



STATE OF MINNESOTA

HMO MINNESOTA d/b/a BLUE PLUS

WORK ORDER CONTRACT NO: 47132

December 3, 2012

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Executive Summary

The Minnesota Department of Commerce (MNDOC) employed the services of Risk and Regulatory Consulting, LLC (RRC) to assist in evaluating the appropriateness of the managed care plans' expense allocations to public programs, the appropriateness of established Premium Deficiency Reserves and the Retrospective Review of Reserves established for such public programs. This evaluation was conducted in accordance with Executive Order 11-06 Creating Public Disclosure for Minnesota's Managed Care Health Care Programs issued March 21, 2011 (see Appendix 1) and information was also collected as provided in Minn. Statutes Section 256B.69, subd 9c (see Appendix 2). The public programs are provided by various Managed Care Organizations, including Blue Plus (hereinafter referred to as "the Company"). The public programs include: Prepaid Medical Assistance Program (PMAP), Minnesota Senior Health Options (MSHO), Minnesota Senior Care Plus (MSC+), MinnesotaCare (MNCare) and Special Needs Basic Care (SNBC).

Expense Allocations – According to the *NAIC Accounting Practices and Procedures Manual - Appendix A-440 – Insurance Holding Companies*, transactions within a holding company system shall be fair and reasonable, in conformity with statutory accounting practices and recorded in a manner as to clearly and accurately disclose the nature and detail of the transactions. SSAP No. 70 "*Allocation of Expenses*" states that any basis adopted to apportion expenses shall be that which yields the most accurate results and may result from special studies of employee activities, salary ratios, premium ratios or similar analyses.

Blue Plus expenses are allocated to the following cost/profit centers:

- Individual Portability-Blue Plus
- Blue Plus Small Group
- Blue Plus Large Group
- Closed Select (HCPP) – Medicare Supplement
- PMAP Prepaid Medicaid
- MSHO-SecureBlue
- MNCare
- Medical Management PPO

We observed instances where the Company does not appear to be allocating expenses in accordance with *NAIC Accounting Practices and Procedures Manual - Appendix A-440 – Insurance Holding Companies* (fair and reasonable). See the "Observations and Findings" section for specific examples.

Premium Deficiency Reserves – According to SSAP No. 54 "*Individual and Group Accident and Health Contracts*", when the expected claims payments or incurred costs, claim adjustment expenses and administration costs exceed the premiums to be collected for the remainder of a contract period, a premium deficiency reserve shall be recognized by recording an additional liability for the deficiency, with a corresponding charge to operations. For purposes of determining if a premium deficiency exists, contracts shall be grouped in a manner consistent

with how policies are marketed, serviced and measured. A liability shall be recognized for each grouping where a premium deficiency is indicated. Deficiencies shall not be offset by anticipated profits in other policy groupings. Such accruals shall be made for any loss contracts, even if the contract period has not yet started.

As of December 31, 2011 and 2010, Blue Plus had Premium Deficiency Reserves ("PDR") of \$32,380,000 and \$10,586,000, respectively, covering all lines of business.

A review of the PDR Calculation for the Company's public programs as of December 31, 2011 was performed. The Company has two lines of business within the public program category - PMAP and MNCare. The PDR for these lines of business at December 31, 2011 amounted to \$29,780,000.

The PDR calculations appear conservative and appropriate. The methodology used appears reasonable and appears to adhere to generally accepted actuarial principles. We did not review or otherwise audit the data included in the information provided, but only reviewed the methodology for reasonableness. Based on claims paid data as of May 31, 2012, the Company re-estimated its 2011 PDR to be approximately \$5,140,000 million lower than originally booked.

Reserves – According to SSAP No. 54 "*Individual and Group Accident and Health Contracts*", claim reserves shall be accrued for estimated costs of future health care services to be rendered that the reporting entity is currently obligated to provide or reimburse as a result of premiums earned to date that would be payable after the reporting date under the terms of the arrangements, regulatory requirements or other requirements if the insured's illness were to continue.

According to the 2011 Annual Statement, the total claims activity related to prior years was \$128,995,583, compared to \$139,055,206 claim reserves accrued at year end 2010. The favorable development of unpaid claims has principally been experienced on the MNCare, Medicaid and MSHO blocks of business. Original estimates are modified as additional information becomes known regarding individual claims.

Annual Statement Liability Line Item	Description	12/31/11 balance	12/31/10 balance
1	Claims unpaid	\$ 137,189,025	\$ 139,055,206
2	Accrued medical incentive pool and bonus amounts	\$ 739,661	\$ 944,403
3	Unpaid claim adjustment expenses	\$ 3,012,394	\$ 2,849,669
4	Aggregate health policy reserves	\$ 32,380,000	\$ 10,586,000

The Company's reserving methodology involves the use of the Developmental Method, also referred to as the Lag Factor Method. The Company utilizes an Oracle program which produces completion factors using 3-of-3, 6-of-6, and 12-of-12 averaging techniques. The Company indicated estimates do not incorporate implicit margins. The method substitutes per-member

per-month methodology for the most recent one, two, or three months. Estimates also incorporate a "days in a month" adjustment.

Best estimates are determined by the Company, and then an explicit margin for adverse claim deviation is applied to the best estimates. A 6.0% margin is used for Blue Plus business. The Company did not have a formal written policy on margin levels as of December 31, 2011. The Company has subsequently developed a formal written policy regarding margin levels. The Company has worked closely over time with their external auditors in selecting margin levels.

The methodology employed appears reasonable and appropriate. It follows generally accepted actuarial practice for coverages with a relatively short time-period between the incurral and payment of claims which includes most health care coverages.

Run-out

The Company provided the files submitted to DHS that show recasts of year-end reserve estimates using claim data through May of the ensuing year. Based upon the information provided, the December 31, 2010 estimates for MNCare appear very close to the eventual run-out. For the December 31, 2011, the original estimates are 2.0% and 3.5% higher for MNCare and PMAP, respectively, than the run-out for January 2012 through May 2012. The difference in total is 3.0%. The estimates appear reasonable.

Background

Blue Plus (hereinafter referred to as "Blue Plus" or "the Company") is a Minnesota nonprofit health maintenance organization which offers health plans and networks throughout Minnesota to individuals and groups and promotes quality improvement.

Blue Plus is a controlled affiliate of Blue Cross and Blue Shield of Minnesota (BCBSM), a Minnesota non-profit corporation. BCBSM serves as the sole corporate member of Blue Plus and elects a majority of the Board of Directors.

Under the terms of management agreements, BCBSM supplies substantially all general and administrative services necessary to Blue Plus' operations. Blue Plus was charged \$64.4 million in 2011 and \$63.0 million in 2010 for these services.

Blue Plus has an administrative services agreement under which BCBSM will provide funds to Blue Plus to enable it to maintain the statutory or regulatory net worth, deposit and capital and surplus requirements. In the event Blue Plus incurs operating deficits, BCBSM agrees to maintain Blue Plus's capital and surplus for future care and contingencies to enable Blue Plus to meet statutory or regulatory reserve requirements, provided that BCBSM is not required to make reserve contributions if BCBSM does not meet its statutory reserve requirements or if the contributions would cause BCBSM to fall below 2.2 months of its statutory reserve requirements or as otherwise set forth in the terms of the administrative agreements. As of December 31, 2011 and 2010, Blue Plus's statutory reserves exceeded minimum statutory requirements.

Blue Plus has contracted with the Minnesota Department of Human Services (DHS) to provide health care coverage to PMAP and MNCare recipients via a managed care model.

Since 2006, Blue Plus has contracted with the Centers for Medicare and Medicaid Services (CMS) as a Special Needs Plan under the Medicare Advantage program. The contract is part of a program sponsored by DHS called MSHO for beneficiaries age 65 and older who are eligible for DHS Medical Assistance and Medicare Parts A and B.

Public Programs administered by DHS and Minnesota Department of Health (MDH) provided by Blue Plus:

PMAP

PMAP, also known as Medical Assistance (MA), is a health care program for families, children, pregnant women, adults without children who meet certain income limits and people who have disabilities. PMAP is Minnesota's Managed Care Medicaid program. There is no monthly fee, but enrollees may need to pay small co-pay for some services.

In 2011, Blue Plus provided coverage to PMAP members in 60 of the 65 counties that are available for prepaid health care contracting. Blue Plus has approximately 21% of the statewide PMAP market share. See Appendix 5 for the PMAP health plan choices by county.

Medicaid Expansion

Beginning in 2011, PMAP also includes Minnesota Medicaid Expansion. Starting March 1, 2011, additional low income adults became eligible for Medicaid benefits when Minnesota expanded the Medical Assistance program. The federal Affordable Care Act (ACA) requires states participating in Medicaid, known in Minnesota as MA, to expand coverage to certain adults who meet specific criteria effective January 1, 2014. The ACA permits states to implement this expansion beginning April 1, 2010.

The 2010 Minnesota Legislature amended state law allowing the governor to authorize coverage of this population by Jan. 15, 2011. Gov. Mark Dayton signed an executive order Jan. 5, for implementation of MA expansion by March 1. The CMS approved the state's plan in February of 2011.

The expansion provides federal matching funds — \$826 million for the 2012-2013 biennium — for health care previously funded with only state dollars through MNCare and General Assistance Medical Care (GAMC). The GAMC program ended February 28, 2011. Enrollees were automatically moved to MA, Minnesota's Medicaid program.

MSC+

MSC+ is a health care program for seniors 65 and older who qualify for Medical Assistance (Medicaid) and are not enrolled in Medicare. There is no monthly fee, but enrollee may need to pay small co-pay for some services. In 2011 Blue Plus provided coverage to approximately 25% of the statewide MSC+ enrollment. See Appendix 7 for the MSC+ health plan choices by county.

MNCare

MNCare is a program for children, adults and seniors who don't have access to affordable health care coverage, but do not meet the eligibility requirements for Medical Assistance (Medicaid). Working adults who are unable to get health care coverage through an employer may qualify.

MNCare provides subsidized coverage for individuals and children who are not covered by group insurance and not eligible for Medical Assistance. In 2011 Blue Plus provided coverage to approximately 38% of the statewide MNCare enrollment and is available in 86 of Minnesota's 87 counties. See Appendix 6 for the MNCare health plan choices by county.

Public Programs Integrated with Federal Programs provided by Blue Plus

MSHO

MSHO is a health care program that combines separate health programs and support systems into one health care package. It is for people ages 65 and older who are eligible for Medical Assistance (MA) and enrolled in Medicare Parts A and B. In 2011 Blue Plus had approximately 27% of the statewide MSHO enrollment. See Appendix 8 for the MSHO health plan choices by county.

SNBC Integrated

SNBC is a managed care program for individuals with disabilities. SNBC contracts include agreements for MCO's to cover the cost of medical assistance co-pays and deductibles for SNBC. SNBC enrollees may have to pay Part D drug co-pays since Medicare does not allow waivers, unless the enrollee is in an institution. Blue Plus offers a SNBC plan which is integrated with Medicare Benefits for eligible enrollees (SNBC Integrated). See Appendix 9 for the SNBC health plan choices by county. Also, the Special Needs Basic Care (SNBC) contract between Blue Plus and DHS that is identified on page 6 ended on 12/31/10 (such that any 2011 activity is simply related to run out of the program).

Public Programs managed by CMS and provided by Blue Plus

Medicare + Choice

Medicare + Choice is a managed care plan for individuals who are over 65 years old and are eligible for Medicare Part A and Part B.

Private Programs provided by Blue Plus

Commercial

Commercial Programs are managed care plans for individuals, families, and groups.

Other

Blue Plus provides Medical Management and Administrative Service Contracts (ASC) for Self-Insured Groups.

