VERMONT

ATTACHMENT C

APPLICATION COVER SHEET AND CHECK-OFF LIST

Identifying Information:

Grant Opportunity: **HHS Health Insurance Rate Review Grants-Cycle I**

DUNS #: 809376601 Grant Award: $1 million

Applicant: Vermont Department of Banking, Insurance, Securities and Health Care Administration (BISHCA)

Primary Contact Person, Name: Christine Oliver

Telephone Number: 802-828-2900 Fax number: 802-828-2949

Email address: christine.oliver@state.vt.us

APPLICATION COVER SHEET AND CHECK-OFF LIST

REQUIRED CONTENTS

A complete proposal consists of the following material organized in the sequence below: Please ensure that the project narrative is page-numbered. The sequence is:

- ☐ Cover Sheet
- ☐ Forms/Mandatory Documents (Grants.gov).

  The following forms must be completed with an original signature and enclosed as part of the proposal:

- ☐ SF-424: Application for Federal Assistance
- ☐ SF-424A: Budget Information
- ☐ SF-424B: Assurances-Non-Construction Programs
- ☐ SF-LLL: Disclosure of Lobbying Activities
- ☐ Additional Assurance Certifications
- ☐ Required Letter of support and Memorandum of Agreement
- ☐ Applicant's Application Cover Letter
- ☐ Project Abstract
- ☐ Project Narrative
- ☐ Work plan and Time Line
- ☐ Proposed Budget (Narrative/Justifications)
- ☐ Required Appendices
- ☐ Resume/Job Description for Project Director and Assistant Director

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

*1. Type of Submission:	*2. Type of Application	* If Revision, select appropriate letter(s)
☐ Preapplication	☒ New	
☒ Application	☐ Continuation	*Other (Specify)
☐ Changed/Corrected Application	☐ Revision	

3. Date Received:	4. Applicant Identifier: N/A

5a. Federal Entity Identifier: N/A	*5b. Federal Award Identifier:

State Use Only:

6. Date Received by State:	7. State Application Identifier:

8. APPLICANT INFORMATION:

*a. Legal Name: Vermont Department of Banking, Insurance, Securities and Health Care Admnistration

*b. Employer/Taxpayer Identification Number (EIN/TIN): 03-6000264	*c. Organizational DUNS: 809376601

d. Address:

*Street 1:	89 Main Street
Street 2:	
*City:	Montpelier
County:	
*State:	Vermont
Province:	
*Country:	USA
*Zip / Postal Code	05620-3101

e. Organizational Unit:

Department Name: Department of BISHCA	Division Name: Division of Health Care Administration

f. Name and contact information of person to be contacted on matters involving this application:

Prefix:	Ms.	*First Name:	Christine
Middle Name:			
*Last Name:	Oliver		
Suffix:			

Title: Deputy Commissioner

Organizational Affiliation: Deputy Commissioner

*Telephone Number: 802-828-2919 Fax Number:

*Email: christine.oliver@state.vt.us

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

***9. Type of Applicant 1: Select Applicant Type:**

A.State Government

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

*Other (Specify)

***10 Name of Federal Agency:**

Department of Health and Human Services

11. Catalog of Federal Domestic Assistance Number:

93.511

CFDA Title:

Grants to States for Health Insurance Premium Review - Cycle 1

***12 Funding Opportunity Number:**

RFA-FD-10-999

*Title:

Grants to States for Health Insurance Premium Review - Cycle 1

13. Competition Identification Number:

N/A

Title:

14. Areas Affected by Project (Cities, Counties, States, etc.):

State of Vermont

***15. Descriptive Title of Applicant's Project:**

Premium Review Grant

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

16. Congressional Districts Of:

*a. Applicant: VT-001 *b. Program/Project: VT-001

17. Proposed Project:

*a. Start Date: August 9, 2010 *b. End Date: September 30, 2011

18. Estimated Funding ($):

*a. Federal	$1,000,000
*b. Applicant	
*c. State	
*d. Local	
*e. Other	
*f. Program Income	
*g. TOTAL	

***19. Is Application Subject to Review By State Under Executive Order 12372 Process?**

☐ a. This application was made available to the State under the Executive Order 12372 Process for review on _____

☐ b. Program is subject to E.O. 12372 but has not been selected by the State for review.

