estimated to conform to a uniform reporting construct. Please contact BISHCA for details and a better understanding of the data.

	Annual Statements			Vermont State Employees Medical Plan	Vermont Medicaid
	BCBSVT (Fully Insured, TVHP, Cost Plus, ASO)	MVP Health Plan - VT Only	CIGNA - VT Only		
Year	2008	2008	2008	2008	2009
Fiscal Year	Calendar	Calendar	Calendar	Calendar	State
Member Months	1,922,487	253,077	514,856	271,656	1,721,684
Avg # Total Covered Lives	160,207	21,090	42,035	22,638	143,474
Hospital/Medical benefits	\$347,887,839	\$68,853,252	\$100,265,144	\$78,411,290	\$312,691,031
Other professional services	\$0	\$2,744,376			
Outside referrals	\$13,770,479	\$0			
Emergency room and out-of-area	\$127,448,618	\$3,883,875			
Prescription Drugs	\$99,269,773	\$9,652,059		\$23,933,097	\$81,669,376
Aggregate write-ins for other hospital and medical	\$0	\$474,607			
Incentive pool, withhold adjustments and bonus amts.	\$1,863,648	\$1,169,693			
Behavioral Health	\$0			\$3,207,110	
Dental	\$0				\$19,319,401
Net reinsurance recoveries	(\$6,127,739)	\$25,388			(\$8,109,422)
Claims (losses)	\$584,112,618	\$86,803,250	\$100,265,144	\$105,551,497	\$405,570,386
Change in Premium Deficiency Reserves	(\$540,000)	\$0	\$0	\$0	\$0
Underwriting Gain/(loss)	(\$6,919,299)	\$606,814	\$6,234,871	\$0	\$0
Premium Tax	\$0	\$0	\$2,426,074	\$0	\$0
BCBSVT Blue Card ITS Fees	\$2,996,491				
Claims adjustment expenses	\$81,330,764	\$1,426,440	\$12,377,625	\$8,264,678	\$38,505,947
General admin expenses		\$10,108,583			
Premiums (premium equivalents, revenues)	\$660,980,574	\$98,945,087	\$121,303,715	\$113,816,175	\$444,076,333
Administrative Cost % of Premiums	12.3%	11.7%	10.2%	7.3%	8.7%
Administrative Costs per Member per Month	\$42.30	\$45.58	N/A	\$30.42	\$22.37