Observations & Findings

Note, this review is not considered a statutory examination but a special review requested by the Governor. Therefore, observations and findings within this report are not necessarily violations of Statutory Accounting Principles or State law. The objective of the review is to report the facts as observed and make recommendations where deemed to be appropriate. The following represents our key observations and findings:

Observations:

1. Blue Plus made a \$10 million cash contribution to the Blue Cross Blue Shield Foundation on December 29, 2011.

The entire \$10 million contribution was included in Column 13 "Med Mgmt" line 21 "general administrative expenses" of the MN Supplement Report #1. The Blue Plus Medical Management "Med Mgmt" program relates to services performed by Blue Plus for the Northern Plains Alliance, a group of six Blue plans covering the seven state region including NE, ND, MT, WY, MN, IA, and SD. These services include managing the business functions for the Northern Plains Alliance related to case management, utilization management, nurse phone line, disease management and select quality improvement functions.

2. RRC reviewed how salaries were allocated to the Company's public and non public programs, including the salaries of its executives. Blue Plus allocates executive management expenses based on an "executive allocation statistic". According to the Company, each executive's allocation rule is determined by collaboration between the Finance area and the executives. The allocation is based on member months and a weighting factor for each executive. The Company was not required to, and did not, cap executive salaries prior to allocating them to the public programs or any other programs administered by the Company.
3. Blue Plus was asked to perform a re-estimation of PDR using actual experience that was available. Based on claims paid data through August 31, 2012, the Company re-estimated its 2011 PDR to be approximately \$5,140,000 million lower than originally booked at December 31, 2011.
4. The Company provided a listing of profit centers for Blue Plus and BCBSM that are considered "government programs". Not all profit centers were allocated government-related expenses.
5. In reviewing the Company's expenses and allocations, it was noted Blue Plus does not have a separate profit center established for MSC+.
6. There are three separate cost centers for IHM-GP. These include case management, disease management and utilization management. According to the Company, these cost

centers provide care management for government program members. This cost center also includes staff that performs access management for commercial business. Costs are allocated based on a fixed percentage determined from staffing. Blue Plus government programs PMAP, MSHO and MNCare are allocated approximately 99% of these costs. BCBSM government programs are allocated the remaining 1%.

7. PMAP & MNCare were allocated approximately \$330,000 of expenses in 2011 for cost center 12600 "Virginia Commercial Claims". PMAP & MNCare were allocated approximately \$35,000 of expenses in 2011 for cost center 89300 "Commercial Accounts Large Group". The Company indicated the naming convention for Cost center 12600 is "Virginia Commercial Claims" but staff in this cost center also work on government claims, including PMAP and MNCare. The different types of claims are identified within a claims tracking system. There also is a cost center "Virginia Government Claims" which is 100% dedicated to government claims. As claim volume fluctuates throughout the month, in addition to having individuals in the government claims cost center work overtime, individuals within the Commercial claims cost center are utilized when needed.
8. The Company allocates costs to the Printing & Postage cost center based on a total membership statistic. Blue Plus was allocated approximately \$1.0 million of printing & postage expenses in 2011. Approximately \$875,000 was allocated to PMAP and MNCare. This is in addition to cost center "Printing & Postage – Govt" 2011 expenses of \$356,000, of which \$330,000 was allocated to PMAP and MNCare. The Company indicated the Printing & Postage cost center contains the cost of transactional print and postage that is business critical. The Company indicated the Printing & Postage – Government cost center contains the cost of marketing print and postage. The Company indicated the membership statistic is utilized due to the volume of transactions.

Findings:

1. Marketing and Corporate Communications

Finding:

The Company allocates Marketing & Corporate Communications expenses based on total MN membership statistics. This includes all Blue Plus profit centers except Med Mgmt. Blue Plus was allocated \$1.4 million of Marketing & Corporate Communications expenses in 2011. Of this amount, PMAP and MNCare were allocated approximately \$1.2 million in 2011.

BCBSM runs a variety of ads including their "Do" campaign on local TV stations. These ads do not target Blue Plus or the public programs. The Company indicated the expenses within the Marketing and Corporate Communications cost center are not specific to any one segment but are for business overall. Blue Plus was allocated 11.4% (10% to PMAP and MNCare) of the following December 2011 expenses (partial listing):

- \$1.0 million - Haworth (TV ads)
- \$133,922 -- Twins Ballpark Sponsorship

In addition to direct expenses, Blue Plus was also allocated a portion of "Tier 1" expenses for payroll, benefits, travel, rent, etc. within the "Marketing & Corporate Communications" account. "Tier 1" expenses spread overhead-type costs to the cost centers. These costs include human resources, payroll, benefits, travel, building services, rent, depreciation, mail services, voice/data systems and local area network.

According to the Medical Assistance (PMAP) and MNCare contract between Blue Plus and DHS section 3.2.4 "Marketing Materials":

(C) Except through mailings and publications as set forth below, the MCO and any of its subcontractors, agents, independent contractors, employees and Providers, is restricted from Marketing and promotion to Recipients who are not enrolled in the MCO. This restriction includes, but is not limited to: telephone marketing, face-to-face marketing, promotion, cold-calling and/or direct mail marketing.

(2) Mailings to recipients. The MCO may make no more than two mailings per calendar year to Enrollees of the MCO covered under this Contract or potential Enrollees who reside in the MCO's Service Area.

- a) The MCO may distribute brochures and display posters at physician offices and clinics, informing patients that the clinic or physician is part of the MCO's provider network...*
- b) The MCO may provide health education materials for Enrollees in Providers' offices.*

Recommendation:

The Company should allocate only those direct expenses allowed by the contract to PMAP and MNCare public programs.

2. Affiliated Medical Center Covenant

Finding:

Affiliated Medical Centers, P.A. (AMC) entered into an Affiliation and Capitalization agreement with BCBSM and Blue Plus on December 21, 1993. The agreement calls for total principal payments from BCBSM to AMC in the amount of \$9,912,754. The amount is being amortized over a thirty year time period on a straight line basis; each year BCBSM allocates to Blue Plus \$330,425 (\$9,912,754 / 30) of amortization expense related to this agreement. Of this amount, 46% is allocated to PMAP, 27% to MNCare, 21% to MSHO and the remaining 6% to Blue Plus Commercial. BCBSM is not allocated any portion of the amortization expense. The amortization expense is included in general administrative expenses. The Company did not provide a complete copy of the agreement between the parties nor a description of the nature of the services or activities underlying the agreement. Based on the information provided by the Company, it is unclear how the agreement specifically relates to the public programs.

Recommendation:

The Company should only allocate expenses that can be shown to directly relate to the public programs. Any portion not allocable to the public programs should be allocated to other programs or entities, including BCBSM.

3. Mankato Covenant

Finding:

The Company entered into an agreement with Mankato Clinic. We were not provided the first 19 pages of the agreement or the last pages of the agreement. The agreement calls for total principal payments from BCBSM/Blue Plus to Mankato in the amount of \$8,000,000. The amount is being amortized over a twenty year time period on a straight line basis; each year BCBSM allocates to Blue Plus \$200,000 ($\$8,000,000 / 20$) of amortization expense related to this agreement. Of this amount, 46% is allocated to PMAP, 27% to MNCare, 21% to MSHO and the remaining 6% to Blue Plus Commercial. BCBSM is also allocated \$200,000 of the amortization expense. The amortization expense is included in general administrative expenses. The Company did not provide a complete copy of the agreement between the parties nor a description of the nature of the services or activities underlying the agreement. Based on the information provided by the Company, it is unclear how the agreement specifically relates to the public programs.

Recommendation:

The Company should only allocate expenses that can be shown to directly relate to the public programs. Any portion not allocable to the public programs should be allocated to other programs or entities, including BCBSM.

4. Government Program Management

Finding:

Allocation to this cost center is based on a fixed percentage statistic. The following costs were included in this cost center: payroll, benefits, car insurance allowance, meals, cell phones and travel. These were in addition to the Company's allocation of "Tier 1" expenses. The Company also included various fees to attend exhibits & conferences in MN as expenses. These exhibits and conferences target the public programs. The Company indicated this cost center also includes sales promotion and travel related to the PMAP, MSHO and MNCare programs. This appears to be in violation of the PMAP and MNCare contract between the Company and DHS.

Expenses in 2011 for this account were approximately \$720,000. There were no allocations to the BCBSM government programs. Expenses were allocated entirely to the following Blue Plus profit centers:

- 150100 PMAP
- 150200 MSHO
- 160100 MNCare

According to the Medical Assistance (PMAP) and MNCare contract between Blue Plus and DHS section 3.2.4 "Marketing Materials":

(C) Except through mailings and publications as set forth below, the MCO and any of its subcontractors, agents, independent contractors, employees and Providers, is restricted from Marketing and promotion to Recipients who are not enrolled in the MCO. This restriction includes, but is not limited to: telephone marketing, face-to-face marketing, promotion, cold-calling and/or direct mail marketing.

Recommendation:

The Company should allocate only those expenses allowed by the contract to PMAP and MNCare programs.

5. Gov't Prog Business Strategy & Development

Finding:

Costs are allocated based on a fixed percentage statistic. Blue Plus profit centers (PMAP, MSHO and MNCare) are allocated approximately 74% and BCBSM profit centers are allocated 26%.

Blue Plus was allocated \$1.1 million of costs in 2011. It was noted Blue Plus was allocated 74% of a \$37,000 Medicare Parts C&D audit. PMAP and MNCare were allocated approximately \$10,000 of the Medicare Parts C&D audit. Medicare Parts C&D do not involve PMAP and MNCare.

Recommendation:

The Company should allocate only those government expenses that directly relate to the public programs.

6. Lobbying Expenses

Finding:

PMAP & MNCare were allocated approximately \$67,000 of expenses in 2011 for cost center 80503 "MN Lobbying".

PMAP & MNCare were allocated approximately \$21,000 of expenses in 2011 for cost center 80504 "Federal Lobbying".

According to the Medical Assistance (PMAP) and MNCare contract between Blue Plus and DHS Article 15 "Lobbying Disclosure":

The MCO certifies, that, to the best of its knowledge, understanding, and belief, that:

(A) No Federal Funds Used. No Federal appropriated funds have been paid or will be paid in what the undersigned believes to be a violation of 31 U.S.C. § 1352, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, Member of Congress, an officer or employee of Congress...

- (B) *Other Funds Used.* If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress or an employee of a Member of Congress in connection with this Federal contract, grant, loan or cooperative agreement,, the undersigned shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.
- (C) *Certification.* The undersigned will require that the language of this certification be included in the award documents for all sub-awards at all tiers (including subcontractors, sub-grants and contracts under grants, loans, and cooperative agreements) and will required that all sub-Recipients certify and disclose accordingly. Submission of this certification is a prerequisite for making or entering into this transaction imposed by 31 U.S.C. § 1352. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

Recommendation:

The Company should allocate only those lobbying expenses that directly relate to the public programs and report them in accordance with the contract.

Scope and Procedures Performed

In accordance with Work Order Contract No. 47132, the specific tasks for which RRC was charged with are listed below.

1. Compare the PMAP detail which is provided to the Department of Human Services to the Minnesota Supplement Report filed with the Minnesota Department of Health.

RRC obtained the Minnesota Supplement Report #1 filed with the MDH and compared this to the PMAP detail provided to the DHS. An example of the Minnesota Supplement Report #1 can be found in Appendix 3. The following PMAP detail was obtained directly from the Minnesota Supplement Report #1.