☒ c. Program is not covered by E. O. 12372

***20. Is the Applicant Delinquent On Any Federal Debt? (If "Yes", provide explanation.)**

☐ Yes ☒ No

21. *By signing this application, I certify (1) to the statements contained in the list of certifications** and (2) that the statements herein are true, complete and accurate to the best of my knowledge. I also provide the required assurances** and agree to comply with any resulting terms if I accept an award. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. (U. S. Code, Title 218, Section 1001)

☒ ** I AGREE

** The list of certifications and assurances, or an internet site where you may obtain this list, is contained in the announcement or agency specific instructions

Authorized Representative:

Prefix: Honorable *First Name: Michael

Middle Name: S.

*Last Name: Bertrand

Suffix:

*Title: Commissioner (Michael Bertrand, Commissioner)

*Telephone Number: 802-828-2380 Fax Number: 802-828-2896

* Email: michael.bertrand@state.vt.us

*Signature of Authorized Representative: *Date Signed: 07/07/2010

Application for Federal Assistance SF-424 Version 02

***Applicant Federal Debt Delinquency Explanation**

The following should contain an explanation if the Applicant organization is delinquent of any Federal Debt.

BUDGET INFORMATION - Non-Construction Programs

OMB Approval No 4040-0006
Expiration Date 04/30/2008

SECTION A - BUDGET SUMMARY

Grant Program Function or Activity (a)	Catalog of Federal Domestic Assistance Number (b)	Estimated Unobligated Funds		New or Revised Budget		
		Federal (c)	Non-Federal (d)	Federal (e)	Non-Federal (f)	Total (g)
1. $332,442		$	$ 332,442	$	$	$ 332,442
2. $266 579			266,579			266,579
3. $379,025			379025			379,025
4. $21,954			21,954			21 954
5. Totals		$	$ 1,000,000	$	$	$ 1,000,000

SECTION B - BUDGET CATEGORIES

6. Object Class Categories	GRANT PROGRAM, FUNCTION OR ACTIVITY (1)	(2)	(3)	(4)	Total (5)
a. Personnel	$ 149,650	$ 104,755	$ 29,930	$ 14,965	$ 299,300
b. Fringe Benefits	46,392	32,477	9,278	4,639	92,783
c. Travel	1,000	700	200	100	2,000
d. Equipment	8,750	6,125	1,750	875	17,500
e. Supplies	3,750	2,625	750	375	7,500
f. Contractual	112,900	112,900	335,117	0	560,917
g. Construction					
h. Other	10,000	7,000	2,000	1,000	20,000
i. Total Direct Charges (sum of 6a-6h)					$ 1,000,000
j. Indirect Charges					$
k. TOTALS (sum of 6i and 6j)	$	$	$	$	$ 1,000,000
7. Program Income	$	$	$	$	$

Authorized for Local Reproduction

Standard Form 424A (Rev. 7- 97)
Prescribed by OMB (Circular A -102)

Note: Grant Program Activity (1a) Combines:
I. Expanding Scope of Current review
II. Improving rate filing requirements

Budget Categories in Section B, Column 1, are Split 50-50%.

SECTION C - NON-FEDERAL RESOURCES

(a) Grant Program	(b) Applicant	(c) State	(d) Other Sources	(e) TOTALS
8.	$	$	$	$
9.				
10.				
11.				
12. TOTAL (sum of lines 8-11)	$	$	$	$

SECTION D - FORECASTED CASH NEEDS

	Total for 1st Year	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
13. Federal	$ 1,000,000	$ 200,000	$ 300,000	$ 300,000	$ 200,000
14. Non-Federal	$				
15. TOTAL (sum of lines 13 and 14)	$ 1,000,000	$ 200,000	$ 300,000	$ 300,000	$ 200,000

SECTION E - BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED FOR BALANCE OF THE PROJECT

(a) Grant Program	FUTURE FUNDING PERIODS (Years) (b) First	(c) Second	(d) Third	(e) Fourth
16.	$	$	$	$
17.				
18.				
19.				
20. TOTAL (sum of lines 16 - 19)	$	$	$	$

SECTION F - OTHER BUDGET INFORMATION

21. Direct Charges:

22. Indirect Charges:

23. Remarks:

OMB Approval No. 4040-0007
Expiration Date 04/30/2008

ASSURANCES - NON-CONSTRUCTION PROGRAMS

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

NOTE: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant, I certify that the applicant:

1. Has the legal authority to apply for Federal assistance and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project cost) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States and, if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to nondiscrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and, (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Titles II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally-assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally-assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clean Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended (P.L. 93-523); and, (h) protection of endangered species under the Endangered Species Act of 1973, as amended (P.L. 93-205).