NAIC Description	2010	2011
	Prepaid Medical Assistance Program (PMAP)	Prepaid Medical Assistance Program (PMAP)
REVENUES:		
1 Member Months	819,258	960,181
2 Net Premium Income	367,274,272	431,682,131
3 Change in unearned premium reserves and serve for rate credits		
4 Fee-for-service		
5 Risk revenue		
6 Aggregate write-ins for other health care related revenues (Line 699)		
7 Aggregate write-ins for other non-health revenues (Line 799)		
8 TOTAL REVENUES (Lines 2 through 7)	367,274,272	431,682,131
EXPENSES:		
9 Hospital/medical benefits	250,584,703	306,005,530
10 Other professional services	11,341,827	14,644,998
11 Outside referrals	299,777	375,035
12 Emergency room and out-of-area	9,305,909	12,208,849
13 Prescription drugs	27,584,606	41,801,189
14 Aggregate write-ins for other hospital and medical expenses (Line 1499)		
15 Incentive Pool and Withhold Adjustments		
16 TOTAL EXPENSES (Lines 9 through 15)	299,116,822	375,035,601
LESS:		
17 Net reinsurance recoveries		
18 Total hospital and medical (Lines 16 minus 17)	299,116,822	375,035,601
19 Non-health claims		
20 Claims adjustment expenses	17,230,940	18,017,149
21 General administrative expenses	14,694,082	16,258,795
22 Increase in reserves for life, accident and health contracts	-	19,729,000
23 Total underwriting deductions (Lines 18 through 22)	331,041,844	429,040,545
24 Net underwriting gain or (loss) (Lines 8 minus 23)	36,232,428	2,641,586
25 Net investment income earned	5,096,126	6,113,955
26 Net realized capital gains or (losses)		
27 Net investment gains or (losses) (Lines 25 plus 26)	5,096,126	6,113,955
28 Net gain or (loss) from agents' or premium balances charged off		
29 Aggregate write-ins for other income or expenses (Line 2999)		
30 Net income or (loss) before federal income taxes (Lines 24 plus 27 plus 28 plus 29)	41,328,554	8,755,541
31 Federal and foreign income taxes incurred		
32 Net income (loss) (Lines 30 minus 31)	41,328,554	8,755,541

The 2011 PMAP detail provided agreed to the 2011 Blue Plus MN Supplemental Report #1. RRC noted the programs reported in the PMAP columns varied from 2010 to 2011.

The PMAP column consisted of the following programs in the 2011 MN Supplement Report #1:

- *PMAP (Non seniors)*
- *Medical Assistance*
- *GAMC run-out*
- *Medicaid Expansion*

The PMAP column consisted of the following programs in the 2010 MN Supplement Report #1:

- *PMAP (Non seniors)*
- *MSC+*

The 2011 PMAP member months, revenues and expenses are higher in 2011 for various reasons. According to the Minnesota Department of Human Services website, the GAMC program ended February 28, 2011. Enrollees were automatically moved to Medical Assistance (MA), Minnesota's Medicaid program. In 2010, the GAMC program information was reflected in a column separate from PMAP. In 2011, Minnesota participated in the Medicaid Expansion, as explained earlier in this report.

2. *Verify the Minnesota Supplement Report #1 was completed in accordance with all instructions currently effective set forth by the Minnesota Department of Health.*

RRC obtained the Minnesota Supplement Report #1 instructions. An example of the Minnesota Supplement Report #1 can be found in Appendix 3 and the instructions can be found in Appendix 4.

The instructions state: "All financial information in reports 1-7 should reconcile with the applicable statement, exhibit or schedule data contained in the NAIC Annual Statement health blank filing." The Minnesota Supplement Report #1 reconciles to the annual statement.

The instructions also state the primary MN Statute reference for MN Supplement Report #1 is §62D.08. See Appendix 2 for §62D.08.

3. *Perform an analytical review comparing the 2010 and 2011 MN Supplement Reports and research any significant fluctuations.*

*An analytical review was performed comparing the 2010 and 2011 MN Supplement Report #1. Any fluctuations greater than 20% and the individual program's materiality were identified and sent to Blue Plus for an explanation. Materiality was calculated for the individual programs based on 5% of the individual programs' 2011 net income (rounded). i.e. materiality for MSHO = \$34,173,338 (2011 net income) * 5% = \$1,708,667 rounded to \$1,709,000.*

The Company provided a response to the significant fluctuations. The majority of the Company's responses appeared reasonable. The following fluctuations were noted as unusual:

Reserves

According to the 2011 Notes to the Financial Statement, reserves for claims attributable to the events of prior years have decreased from \$139,055,277 in 2010 to \$128,995,583 in 2011 as a result of re-estimation of unpaid claims and provider settlement liabilities. The favorable development of unpaid claims has principally been experienced on the MNCare, Medicaid (PMAP) and MSHO blocks of business. This development is the result of ongoing analysis of the reserves based on recent claim trends. Original estimates are modified as additional information becomes known regarding the block of business.

According to the MN Supplement Report #1, the PMAP PDR went from \$0 in 2010 to \$19.7 million in 2011. The Company indicated the deficiency reserve shown on this line for PMAP is the value of the expected loss in the following year for this line of business. As of December 31, 2010, Blue Plus did not anticipate a loss in 2011 for the PMAP line of business, and therefore did not hold a deficiency reserve. However, as of December 31, 2011 Blue Plus anticipated a \$19.7 million loss.

According to the MN Supplement Report #1, the MNCare PDR increased \$6.6 million in 2010 and \$3.5 million in 2011. The Company indicated that as of December 31, 2010, Blue Plus anticipated a \$6.6 million loss in 2011 for the MNCare line of business. As of December 31, 2011 Blue Plus anticipated a \$10.1 million loss in 2012 resulting in an increase in the deficiency reserve of \$3.5 million.

Med Management Expenses

The general administrative expenses in Column 13 "Other: Med Management" of the MN Supplement Report #1 increased from \$764,000 in 2010 to \$10.3 million in 2011. The large increase in administrative expenses was due to a \$10,000,000 contribution from Blue Plus to the Blue Cross and Blue Shield of Minnesota Foundation made in 2011.

Capital Gains

In 2011 Blue Plus had net realized capital gains of \$10.3 million. All of the capital gains were included in the "Med Management" column. The Company indicated they did not allocate capital gains but rather included the entire balance as "Med Management/Other" in column 13 of the MN Supplement.

4. Review (by total) the MN Supplement Report to the Expense page of the Statutory Annual Statement. Review the expense categories in terms of:
 - Expense allocation between legal entities is consistent with the Statement of Statutory Accounting Principles Appendix A-440 (fair and reasonable) and SSAP No. 70 "Allocation of Expenses".
 - Identify expense allocation between public and private programs.

- Perform analytical review and/or testing by sampling various expense categories to determine if expenses were accounted for in accordance with the entity's expense allocation agreements and guidelines.

We obtained the 2011 expense detail from Blue Plus. The \$92,225,977 expense detail provided was agreed to the Underwriting and Investment Exhibit Part 3 - Analysis of Expenses in the 2011 annual statement for completeness. We sorted the allocated expense amounts from largest to smallest and chose the 10 largest allocated expenses. In addition to these 10 largest expenses, 4 additional expenses were chosen judgmentally consisting of 2 PMAP expenses in addition to an IT expense and a government program expense. These were chosen to specifically review the Company's allocation process. For all of the expenses, we chose the smallest and largest month to review.

In addition to the allocated expenses, Blue Plus has expenses they do not allocate across programs. All of these expenses were chosen to review the Company's criteria and documentation.

Blue Plus Cost Allocation Process

Administrative expenses are recorded in organizational cost centers where the costs are incurred. At the end of each month, these costs are allocated out in a series of stages called "tiers". When all of the allocation tiers are complete, all administrative expenses have been allocated to customer/products cost centers.

Tier 1 allocations spread overhead-type costs to other organizational cost centers. Cost centers such as human resources, benefits, building services, mail services, voice/data systems and local area network are allocated in Tier 1. Allocations statistics used in Tier 1 include headcount, square feet and others.

Tier 2 allocations are performed mainly on cost centers with multiple functions. An example is a dedicated cost center that provides membership, claims processing and customer service functions. Tier 2 allocations are based on fixed percentages determined through information obtained from cost center managers. In many instances, time reporting or staffing levels are used to validate the cost allocations.

Tier 3 allocates administrative expenses to customer/product cost centers. The allocations from each of the cost centers are determined from information received from cost center managers. Each cost center is allocated to the appropriate receiver customer/product cost centers based on a cost allocation method. Cost allocation methods include fixed percentages and variable statistic allocations. Allocation statistics used in Tier 3 include membership counts, claim counts, contract counts and others.

In addition to the cost center allocation process, there are two other methods used to allocate expenses. If a cost center incurs an expense that should not follow the allocation method used for the cost center as a whole, the expense may be allocated via a special general ledger account or a real internal order. Special general ledger accounts are established to allocate an expense to a company or a select group of customer/product cost centers. Real internal

orders are set up to allocate an expense to a single customer/product cost center. The expense is coded to the real internal order and then allocated directly to the appropriate customer/product cost center.

In reviewing the Company's expenses and allocations, it was noted Blue Plus does not have a separate cost/profit center set up for MSC+ business.

See the "Observations and Findings" section for details on specific expense accounts that did not appear to be accounted for in accordance with the Company's expense allocation agreements and guidelines and in accordance with Appendix A-440 (fair and reasonable) and SSAP No. 70 "Allocation of Expenses".

5. Verify appropriateness with regards to the establishment of any PDR allocated to the public programs.

As of December 31, 2011 and 2010, Blue Plus had PDR of \$32,380,000 and \$10,586,000, respectively.

A review of the PDR Calculation for the Company's public programs as of December 31, 2011 was performed. The Company has two lines of business within the public program category - PMAP and MNCare.

The PDR calculation develops a contribution margin for each market segment based on forecasted results in each entity's business plan.

Premiums
minus Claims
minus Taxes & Assessments
minus Administrative Expenses

Policy reserves are subtracted, if applicable, from the amount calculated above to arrive at the PDR.

The Company does not include investment income in the PDR calculations. Blue Plus received permission from the Minnesota Department of Commerce to exclude investment income from the PDR calculation.

The original calculation results in a PDR of \$29,780,000 as of December 31, 2011.

The PDR calculations appear reasonable and appropriate. The methodology used appears reasonable and appears to adhere to generally accepted actuarial principles. We did not review or otherwise audit the data included in the information provided, but only reviewed the methodology.

The Company combines PMAP and MNCare (i.e., Public Programs) for the purpose of determining a need for a PDR. Statement of Statutory Accounting Principle ("SSAP") No. 54, paragraph 18 states:

"For purposes of determining if a premium deficiency exists, contracts shall be grouped in a manner consistent with how policies are marketed, serviced and measured."

The Company has a single contract with the State of Minnesota, acting through its Department of Human Services for PMAP and MNCare. Further, the Company represented to us that its grouping is a result of the residing Company of the business, underwriting methodology and marketing method. It is an approach consistent with that seen during the Financial Examination as of December 31, 2010. As of December 31, 2011, combining results for these two lines of business did not impact the need for or magnitude of a PDR. The Company projected negative operating income for both programs for the calendar year 2012. In the December 31, 2010 Financial Examination, the Company had projected an operating loss for MNCare and an operating gain for PMAP. These results were combined and the resulting PDR was less as opposed to viewing the line of business independently since the PMAP operating gain partially offset a portion of the MNCare operating loss.

From the information provided, it appears that the grouping PMAP and MNCare appears reasonable and appears to follow SSAP No. 54.

Blue Plus was asked to perform a re-estimation using actual experience that was available. It is noted that the original estimates include an expense item titled "Additional Administrative Allocation for 2012 Strategic Spend". The "Additional Administrative Allocation for 2012 Strategic Spend" amounts were \$861,000 and \$511,000 for PMAP and MNCare, respectively. The revised estimates do not include an amount for "Additional Administrative Allocation for 2012 Strategic Spend". The following page shows the original estimates, revised estimates, and the differences. It appears that experience is emerging better than the original estimates. Based on claims paid data as of May 31, 2012, the Company re-estimated its 2011 PDR to be approximately \$5,140,000 lower than originally booked.

6. Perform retrospective review of reserves established for public programs at year end 2009, 2010 and 2011.

The Company's reserving methodology involves the use of the Developmental Method, also referred to as the Lag Factor Method. The Company utilizes an Oracle program which produces completion factors using 3-of-3, 6-of-6, and 12-of-12 averaging techniques. The Company indicated the estimates do not incorporate implicit margins. The method substitutes per-member per-month methodology for the most recent one, two, or three months. Estimates also incorporate a "days in a month" adjustment.

Best estimates are determined by the Company, and then an explicit margin for adverse claim deviation is applied to the best estimates. A 6.0% margin is used for Blue Plus

business. The Company does not have a formal written policy on margin levels. The Company has worked closely over time with their external auditors and MNDOC in selecting reasonable margin levels. The explicit margin is the same as applied for 2010. It is considered reasonable by the Company's auditors, a similar conclusion as drawn during the 2010 Examination by MNDOC.

The methodology employed appears reasonable and appropriate. It follows generally accepted actuarial practice for coverages with a relatively short time-period between the incurral and payment of claims which includes most health care coverages.

7. Compare the 2010 run-out provided to the Department of Human Services in 2011 to the retrospective review of reserves.

The Company provided the files submitted to DHS that show recasts of year-end reserve estimates using claim data through May 31, 2012. The following tables summarize these results. Initial estimates do not include margin for adverse claim deviation.

<p style="text-align: center;">Blue Plus Unpaid Claim Liabilities as of December 31, 2010 Data Through May 2012</p>			
	<u>Initial Estimate</u>	<u>Paid-on- Incurred</u>	<u>Remaining Reserve</u>
MNCare Adults w/o Children	\$12,007,518	\$12,007,310	\$208
MNCare Families and Children	<u>9,368,257</u>	<u>9,367,959</u>	<u>298</u>
MNCare Total	\$21,375,775	\$21,375,269	\$505
PMAP Expansion*	\$0	\$0	\$0
PMAP F&C	<u>27,691,866</u>	<u>27,661,186</u>	<u>30,680</u>
PMAP Total	\$27,691,866	\$27,661,186	\$30,680

* Starting March 1, 2011, additional low income adults became eligible for Medicaid benefits when Minnesota expanded the Medical Assistance program (PMAP Expansion).

<p style="text-align: center;">Blue Plus Unpaid Claim Liabilities as of December 31, 2011 Data Through May 2012</p>			
	<u>Initial Estimate</u>	<u>Paid-on- Incurred</u>	<u>Remaining Reserve</u>
MNCare Adults w/o Children	\$6,523,676	\$6,399,392	\$124,284
MNCare Families and Children	<u>10,172,552</u>	<u>9,977,054</u>	<u>195,497</u>
MNCare Total	\$16,696,228	\$16,376,446	\$319,782
PMAP Expansion	\$11,607,203	\$11,064,170	\$543,033
PMAP F&C	<u>31,846,126</u>	<u>30,934,634</u>	<u>911,492</u>
PMAP Total	\$43,453,329	\$41,998,804	\$1,454,525

- Based upon the information provided, the December 31, 2010 estimates for MNCare appear very close to the eventual run-out. For the December 31, 2011, the original estimates are 2.0% and 3.5% higher for MNCare and PMAP, respectively, than the run-out for January 2012 through May 2012. The difference in total is 3.0%. It was concluded that a majority of run-out has emerged in the first five months of 2012, with a small amount of run-out expected yet to be incurred. The estimates as of December 31, 2011 appear reasonable.

Beginning in 2008, the Company began to slow claim payment speed as a cash flow management technique while still abiding by appropriate prompt payment rules and regulations. A reserve is held for these held claims, which are referred to as Special Reserves. With this approach, the Company has partitioned the Unpaid Claim Liability into 2 components: (1) Incurred But Not Reported Liability, and (2) Reported But Not Paid Liability. Special Reserves fall into category (2). The Company removes "held claims" when developing the claim lag reports which are used to develop the IBNR liability estimates. The change in the Company's claims payment speed was reviewed in detail during the 2010 examination by MNDOC and no specific concerns were noted.

Appendix 1 – Executive Order 11-06

This document is made available electronically by the Minnesota Legislative Reference Library as part of an ongoing digital archiving project. <http://www.leg.state.mn.us/lrl/execorders/execorders.asp>

STATE OF MINNESOTA EXECUTIVE DEPARTMENT



MARK DAYTON
GOVERNOR

Executive Order 11-06

Creating Public Disclosure for Minnesota's Managed Care Health Care Programs

I, Mark Dayton, Governor of the State of Minnesota, by virtue of the authority vested in me by the Constitution and applicable statutes, do hereby issue this Executive Order;

Whereas, over 500,000 Minnesotans receiving public health insurance coverage are enrolled in managed care; and

Whereas, the State spends approximately \$3 billion annually on purchasing health care from managed care plans for state public programs; and

Whereas, it is critical for public trust that Minnesota's taxpayers understand how public dollars for health care are being used; and

Whereas, the State needs greater disclosure and accountability of managed care plan spending on health care and long-term care services and administrative expenses for state public programs;

Now, Therefore, I hereby order the Commissioner of Human Services to:


- 1. Establish a managed care website for all publicly available information and reports that relate to the managed care procurement, financials, health outcome performance measures, contracts, and other public information for state public programs.**
- 2. Develop an annual comprehensive managed care report in consultation with the Commissioners of Health and Commerce that includes detailed information on administrative expenses, premium revenues, provider payments and reimbursement**

rates, contributions to reserves, enrollee quality measures, service costs and utilization, enrollee access to services, capitation rate-setting and risk adjustment methods, and managed care procurement and contracting processes.

3. Submit data from the managed care plans for state public programs to the Commissioner of Commerce so that regular financial audits of data will be conducted.

Under Minnesota Statutes, section 4.035, subdivision 2, this Executive Order is effective 15 days after publication in the State Register and filing with the Secretary of State.

In Testimony Whereof, I have set my hand on March 23, 2011.



Mark Dayton
Governor

Filed According to Law:



Mark Ritchie
Secretary of State



Appendix 2 – Minnesota Statutes §62D.08 and 256B.69, subd 9c

62D.08 ANNUAL REPORT.

Subdivision 1. Notice of changes.

A health maintenance organization shall, unless otherwise provided for by rules adopted by the commissioner of health, file notice with the commissioner of health prior to any modification of the operations or documents described in the information submitted under clauses (a), (b), (e), (f), (g), (i), (j), (l), (m), (n), (o), (p), (q), (r), (s), and (t) of section 62D.03, subdivision 4. If the commissioner of health does not disapprove of the filing within 60 days, it shall be deemed approved and may be implemented by the health maintenance organization.

Subd. 2. Annual report required.

Every health maintenance organization shall annually, on or before April 1, file a verified report with the commissioner of health covering the preceding calendar year. However, utilization data required under subdivision 3, clause (c), shall be filed on or before July 1.

Subd. 3. Report requirements.

Such report shall be on forms prescribed by the commissioner of health, and shall include:

(a) a financial statement of the organization, including its balance sheet and receipts and disbursements for the preceding year certified by an independent certified public accountant, reflecting at least (1) all prepayment and other payments received for health care services rendered, (2) expenditures to all providers, by classes or groups of providers, and insurance companies or nonprofit health service plan corporations engaged to fulfill obligations arising out of the health maintenance contract, (3) expenditures for capital improvements, or additions thereto, including but not limited to construction, renovation or purchase of facilities and capital equipment, and (4) a supplementary statement of assets, liabilities, premium revenue, and expenditures for risk sharing business under section 62D.04, subdivision 1, on forms prescribed by the commissioner;

(b) the number of new enrollees enrolled during the year, the number of group enrollees and the number of individual enrollees as of the end of the year and the number of enrollees terminated during the year;

(c) a summary of information compiled pursuant to section 62D.04, subdivision 1, clause (c), in such form as may be required by the commissioner of health;

(d) a report of the names and addresses of all persons set forth in section 62D.03, subdivision 4, clause (c), who were associated with the health maintenance organization or the major participating entity during the preceding year, and the amount of wages, expense reimbursements, or other payments to such individuals for services to the health maintenance organization or the major participating entity, as those services relate to the health maintenance organization,

including a full disclosure of all financial arrangements during the preceding year required to be disclosed pursuant to section 62D.03, subdivision 4, clause (d);

(e) a separate report addressing health maintenance contracts sold to individuals covered by Medicare, title XVIII of the Social Security Act, as amended, including the information required under section 62D.30, subdivision 6; and

(f) such other information relating to the performance of the health maintenance organization as is reasonably necessary to enable the commissioner of health to carry out the duties under sections 62D.01 to 62D.30.

Subd. 4. Penalty; extension for good cause.

Any health maintenance organization which fails to file a verified report with the commissioner on or before April 1 of the year due shall be subject to the levy of a fine up to \$500 for each day the report is past due. This failure will serve as a basis for other disciplinary action against the organization, including suspension or revocation, in accordance with sections 62D.15 to 62D.17. The commissioner may grant an extension of the reporting deadline upon good cause shown by the health maintenance organization. Any fine levied or disciplinary action taken against the organization under this subdivision is subject to the contested case and judicial review provisions of sections 14.57 to 14.69.

Subd. 5. Changes in participating entities; penalty.

Any cancellation or discontinuance of any contract or agreement listed in section 62D.03, subdivision 4, clause (e), or listed subsequently in accordance with this subdivision, shall be reported to the commissioner 120 days before the effective date. When the health maintenance organization terminates a provider for cause, death, disability, or loss of license, the health maintenance organization must notify the commissioner within ten working days of the date the health maintenance organization sends out or receives the notice of cancellation, discontinuance, or termination. Any health maintenance organization which fails to notify the commissioner within the time periods prescribed in this subdivision shall be subject to the levy of a fine up to \$200 per contract for each day the notice is past due, accruing up to the date the organization notifies the commissioner of the cancellation or discontinuance. Any fine levied under this subdivision is subject to the contested case and judicial review provisions of chapter 14. The levy of a fine does not preclude the commissioner from using other penalties described in sections 62D.15 to 62D.17.

Subd. 6. Financial statements.

A health maintenance organization shall submit to the commissioner unaudited financial statements of the organization for the first three quarters of the year on forms prescribed by the commissioner. The statements are due 30 days after the end of the quarter and shall be maintained as nonpublic data, as defined by section 13.02, subdivision 9. Unaudited financial statements for the fourth quarter shall be submitted at the request of the commissioner.

Subd. 7. Consistent administrative expenses and investment income reporting.

(a) Every health maintenance organization must directly allocate administrative expenses to specific lines of business or products when such information is available. Remaining expenses that cannot be directly allocated must be allocated based on other methods, as recommended by the Advisory Group on Administrative Expenses. Health maintenance organizations must submit this information, including administrative expenses for dental services, using the reporting template provided by the commissioner of health.

(b) Every health maintenance organization must allocate investment income based on cumulative net income over time by business line or product and must submit this information, including investment income for dental services, using the reporting template provided by the commissioner of health.

256B.69 PREPAID HEALTH PLANS.

Subd. 9c. Managed care financial reporting.