12 Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead-based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."

18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations, and policies governing this program.

* SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL Completed on submission to Grants.gov	* TITLE Commissioner of BISHCA
* APPLICANT ORGANIZATION Vermont Department of Banking, Insurance, Securities and Health Care Administration	* DATE SUBMITTED 07/07/2010 Completed on submission to Grants.gov

INSTRUCTIONS FOR THE SF-424

This is a standard form (including the continuation sheet) required for use as a cover sheet for submission of preapplications and applications and related information under discretionary programs. Some of the items are required and some are optional at the discretion of the applicant or the Federal agency (agency). Required items are identified with an asterisk on the form and are specified in the instructions below. In addition to the instructions provided below, applicants must consult agency instructions to determine specific requirements.

Item	Entry:	Item	Entry:
1.	**Type of Submission:** (Required): Select one type of submission in accordance with agency instructions. • Preapplication • Application • Changed/Corrected Application – If requested by the agency, check if this submission is to change or correct a previously submitted application. Unless requested by the agency, applicants may not use this to submit changes after the closing date.	10.	**Name Of Federal Agency:** (Required) Enter the name of the Federal agency from which assistance is being requested with this application.
		11.	**Catalog Of Federal Domestic Assistance Number/Title:** Enter the Catalog of Federal Domestic Assistance number and title of the program under which assistance is requested, as found in the program announcement, if applicable.
2.	**Type of Application:** (Required) Select one type of application in accordance with agency instructions. • New – An application that is being submitted to an agency for the first time. • Continuation - An extension for an additional funding/budget period for a project with a projected completion date. This can include renewals. • Revision - Any change in the Federal Government's financial obligation or contingent liability from an existing obligation. If a revision, enter the appropriate letter(s). More than one may be selected. If "Other" is selected, please specify in text box provided. A. Increase Award B. Decrease Award C. Increase Duration D. Decrease Duration E. Other (specify):	12.	**Funding Opportunity Number/Title:** (Required) Enter the Funding Opportunity Number and title of the opportunity under which assistance is requested, as found in the program announcement.
		13.	**Competition Identification Number/Title:** Enter the Competition Identification Number and title of the competition under which assistance is requested, if applicable.
		14.	**Areas Affected By Project:** List the areas or entities using the categories (e.g., cities, counties, states, etc.) specified in agency instructions. Use the continuation sheet to enter additional areas, if needed.
3.	**Date Received:** Leave this field blank. This date will be assigned by the Federal agency.	15.	**Descriptive Title of Applicant's Project:** (Required) Enter a brief descriptive title of the project. If appropriate, attach a map showing project location (e.g., construction or real property projects). For preapplications, attach a summary description of the project.
4.	**Applicant Identifier:** Enter the entity identifier assigned by the Federal agency, if any, or applicant's control number, if applicable.		
5a	**Federal Entity Identifier:** Enter the number assigned to your organization by the Federal Agency, if any.	16.	**Congressional Districts Of:** (Required) 16a. Enter the applicant's Congressional District, and 16b. Enter all District(s) affected by the program or project. Enter in the format: 2 characters State Abbreviation – 3 characters District Number, e.g., CA-005 for California 5th district, CA-012 for California 12th district, NC-103 for North Carolina's 103rd district. • If all congressional districts in a state are affected, enter "all" for the district number, e.g., MD-all for all congressional districts in Maryland. • If nationwide, i.e. all districts within all states are affected, enter US-all. • If the program/project is outside the US, enter 00-000.
5b.	**Federal Award Identifier:** For new applications leave blank. For a continuation or revision to an existing award, enter the previously assigned Federal award identifier number. If a changed/corrected application, enter the Federal identifier in accordance with agency instructions.		
6.	**Date Received by State:** Leave this field blank. This date will be assigned by the State, if applicable.		
7.	**State Application Identifier:** Leave this field blank. This identifier will be assigned by the State, if applicable.		
8.	**Applicant Information:** Enter the following in accordance with agency instructions: **a. Legal Name.** (Required): Enter the legal name of applicant that will undertake the assistance activity. This is the name that the organization has registered with the Central Contractor Registry. Information on registering with CCR may be obtained by visiting the Grants.gov website.	17.	**Proposed Project Start and End Dates:** (Required) Enter the proposed start date and end date of the project.
	b. Employer/Taxpayer Number (EIN/TIN): (Required): Enter the Employer or Taxpayer Identification Number (EIN or TIN) as assigned by the Internal Revenue Service. If your organization is not in the US, enter 44-4444444.	18.	**Estimated Funding:** (Required) Enter the amount requested or to be contributed during the first funding/budget period by each contributor. Value of in-kind contributions should be included on appropriate lines, as applicable. If the action will result in a dollar change to an existing award, indicate only the amount of the change. For decreases, enclose the amounts in parentheses.
	c. Organizational DUNS: (Required) Enter the organization's DUNS or DUNS+4 number received from Dun and Bradstreet. Information on obtaining a DUNS number may be obtained by visiting the Grants.gov website.		
	d. Address: Enter the complete address as follows: Street address (Line 1 required), City (Required), County, State (Required if country is US), Province, Country (Required), Zip/Postal Code (Required, if country is US).	19.	**Is Application Subject to Review by State Under Executive Order 12372 Process?** Applicants should contact the State Single Point of Contact (SPOC) for Federal Executive Order 12372 to determine whether the application is subject to the
	e. Organizational Unit: Enter the name of the primary organizational unit (and department or division, if applicable) that will undertake the		