(a) The commissioner shall collect detailed data regarding financials, provider payments, provider rate methodologies, and other data as determined by the commissioner and managed care and county-based purchasing plans that are required to be submitted under this section. The commissioner, in consultation with the commissioners of health and commerce, and in consultation with managed care plans and county-based purchasing plans, shall set uniform criteria, definitions, and standards for the data to be submitted, and shall require managed care and county-based purchasing plans to comply with these criteria, definitions, and standards when submitting data under this section. In carrying out the responsibilities of this subdivision, the commissioner shall ensure that the data collection is implemented in an integrated and coordinated manner that avoids unnecessary duplication of effort. To the extent possible, the commissioner shall use existing data sources and streamline data collection in order to reduce public and private sector administrative costs. Nothing in this subdivision shall allow release of information that is nonpublic data pursuant to section 13.02.

(b) Each managed care and county-based purchasing plan must annually provide to the commissioner the following information on state public programs, in the form and manner specified by the commissioner, according to guidelines developed by the commissioner in consultation with managed care plans and county-based purchasing plans under contract:

- (1) administrative expenses by category and subcategory consistent with administrative expense reporting to other state and federal regulatory agencies, by program;
- (2) revenues by program, including investment income;
- (3) nonadministrative service payments, provider payments, and reimbursement rates by provider type or service category, by program, paid by the managed care plan under this section or the county-based purchasing plan under section 256B.692 to providers and vendors for administrative services under contract with the plan, including but not limited to:
 - (i) individual-level provider payment and reimbursement rate data;

- (ii) provider reimbursement rate methodologies by provider type, by program, including a description of alternative payment arrangements and payments outside the claims process;
 - (iii) data on implementation of legislatively mandated provider rate changes; and
 - (iv) individual-level provider payment and reimbursement rate data and plan-specific provider reimbursement rate methodologies by provider type, by program, including alternative payment arrangements and payments outside the claims process, provided to the commissioner under this subdivision are nonpublic data as defined in section 13.02;
- (4) data on the amount of reinsurance or transfer of risk by program; and
 - (5) contribution to reserve, by program.

(c) In the event a report is published or released based on data provided under this subdivision, the commissioner shall provide the report to managed care plans and county-based purchasing plans 30 days prior to the publication or release of the report. Managed care plans and county-based purchasing plans shall have 30 days to review the report and provide comment to the commissioner.

Appendix 3 – Minnesota Supplement Report #1

< Name of HMO >

Minnesota Supplement Report #1 STATEMENT OF REVENUE, EXPENSES AND NET INCOME For the year ending December 31, 2011 Public Information, Minnesota Statutes § 62D.08

C#	NAIC Description	1	2	3	4	5	6	7	8	9	10	11	12
	As found on page 4 of the Annual Statement												
		NAIC Totals	Non-Minnesota Products (Eliminations)	Total Minnesota Products	Commercial	Medicare + Choice	Medicare Cost	Minnesota Senior Health Options (MSHO)	SNBC (MA Only)	SNBC (Integrated)	Prepaid Medical Assistance Program (PMAP)	MNCare	Dental
1	Member Months												
2	Net Premium Income (including S. non-health premium income)												
3	Change in unearned premium reserves and serve for rate credits												
4	Fee-for-service (net of S. medical expenses)												
5	Risk revenue												
6	Aggregate write-ins for other health care related revenues (Line 696)	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
7	Aggregate write-ins for other non-health revenues (Line 799)	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
8	TOTAL REVENUES (Lines 2 through 7)	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
9	Hospital/medical benefits												
10	Other professional services												
11	Outside referrals												
12	Emergency room and out-of-area												
13	Prescription drugs												
14	Aggregate write-ins for other hospital and medical expenses (Line 1498)	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
15	Incentive-Pool and Withhold Adjustments												
16	TOTAL EXPENSES (Lines 9 through 15)	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
17	Net reinsurance recoveries												
18	Total hospital and medical (Lines 16 minus 17)	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
19	Non-health claims												
20	Claims adjustment expenses												
21	General administrative expenses												
22	Increase in reserves for life, accident and health contracts (including S. increase in reserves for life only)												
23	Total underwriting deductions (Lines 18 through 22)	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
24	Net underwriting gain or (loss)(Lines 8 minus 23)	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
25	Net investment income earned												
26	Net realized capital gains or (losses)												
27	Net investment gains or (losses)(Lines 25 plus 26)	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
28	Net gain or (loss) from agents' or premium balances charged off												
29	Aggregate write-ins for other income or expenses (Line 2999)	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
30	Net income or (loss) before federal income taxes (Lines 24 plus 27 plus 28 plus 29)	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
31	Federal and foreign income taxes incurred												
32	Net income (loss) (Lines 30 minus 31)	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR

Appendix 4 – MN HMO Instructions

Date: December 1, 2011

To: Minnesota Domiciled Health Maintenance Organizations and County Based Purchasers

From: Mike Rothman, Commissioner
Minnesota Department of Commerce

Subject: Filing of Annual Statement, Supplements, Exhibits, Certificates and Reports

Contacts: Minnesota Department of Commerce
Constance Peterson, Constance.Peterson@state.mn.us (651)297-8943
Robert Rivera, Robert.Rivera@state.mn.us (651)296-4523 (Questions about Medical Necessity Evaluation Filing Only)

Minnesota Department of Health
MaryAnn (Fena) Benke, Maryann.Benke@state.mn.us (651)201-5164

NAIC Instructions and Blanks

The National Association of Insurance Commissioners (NAIC) Annual Statement health blank is required to be filed with the Department of Commerce no later than 4/1/12 per Minnesota Statutes §62D.08. Refer to the following table for details regarding the Annual Statement filing and other required filings for the year 2012:

Description	Number of Copies	Due Date	Primary MN Statute Reference	Additional Notes
Annual Statement (hard copy)	5	4/1/12	§62D.08, Subd. 2 & 3	
Annual Statement (electronic filing)	1	4/1/12	§62D.08, Subd. 2 & 3	Those organizations not filing electronically with the NAIC are required to file the Annual Statement in PDF format in addition to the required hard copies.
Investment Policy Certification	5	4/1/12	§62D.045, Subd. 2 and §60A.112	Not required for County Based Purchasers.
Audited Financial Statement	3	4/1/12	§62D.08, Subd. 3(a)	
Risk Based Capital Report	3	4/1/12	§62D.04, Subd. 1(e)	
Notification of Change in Appointed Actuary	1	Within 5 business days	§62D.08, Subd. 2 & 3	According to the NAIC Annual Statement Instructions, documentation for a newly appointed actuary needs to include the following: <ul style="list-style-type: none"> The insurer shall provide the Commissioner with a letter within 10 business days stating whether, in the preceding 24 months, there were any disagreements with the former actuary. The insurer shall request the former actuary to furnish a letter addressed to the insurer stating whether the actuary

				agrees or disagrees with the statements contained in the insurer's letter, to be forwarded to the Commissioner. • Please provide the requested information electronically by emailing it to a special email box we have established for these appointments (and illustration actuary filings): insurance.actuary@state.mn.us
Quarterly Financial Statements (hard copy)	4	4/30, 7/30 and 10/30	§62D.08, Subd. 6	
Quarterly Financial Statements (electronic filing)	1	4/30, 7/30 and 10/30	§62D.08, Subd. 6	Those organizations not filing electronically with the NAIC are required to file the Quarterly Statements in PDF format in addition to the required hard copies.

Filing Address: Department of Commerce
 Financial Institutions - Insurance
 85 Seventh Place East, Suite 500
 St. Paul, MN 55101-2198

Filing Fees: Health Maintenance Organizations: Send the filing fee of \$400 for the Annual Statement and \$200 for each Quarterly Statement, **payable to the Minnesota Department of Health** (not the Minnesota Department of Commerce), to: Managed Care Systems Section, Minnesota Department of Health, P.O. Box 64882, St. Paul, MN 55164-0882 by the filing due dates. County Based Purchasers: Filing fees not required.

Minnesota Supplemental Reports (excluding HEDIS)

Pursuant to applicable Minnesota law, complete the following reports. These report forms, with the exception of the HEDIS 2012 Data Submission Tool, can be downloaded from the "HMO Annual Report Forms" link at the bottom of the following Department of Health Web page:

www.health.state.mn.us/divs/hpsc/mcs/forms.htm

Report	Due Date	Primary MN Statute Reference	Description
1.	4/1/12	§62D.08	Statement of Revenue, Expenses and Net Income
2.	4/1/12	§4685.2000	Summary of Complaints and Grievances
3.	4/1/12	§72A.201, Subd. 8(7)	Summary of Chemical Dependency Claims and Appeals
4.	4/1/12	§62D.08, Subd. 3(d) and 4685.2100D	Participating Providers Listing
5.	4/1/12	§62M.09, Subd. 9	Medical Necessity Evaluation
6.	7/1/12	§62D.04(1)(c),(5) & 62D.08	Enrollment Statistics By Products and County
7.	7/1/12	§62D.04(1)(c),(5) & 62D.08	HEDIS 2012 (For Calendar Year 2011) Data Submission Tool (through NCQA). Separate Instructions to Follow.

Instructions for filing the HEDIS data (through NCQA) will be sent from the Minnesota Department of Health under separate cover.

In addition to the electronic copy of the Medical Necessity Evaluation Form filing (Supplemental Report #5) with the Department of Health, e-mail a copy of the filing to Robert Rivera at the Department of Commerce: Robert.Rivera@state.mn.us.

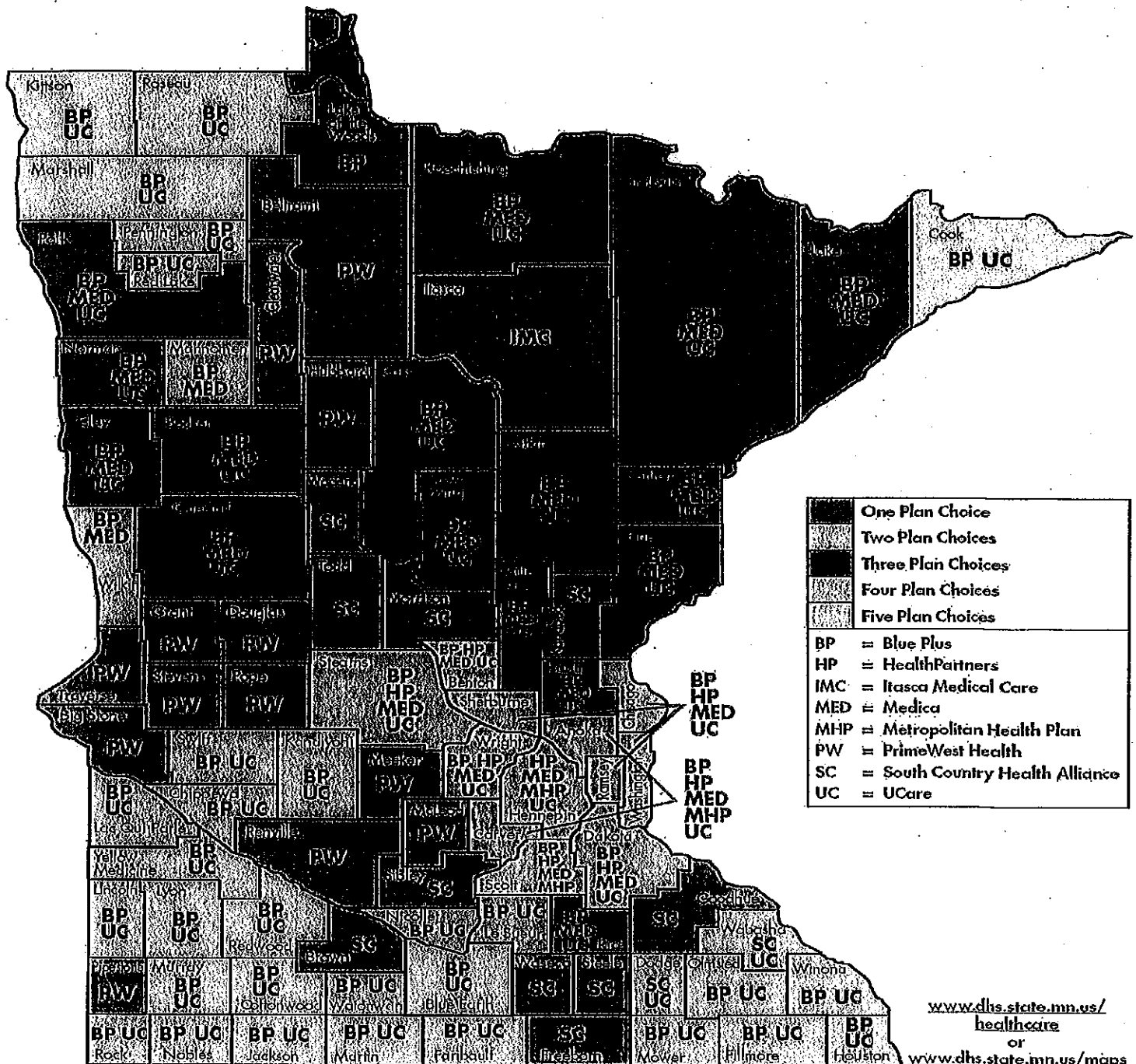
All financial information in reports 1-7 should reconcile with the applicable statement, exhibit or schedule data contained in the NAIC Annual Statement health blank filing.

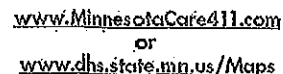
Minnesota Supplements Filing Instructions: It is not necessary to send a paper copy in addition to the electronic submission; none of these reports require a signature. Send the completed Minnesota Supplement forms on a CD to:

Mailing Address: Dedra Johnson
Managed Care Systems Section
Minnesota Department of Health
P.O. Box 64882
St. Paul, MN 55164-0882

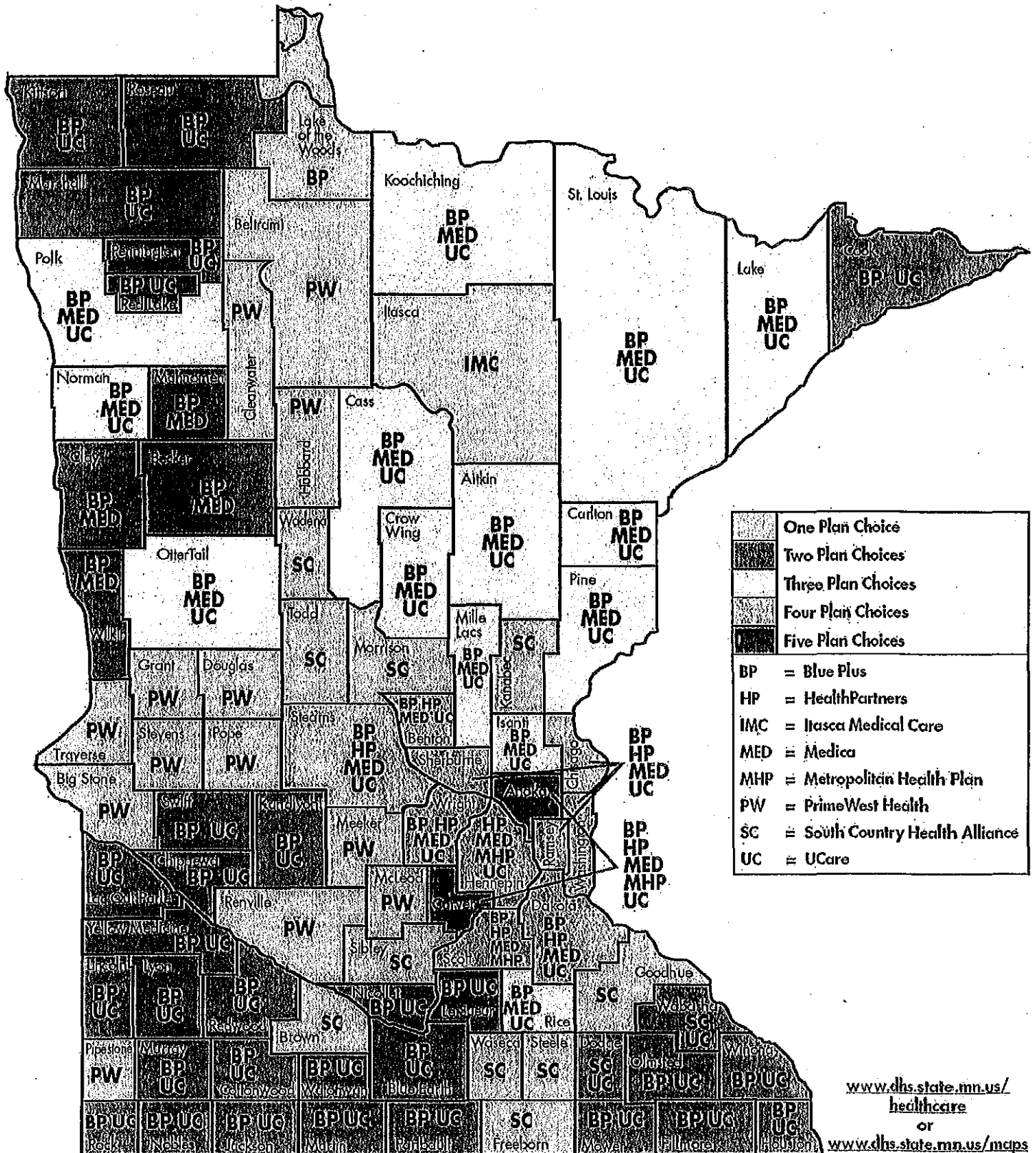
Courier Address: Managed Care Systemis Section
Minnesota Department of Health
85 Seventh Place East, Suite 220
St. Paul, MN 55101

Appendix 5 - Prepaid Medical Assistance Program (PMAP) map
Health Plan Choices by County Effective April 1, 2011