	assistance activity, if applicable.			State intergovernmental review process. Select the appropriate box. If "a." is selected, enter the date the application was submitted to the State
	f. Name and contact information of person to be contacted on matters involving this application: Enter the name (First and last name required), organizational affiliation (if affiliated with an organization other than the applicant organization), telephone number (Required), fax number, and email address (Required) of the person to contact on matters related to this application		20.	**Is the Applicant Delinquent on any Federal Debt?** (Required) Select the appropriate box. This question applies to the applicant organization, not the person who signs as the authorized representative. Categories of debt include delinquent audit disallowances, loans and taxes. If yes, include an explanation on the continuation sheet.
8.	Type of Applicant: (Required) Select up to three applicant type(s) in accordance with agency instructions.		21.	**Authorized Representative**: (Required) To be signed and dated by the authorized representative of the applicant organization. Enter the name (First and last name required), title (Required), telephone number (Required), fax number, and email address (Required) of the person authorized to sign for the applicant. A copy of the governing body's authorization for you to sign this application as the official representative must be on file in the applicant's office. (Certain Federal agencies may require that this authorization be submitted as part of the application.)
	A. State Government B. County Government C. City or Township Government D. Special District Government E. Regional Organization F. U.S. Territory or Possession G. Independent School District H. Public/State Controlled Institution of Higher Education I. Indian/Native American Tribal Government (Federally Recognized) J. Indian/Native American Tribal Government (Other than Federally Recognized) K. Indian/Native American Tribally Designated Organization L. Public/Indian Housing Authority	M. Nonprofit with 501C3 IRS Status (Other than Institution of Higher Education) N. Nonprofit without 501C3 IRS Status (Other than Institution of Higher Education) O. Private Institution of Higher Education P. Individual Q. For-Profit Organization (Other than Small Business) R. Small Business S. Hispanic-serving Institution T. Historically Black Colleges and Universities (HBCUs) U. Tribally Controlled Colleges and Universities (TCCUs) V. Alaska Native and Native Hawaiian Serving Institutions W. Non-domestic (non-US) Entity X. Other (specify)		

DISCLOSURE OF LOBBYING ACTIVITIES

Complete this form to disclose lobbying activities pursuant to 31 U.S.C.1352

Approved by OMB
0348-0046

1. * Type of Federal Action:	2. * Status of Federal Action:	3. * Report Type:
☐ a. contract	☐ a. bid/offer/application	☒ a. initial filing
☒ b. grant	☒ b. initial award	☐ b. material change
☐ c. cooperative agreement	☐ c post-award	
☐ d. loan		
☐ e. loan guarantee		
☐ f loan insurance		

4. Name and Address of Reporting Entity:

☒ Prime ☐ SubAwardee

*Name: Vermont Department of Banking, Insurance, Securities & Health Care Administration

*Street 1: 89 Main Street Street 2:

*City: Montpelier State: Vermont Zip: 05620

Congressional District, if known:

5. If Reporting Entity in No.4 is Subawardee, Enter Name and Address of Prime:

6. * Federal Department/Agency:	7. * Federal Program Name/Description:
Dept. of Health & Human Service (HHS)	Grants to States for Health Insurance Premium Review Cycle I CFDA Number, *if applicable:*
8. Federal Action Number, *if known:*	**9. Award Amount,** *if known:*
CFDA: 93,511	$

10. a. Name and Address of Lobbying Registrant: NA

Prefix *First Name Middle Name

*Last Name Suffix

*Street 1 Street 2

*City State Zip

b. Individual Performing Services (including address if different from No. 10a) NA

Prefix *First Name Middle Name

*Last Name Suffix

*Street 1 Street 2

*City State Zip

11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when the transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

*Signature: Completed on submission to Grants.gov

*Name: Prefix: Mr. *First Name: Michael Middle Name: S.

*Last Name: Bertrand Suffix:

Title: Commissioner Telephone No.: 802-828-2380 Date: 07/07/2010

ADDITIONAL ASSURANCES

CERTIFICATIONS

1. CERTIFICATION REGARDING DRUG-FREE WORK-PLACE REQUIREMENTS

The undersigned (authorized official signing for the applicant organization) certifies that it will provide a drug-free workplace in accordance with the Drug-Free Workplace Act of 1988, 45 CFR Part 76, subpart F. The certification set out below is a material representation of fact upon which reliance will be placed when SSA determines to award the grant. If it is later determined that the grantee knowingly rendered a false certification, or otherwise violates the requirements of the Drug-Free Workplace Act, SSA, in addition to any other remedies available to the Federal Government, may take action authorized under the Drug-Free Workplace Act. False certification or violation of the certification shall be grounds for suspension of payments, suspension or termination of grants or government wide suspension or debarment.

The grantee certifies that it will or will not continue to provide a drug-free workplace by:

(a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

(b) Establishing an ongoing drug-free awareness program to inform employees about--

(1) The dangers of drug abuse in the workplace;

(2) The grantee's policy of maintaining a drug-free workplace;

(3) Any available drug counseling, rehabilitation, and employee assistance programs; and

(4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

(c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;

(d) Notifying the employee in the statement required by paragraph (a), above, that as a condition of employment under the grant, the employee will:

(1) Abide by the terms of the statement; and

(2) Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

(e) Notifying the agency within ten calendar days after receiving notice under subparagraph (d)(2), above, from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices.

Notices shall include the identification number(s) of each affected grant;

(f) Taking one of the following actions, within 30 days of receiving notice under subparagraph (d)(2), above, with respect to any employee who is so convicted--

(1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or

(2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

(g) Making a good faith effort to continue to maintain a drug free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f), above.

The grantee certifies that, as a condition of the grant, it will not engage in the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance in conducting any activity with the grant.

2. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

(a) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, 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 the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(b) If any funds other than Federally 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 of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

(c) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, U.S. Code. 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."

3. CERTIFICATION REGARDING DEBARMENT, SUSPENSION, AND OTHER RESPONSIBILITY MATTERS

NOTE: In accordance with 45 CFR Part 76, amended June 26, 1995, any debarment, suspension, proposed debarment or other government wide exclusion initiated under the Federal Acquisition Regulation (FAR) on or after August 25, 1995, shall be recognized by and effective for Executive Branch agencies and participants as an exclusion under 45 CFR Part 76.

(a) Primary Covered Transactions

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

(1) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency;

(2) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

(3) are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (a)(2) of this certification; and

(4) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed under the assurances page in the application package.

(b) Lower Tier Covered Transactions

The applicant agrees by submitting this proposal that it will include, without modification, **the following clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion -- Lower Tier Covered Transaction"** (Appendix B to 45 CFR Part 76) in all lower tier covered transactions (i.e., transactions with subgrantees and/or contractors) and in all solicitations for lower tier covered transactions:

Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion -- Lower Tier Covered Transactions

(1) The prospective lower tier participant certifies by submission of this proposal, that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal department or agency.

(2) Where the prospective lower tier participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal.

* SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	
Completed on submission to Grants.gov	Commissioner of BISHCA
	* DATE SUBMITTED
Vermont Department of Banking, Insurance, Securities, and Health Care Administration	Completed on submission to Grants.gov 07/07/2010

OMB Number: 4040-0010
Expiration Date: 08/31/2011

Project/Performance Site Location(s)

Project/Performance Site Primary Location ☐ I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Organization Name: Vermont Department of Banking, Insurance, Securities & Health Care Administration

DUNS Number: 809376601

* Street1: 89 Main Street

Street2:

* City: Montpelier County:

* State: Vermont

Province:

* Country: USA: UNITED STATES

* ZIP / Postal Code: 05620 * Project/ Performance Site Congressional District:

Project/Performance Site Location 1 ☐ I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Organization Name: Vermont Department of Banking, Insurance, Securities & Health Care Administration

DUNS Number:

* Street1: 89 Main Street

Street2:

* City: Montpelier County:

* State: Vermont

Province:

* Country: USA: UNITED STATES

* ZIP / Postal Code: 05620 * Project/ Performance Site Congressional District:

Additional Location(s) Add Attachment Delete Attachment View Attachment

List of Key Contacts

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2. Project Assistant – Rate Analysis: Sean Londergan, Director of Rates and Forms & Assistant General Counsel
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JAMES H. DOUGLAS
GOVERNOR

State of Vermont
OFFICE OF THE GOVERNOR

July 7, 2010

The Honorable Kathleen Sebelius
Secretary, Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

RE: Department of Health and Human Services, Grants to States for Health Insurance Premium Review-Cycle I
CFDA No. 93.511
Opportunity No. RFA-FD-10-999

Dear Secretary Sebelius:

Enclosed please find the State of Vermont's application and submission information for the announced federal grant: "Grants to States for Health Insurance Premium Review – Cycle 1" (Office of Consumer Information and Insurance Oversight). I support the enhanced health insurance rate review activities described in this application.

Sincerely,

James H. Douglas
Governor

JHD/qht

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TELEPHONE: 802.828.3333 • FAX: 802.828.3339 • TDD: 802.828.3345

Vermont . . .

Department of Banking, Insurance, Securities and Health Care Administration

July 7, 2010

The Honorable Kathleen Sebelius
Secretary, Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: Grants to States for Health Insurance Premium Review – Cycle 1
CFDA: 93.511
Opportunity No. RFA-FD-10-999

Dear Secretary Sebelius:

The Vermont Department of Banking, Insurance, Securities and Health Care Administration (hereinafter "the Department"), on behalf of the State of Vermont, hereby makes Application for the above-referenced grant.

The over-all project to be funded by the grant will be called "The Vermont Rate Review Enhancement Project."

The Project Leader will be: Christine Oliver, Deputy Commissioner
Division of Health Care Administration
89 Main Street, Montpelier, VT 05620-3101;
802-828-2900; christine.oliver@state.vt.us

The Department has existing authority under Vermont law to oversee, coordinate and implement the rate review enhancement activities described in the Project Narrative. Title 8, Vermont Statutes Annotated, Sections 12 and 4062; Title 18 Vermont Statutes Annotated, Sections 9403 and 9410(h).

The Department further certifies, subject to the Department's annual appropriation enacted by the Vermont General Assembly, that the state share of funds expended for rate review activities under this Application will not be less than the funds expended during State fiscal Year 2011, and that the grant funds will not supplant existing state appropriations.

Please let me or Deputy Commissioner Oliver know if there are any questions concerning this application.

Yours truly,

Michael S. Bertrand, Commissioner

Vermont Rate Review Enhancement Project
Project Abstract

Overall goal. Vermont law requires the prior approval of health insurance rates by the Vermont Department of Banking, Insurance, Securities and Health Care Administration (Department). The Department proposes to enhance its rate review process to accomplish the overall goal of offering consistent, comprehensive and effective regulation of health insurance rates for all carriers and all markets, in order to ensure that health insurance rates are neither unjust, unfair, inequitable, excessive, inadequate or unfairly discriminatory.

Rate Review Enhancements. The following initiatives will be undertaken to achieve Vermont's overall goal during the Cycle I time period:

A. Expand the scope of current review and approval activities by conducting reviews of large group rates; and rate review of minor lines of health insurance such as student blanket policies.