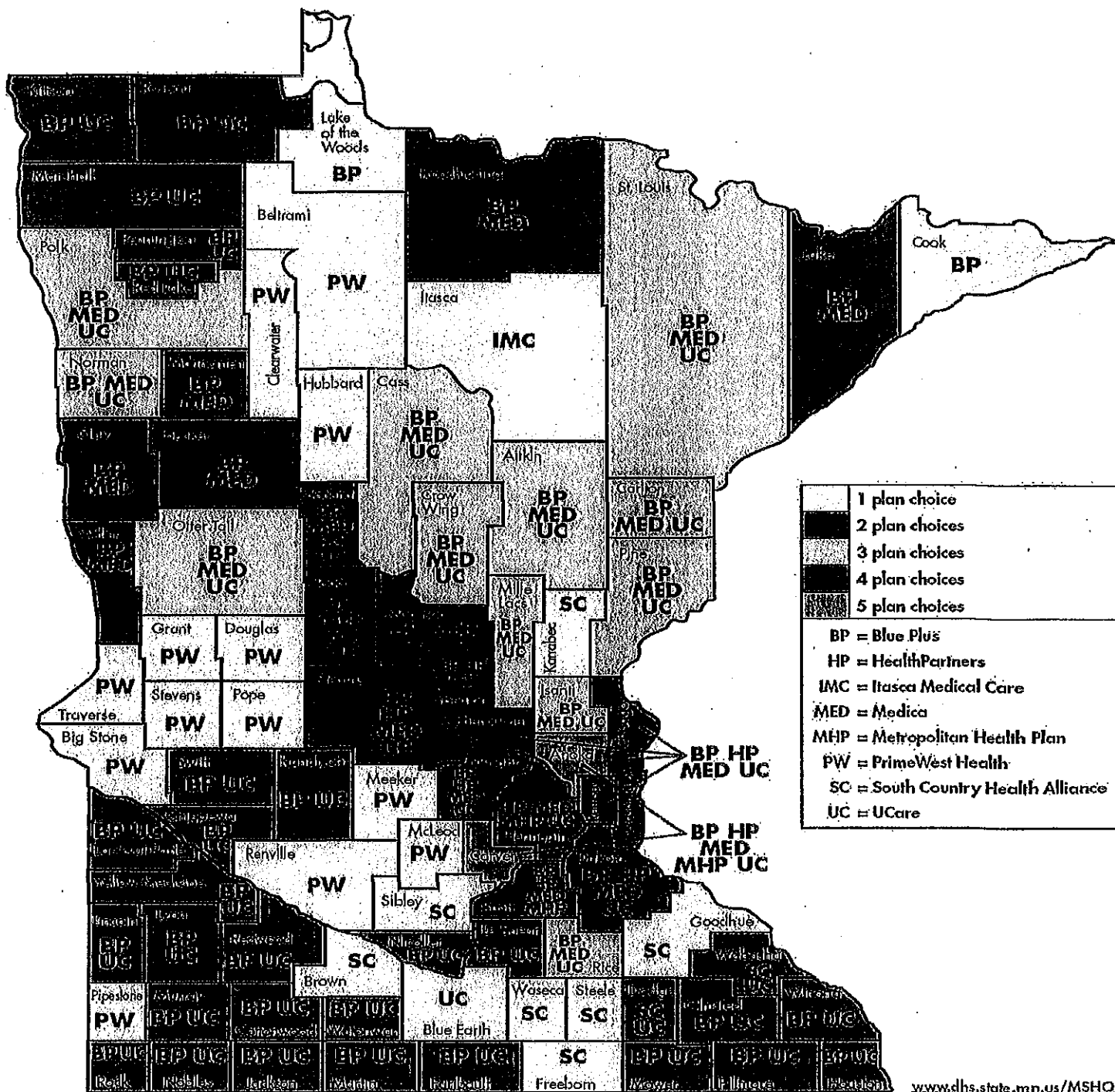


Health Plan Choices by County Effective April 1, 2011

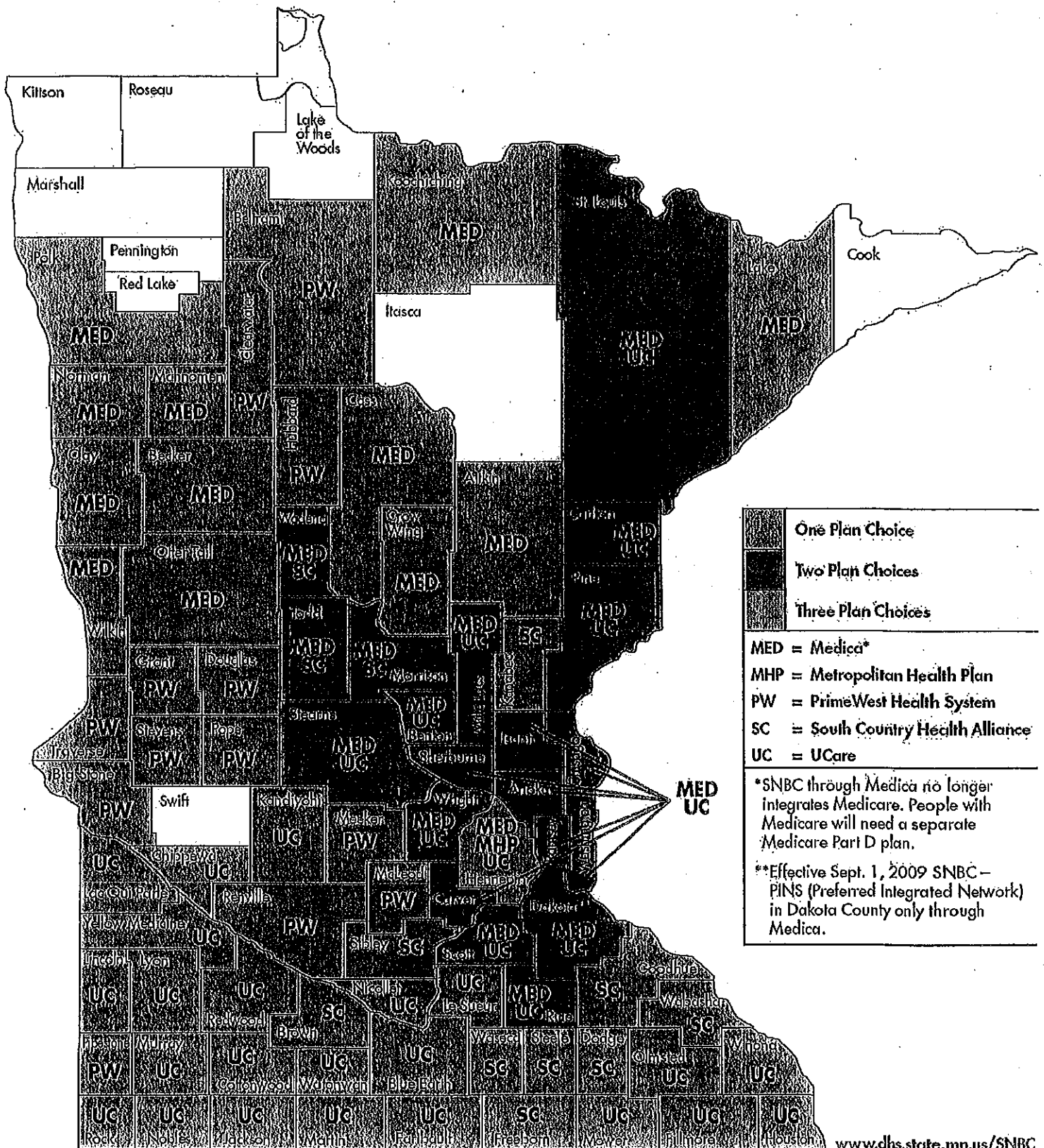
Appendix 7 - Minnesota Senior Care Plus (MSC+) map
Health Plan Choices by County Effective April 1, 2011



Health Plan Choices by County for Effective Jan. 1, 2011

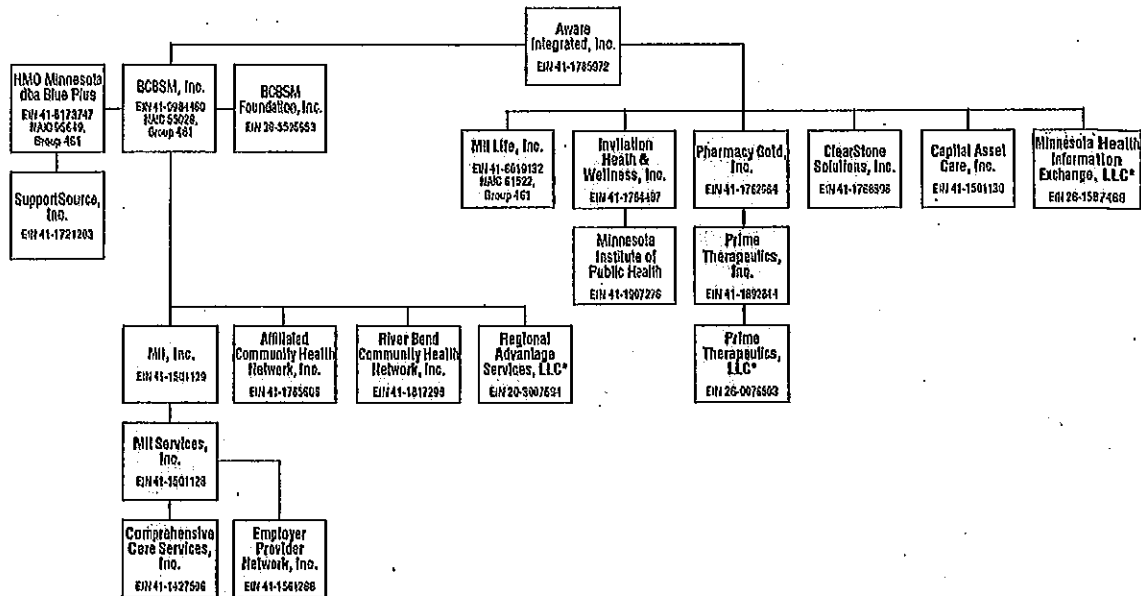


Appendix 9 - Special Needs Basic Care (SNBC) map **Health Plan Choices by County Effective Jan. 1, 2011**



Appendix 10 – Corporate Organization Chart

Aware Integrated, Inc. Corporate Organization



X10852R06 (1/12)

Bolded and Shadowed Entities are For-Profit.
*Minority Ownership Interest

1/2012

Addendum to Report

Blue Plus Comment Letter

Blue Cross and Blue Shield of Minnesota
and Blue Plus

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For the health of all.

The Minnesota Department of Commerce (MNDOC) employed the services of Risk and Regulatory Consulting, LLC (RRC) in order to assist it in evaluating the appropriateness of managed care plans' expense allocations to public programs, the appropriateness of established Premium Deficiency Reserves and the Retrospective Review of Reserves established for such public programs. This evaluation was conducted in accordance with Executive Order 11-06 Creating Public Disclosure for Minnesota's Managed Care Health Care Programs issued March 21, 2011 and information was also collected as provided in Minn. Statutes Section 256B.69, subd 9c. The public programs are provided by various Managed Care Organizations, including Blue Plus.

Below are HMO Minnesota's (Blue Plus or the Company) responses to the observations and findings noted in the final report labeled:

**STATE OF MINNESOTA
HMO MINNESOTA d/b/a BLUE PLUS
WORK ORDER CONTRACT NO: 47132
December 04, 2012**

Within the scope and procedures of the review, there were limited exceptions and Blue Plus' responses to those items are contained herein. This document should be read in conjunction with the final report to give a complete and comprehensive understanding of the observations and findings.

As stated by RRC, the observations and findings are not in violations of Statutory Accounting Principles and State Law.

The recommendations in each finding below are that the Company should allocate only those expenses that are directly related to the public programs. The Company follows Statutory Accounting Principles and its internal corporate allocation policies. When possible specific identification of expenses is recorded and in all cases a reasonable methodology is employed. The Company disagrees with each of the findings below, with the exception of one in which the Company acknowledges an error of \$10,000.

Observations & Blue Plus Responses:

1. Blue Plus made a \$10 million cash contribution to the BCBSM Foundation on December 29, 2011.

The entire \$10 million contribution was included in Column 13 "Med Mgmt" line 21 "general administrative expenses" of the MN Supplement Report #1. The Blue Plus Medical Management "Med Mgmt" program relates to services performed by Blue Plus for the Northern Plains Alliance, a group of six Blue plans covering the seven state region including NE, ND, MT, WY, MN, IA, and SD. These services include managing the business functions for the Northern Plains Alliance related to case management, utilization management, nurse phone line, disease management and select quality improvement functions.

bluecrossmn.com

Blue Plus Response:

Column 13 of the Minnesota Supplement Report #1 is for "Other" activities that do not fit into the other predetermined columns. For Blue Plus the majority of this column is for its Medical Management activities. In 2011 this column also included the \$10 million contribution to the Blue Cross Blue Shield Foundation such that this expense would not be allocated to/or included in any public program or government business results.

The contribution to the foundation is being utilized to fund charitable initiatives benefitting populations eligible for state public programs and to improve community conditions affecting the health and well-being of low income children and families in Minnesota.

2. RRC reviewed how salaries were allocated to the Company's public and non-public programs, including the salaries of its executives. Blue Plus was allocated approximately \$1.8 million of "Executive Management" expenses in 2011. Blue Plus allocates executive management expenses based on an "executive allocation statistic". According to the Company, each executive's allocation rule is determined by collaboration between the Finance area and the executives. The allocation is based on member months and a weighting factor for each executive. The Company was not required to, and did not, cap executive salaries prior to allocating them to the public programs or any other programs administered by the Company.

Blue Plus Response:

It is not clear to Blue Plus why this is included as an observation, when it states in the observation that there is no requirement to cap executive salaries. The allocation methodology for executive salaries is appropriate, reasonable and in accordance with our policies.

3. Blue Plus was asked to perform a re-estimation of PDR using actual experience that was available. Based on claims paid data through May 31, 2012, the Company re-estimated its 2011 PDR to be approximately \$5,140,000 million lower than originally booked at December 31, 2011.

Blue Plus Response:

The premium deficiency reserve (PDR) is an estimate required to be made under accounting principles based on the best information available at year end. This liability will develop favorably or unfavorably as actual experience occurs in the following year. The \$5,140,000 difference that is currently estimated is 0.76% of 2011 public program revenue and is before taking into account the \$11.2 million that was required to be paid to the State under the 2011 1% operating margin cap. If this were to be taken into account, the PDR developed unfavorably by \$6.2 million. Within the

report RRC states that the PDR is conservative, appropriate and adheres to generally accepted actuarial principles.

4. The Company provided a listing of profit centers for Blue Plus and BCBSM that are considered "government programs". Not all profit centers were allocated government-related expenses.

Blue Plus Response:

Government related expenses are allocated to the appropriate profit centers based on activities that are performed and to which programs they relate.

5. In reviewing the Company's expenses and allocations, it was noted Blue Plus does not have a separate profit center established for MSC+.

Blue Plus Response:

MSC+ was originally part of the PMAP contract and therefore was combined with and accounted for as part of that profit center. In order to separate MSC+ from the PMAP column on the 2011 Minnesota Supplement Report the revenue and claims were specifically identified and administrative costs were allocated based on the ratio of member months. A separate MSC+ profit center has been set up for 2012 and beyond.

6. There are three separate cost centers for IHM-GP. These include case management, disease management and utilization management. According to the Company, these cost centers provide care management for government program members. This cost center also includes staff that performs access management for commercial business. Costs are allocated based on a fixed percentage determined from staffing. Blue Plus government programs PMAP, MSHO and MNCare are allocated approximately 99% of these costs. BCBSM government programs are allocated the remaining 1%.

Blue Plus Response:

The three cost centers for IHM-GP are allocated to government programs and do not include staff that perform access management for commercial business. The commercial staff are included in a separate cost center and are not allocated to any government program business.

7. PMAP & MNCare were allocated approximately \$330,000 of expenses in 2011 for cost center 12600 "Virginia Commercial Claims". PMAP & MNCare were allocated approximately \$35,000 of expenses in 2011 for cost center 89300 "Commercial Accounts Large Group". The

Company indicated the naming convention for cost center 12600 is "Virginia Commercial Claims" but staff in this cost center also works on government claims, including PMAP & MNCare. The different types of claims are identified within a claims tracking system. There also is a cost center "Virginia Government Claims" which is 100% dedicated to government claims. As claim volume fluctuates throughout the month, in addition to having individuals in the government claims cost center work overtime, individuals within the Commercial claims cost center are utilized when needed.

Blue Plus Response:

The allocation methodology is appropriate, reasonable and in accordance with our policies.

8. The Company allocates costs to the Printing & Postage cost center based on a total membership statistic. Blue Plus was allocated approximately \$1.0 million of printing & postage expenses in 2011. Approximately \$ 875,000 was allocated to PMAP and MNCare. This is in addition to cost center "Printing & Postage - Govt" 2011 expenses of \$ 356,000, of which \$330,000 was allocated to PMAP and MNCare. The Company indicated the Printing & Postage cost center contains the cost of transactional print and postage that is business critical. The Company indicated the Printing & Postage - Government cost center contains the cost of marketing print and postage. The Company indicated the membership statistic is utilized due to the volume of transactions.

Blue Plus Response:

The allocation methodology is appropriate, reasonable and in accordance with our policies.

Findings & Blue Plus Responses:

1. Marketing and Corporate Communications

Finding:

The Company allocates Marketing & Corporate Communications expenses based on total MN membership statistics. This includes all Blue Plus profit centers except Med Mgmt. Blue Plus was allocated \$1.4 million of Marketing & Corporate Communications expenses in 2011. Of this amount, PMAP and MNCare were allocated approximately \$1.2 million in 2011.

BCBSM runs a variety of ads including their "Do" campaign on local TV stations. These ads do not target Blue Plus or the public programs. The Company indicated the expenses within the Marketing and Corporate Communications cost center are not specific to any one segment but are for business overall. Blue Plus was allocated 11.4% (10% to PMAP and MNCare) of the following December 2011 expenses (partial listing):

\$1.0 million - Haworth (TV ads)
\$133,922 - Twins Ballpark Sponsorship

In addition to direct expenses, Blue Plus was also allocated a portion of "Tier 1" expenses for payroll, benefits, travel, rent, etc. within the "Marketing & Corporate Communications" account. "Tier 1" expenses spread overhead-type costs to the cost centers. These costs include human resources, payroll, benefits, travel, building services, rent, depreciation, mail services, voice/data systems and local area network.

According to the Medical Assistance (PMAP) and MNCare contract between Blue Plus and DHS section 3.2.4 "Marketing Materials":

(C) Except through mailings and publications as set forth below, the MCO and any of its subcontractors, agents, independent contractors, employees and Providers, is restricted from Marketing and promotion to Recipients who are not enrolled in the MCO. This restriction includes, but is not limited to: telephone marketing, face-to-face marketing, promotion, cold-calling and/or direct mail marketing.

(2) Mailings to recipients. The MCO may make no more than two mailings per calendar year to Enrollees of the MCO covered under this Contract or potential Enrollees who reside in the MCO's Service Area.

a) The MCO may distribute brochures and display posters at physician offices and clinics, informing patients that the clinic or physician is part of the MCO's provider network...

b) The MCO may provide health education materials for Enrollees in Providers' offices.

Recommendation:

The Company should allocate only those direct expenses allowed by the contract to PMAP and MNCare public programs.

Blue Plus Response:

The expenses accounted for in the marketing and communications cost center are not for the expenses addressed in the contract section above but rather are corporate business expenses that promote recognition of the organization in the wider community and are a normal cost of doing business. The expenses noted are not targeted to a specific population and do not promote any specific products but are related to health awareness and brand. Of the specific expenses identified above, PMAP and MNCare were allocated 11.4% or \$129,267.

2. Affiliated Medical Center Covenant

Finding:

Affiliated Medical Centers, P.A. (AMC) entered into an Affiliation and Capitalization agreement with BCBSM and Blue Plus on December 21, 1993. The agreement calls for total principal payments from BCBSM to AMC in the amount of \$9,912,754. The amount is being amortized over a thirty year time period on a straight line basis; each year BCBSM allocates to Blue Plus \$330,425 ($\$9,912,754 / 30$) of amortization expense related to this agreement. Of this amount, 46% is allocated to PMAP, 27% to MNCare, 21% to MSHO and the remaining 6% to Blue Plus Commercial. BCBSM is not allocated any portion of the amortization expense. The amortization expense is included in general administrative expenses. The Company did not provide a complete copy of the agreement between the parties nor a description of the nature of the services or activities underlying the agreement. Based on the information provided by the Company, it is unclear how the agreement specifically relates to the public programs.

Recommendation:

The Company should only allocate expenses that can be shown to directly relate to the public programs. Any portion not allocable to the public programs should be allocated to other programs or entities, including BCBSM.

Blue Plus Response:

The Affiliation and Capitalization Agreement was originally filed, reviewed and approved in its entirety by the Minnesota Department of Health. Affiliated Medical Centers, P.A. (now known as Affiliated Community Medical Centers, P.A.) (ACMC), BCBSM, Inc. dba Blue Cross and Blue Shield of Minnesota (Blue Cross) and Blue Plus are parties to an Affiliation and Capitalization Agreement entered into in 1993. A primary purpose of the agreement was to assure the long term independence of ACMC and to ensure continued access to quality and cost effective health services for Blue Plus' managed care members in ACMC's service area. ACMC continues to be the primary service provider for Blue Plus public programs members in ACMC's service area. All payments made pursuant to a promissory note signed by Blue Plus were allocated to Blue Plus business.

3. Mankato Covenant

Finding:

The Company entered into an agreement with Mankato Clinic. We were not provided the first 19 pages of the agreement or the last pages of the agreement. The agreement calls for total principal payments from BCBSM/Blue Plus to Mankato in the amount of \$8,000,000. The amount is being amortized over a twenty year time period on a straight line basis; each year BCBSM allocates to Blue Plus \$200,000 ($\$8,000,000 / 20$) of amortization expense related to this agreement. Of this

amount, 46% is allocated to PMAP, 27% to MNCare, 21% to MSHO and the remaining 6% to Blue Plus Commercial. BCBSM is also allocated \$200,000 of the amortization expense. The amortization expense is included in general administrative expenses. The Company did not provide a complete copy of the agreement between the parties nor a description of the nature of the services or activities underlying the agreement. Based on the information provided by the Company, it is unclear how the agreement specifically relates to the public programs.

Recommendation:

The Company should only allocate expenses that can be shown to directly relate to the public programs. Any portion not allocable to the public programs should be allocated to other programs or entities, including BCBSM.

Blue Plus Response:

The Joint Venture and Affiliation Agreement was originally filed, reviewed and approved in its entirety by the Minnesota Department of Health. A Joint Venture and Affiliation Agreement was entered into by Mankato Clinic, Ltd, BCBSM, Inc. dba Blue Cross and Blue Shield of Minnesota (Blue Cross) and Blue Plus in 1995. A primary purpose of the agreement was to assure the long term independence of Mankato Clinic and to ensure continued access to quality and cost effective health services for our members in Mankato Clinic's service area. Mankato Clinic continues to be a significant service provider for Blue Plus public programs members in Mankato Clinic's service area. Pursuant to the agreement, Blue Cross and Blue Plus jointly agreed to pay Mankato Clinic the sum of \$8.0 million per a payment schedule ending in 2014.

4. Government Program Management

Finding:

Allocation to this cost center is based on a fixed percentage statistic. The following costs were included in this cost center: payroll, benefits, car insurance allowance, meals, cell phones and travel. These were in addition to the Company's allocation of "Tier 1" expenses. The Company also included various fees to attend exhibits & conferences in MN as expenses. These exhibits and conferences target the public programs. The Company indicated this cost center also includes sales promotion and travel related to the PMAP, MSHO and MNCare programs. This appears to be in violation of the PMAP and MNCare contract between the Company and DHS.

Expenses in 2011 for this account were approximately \$720,000. There were no allocations to the BCBSM government programs. Expenses were allocated entirely to the following Blue Plus profit centers:

150100 PMAP
150200 MSHO
160100 MNCare

According to the Medical Assistance (PMAP) and MNCare contract between Blue Plus and DHS section 3.2.4 "Marketing Materials":

(C) Except through mailings and publications as set forth below, the MCO and any of its subcontractors, agents, independent contractors, employees and Providers, is restricted from Marketing and promotion to Recipients who are not enrolled in the MCO. This restriction includes, but is not limited to: telephone marketing, face-to-face marketing, promotion, cold-calling and/or direct mail marketing.

Recommendation:

The Company should allocate only those expenses allowed by the contract to PMAP and MNCare programs.

Blue Plus Response:

The expenses allocated to this cost center are not related to the marketing mailings and promotional activities targeted to enrollees or potential enrollees as described in Section 3.2.4 (C) of the Contract quoted in the report. This cost center has responsibility for business partnerships statewide that support government programs. This responsibility includes education, problem solving, regulatory adherence, training Care Coordinators for the Counties and Clinics, auditing case files and ensuring that assessments, CMS and DHS requirements are met.

Of the \$720,000 allocated to Blue Plus, \$144,011 was allocated to PMAP and MNCare. These costs are for the purpose of managing the business and developing and maintaining relationships with stakeholders, delegates and counties. There are also state-wide travel expenses included in this amount related to providing Child and Teen Check Up/Blood Lead Screening clinic training, Home Care Association Provider Training, attending C&TC Coordinator meetings, Public Health Conferences and collaborative meetings; DHS work group meetings, etc. Activities related to lead screening and C & TC activities are specifically referenced in the contract. Blue Plus staff attend and exhibit at numerous state-wide conferences to connect with its provider and county partners. These expenses were reasonable, allowed under the contract and appropriately allocated in accordance with our policies.

5. Gov't Prog Business Strategy & Development

Finding:

Costs are allocated based on a fixed percentage statistic. Blue Plus profit centers (PMAP, MSHO and MNCare) are allocated approximately 74% and BCBSM profit centers are allocated 26%.

Blue Plus was allocated \$1.1 million of costs in 2011. It was noted Blue Plus was allocated 74% of a \$37,000 Medicare Parts C&D audit. PMAP and MNCare were allocated approximately \$10,000 of the Medicare Parts C&D audit. Medicare Parts C&D do not involve PMAP and MNCare.

Recommendation:

The Company should allocate only those government expenses that directly relate to the public programs.

Blue Plus Response:

Blue Plus agrees with the above finding. The audit costs were inadvertently allocated across programs rather than being directly allocated 100% to MSHO.

6. Lobbying Expenses

Finding:

PMAP & MNCare were allocated approximately \$67,000 of expenses in 2011 for cost center 80503 "MN Lobbying".

PMAP & MNCare were allocated approximately \$21,000 of expenses in 2011 for cost center 80505 "Federal Lobbying".

According to the Medical Assistance (PMAP) and MNCare contract between Blue Plus and DHS Article 15 "Lobbying Disclosure":

The MCO certifies, that, to the best of its knowledge, understanding, and belief, that:

- (A) No Federal Funds Used. No Federal appropriated funds have been paid or will be paid in what the undersigned believes to be a violation of 31 U.S.C. § 1352, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, Member of Congress, an officer or employee of Congress...*
- (B) Other Funds Used. If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress or an employee of a Member of Congress in connection with this Federal contract, grant, loan or cooperative agreement,, the undersigned shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.*
- (C) Certification. The undersigned will require that the language of this certification be included in the award documents for all sub-awards at all tiers (including subcontractors, sub-grants and contracts under grants, loans, and cooperative agreements) and will required that all sub-Recipients certify and disclose accordingly. Submission of this certification is a prerequisite for making or entering into this transaction imposed by 31 U.S.C. § 1352. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.*

Recommendation:

The Company should allocate only those lobbying expenses that directly relate to the public programs and report them in accordance with the contract.

Blue Plus Response:

These expenses are not specific to a contract, but represent an allocation of overall lobbying expenses including expenses at the State and Federal level, relating to health care reform, review of legislative proposals and the impact of health care reform on all health care programs including the Medicaid program. These expenses were reasonable and appropriately allocated in accordance with our policies.

Blue Plus' Summary Comments

RRC performed specific tasks under the Scope and Procedures in accordance with the Executive Order. There were no exceptions with respect to the reporting and accuracy of the Minnesota Supplement Report #1 and its PDR and claim reserve methodologies were found to be appropriate and the amounts recorded reasonable. The allocation methodology followed by Blue Plus was in accordance with Statutory Accounting Principles.