B. Improve rate filing requirements by developing rate filing standards; and by collecting informational data for plans administered by Third Party Administrators.

C. Enhance the rate review process by verifying claims experience and by analyzing public program mitigation.

D. Enhance the rate review process with a significant upgrade in Vermont's IT capacity. IT enhancements will include: updating the NAIC's SERFF program to include federal reporting elements; collecting and integrating historical rate filing data with current filed data; customizing Vermont's all payer claims utilization and reporting system to support rate review; consolidating carrier "carve-out" data; providing claims reporting by product type; and providing claims reporting by provider.

E. Enhance consumer protection standards by posting readable, layperson summaries of rate increase requests on the Department's website; and by adding a ratepayer comment functionality to the Department's website.

Project Budget. The total budget for the Vermont Rate Review Enhancement Project for the Cycle I time period is one million ($1,000,000.00) dollars. The Department intends to use these grant funds to employ or contract with additional actuaries; rate analysts; a data entry clerk; a claims analyst; and a grant administrator. The Department will support the Project through the allocation of time by existing staff, but does not intend to use grant funds for existing staff.

Project Narrative – The Vermont Rate Review Enhancement Project

Section 1. Current health insurance rate review capacity and process

A. General health insurance rate regulation in Vermont

The rates and rate increases of all group and health insurance product lines are reviewed and approved before use by the Vermont Department of Banking, Insurance, Securities and Health Care Administration ("the Department"). The actual premium to be charged subscribers in large groups for large group comprehensive insurance is not reviewed; however the trend and rating methodology used to produce the premium must be approved by the Department.

Vermont's rating rules have been established in statute and regulation. Vermont's general authority to review health insurance rates is pursuant to 8 V.S.A §§ 4062 and 4515a.[1] In the small group market, a small group carrier must offer a small group plan rate structure which at least differentiates between single person, two person and family rates, must use a community rating method, acceptable to the Commissioner, to determine premiums, is prohibited from using medical underwriting and screening, and must guarantee rates on a small group plan for a minimum of six months. 8 V.S.A § 4080a.

Similar rules apply to the non-group market. 8 V.S.A § 4080b. In addition, the Commissioner must disprove any nongroup rates unless the anticipated loss ratios for the entire period for which rates are computed are at least 70 percent. 8 V.S.A § 4080b(m).

The Department has adopted the following regulations relating to the rate review process: Regulation 91-4b, Minimum Regulation for Compliance with 8 V.S.A. § 4080a; Regulation 93-5, Minimum Regulation for compliance with 8 V.S.A. § 4080b; and Regulation H-99-4 Community Rating & Approval of Community Rating Formulas.

B. Health insurance rate review and filing requirements in Vermont

[1] See Appendix 1 for copies of Vermont's health insurance rate review statutes and regulations.

All rates for health insurance products are subject to review and must be approved prior to use. For health insurance rate filings submitted to the Department, health insurers must provide: an actuarial memorandum, signed and dated by a qualified actuary and supporting documentation (e.g., claims experience, historical loss ratios). The specific exhibits and documents are submitted directly to the Department via the System for Electronic Rates and Form Filings ("SERFF") program administered by the National Association of Insurance Commissioners ("NAIC").

Generally, in reviewing a rate filing, Vermont examines the past history of rate changes; past Vermont experience; past nationwide experience; projected Vermont experience; projected nationwide experience; Vermont lifetime loss ratios; nationwide lifetime loss ratios; the credibility of Vermont experience; the health insurer's administrative costs, rating manuals, loss ratios, adequacy of reserves, and profitability or surplus. Also, if necessary, the Department will examine regional past experience, regional projected experience and regional lifetime loss ratios. A rate analyst and the Director of Rates & Forms review all health product line rate filings.

The rate filings of insurers representing the largest market share of comprehensive medical coverages are reviewed by the Department's contracted actuarial firm. The Department's contracted actuaries review medical trends submitted by an insurer, and calculate an independent range for the trends using their own proprietary software. Contracted actuaries compare the medical trends used in the insurer's rate filing to their independent calculations. For a rate filing to be approved the health insurer's proposed medical trends must be within the actuary's acceptable range. If the rate filing is found deficient during review, the filing is declined. When a rate filing is declined the carrier may respond and correct the deficiencies. If the carrier is unable to correct the deficiencies, the filing is closed and no rate increase is allowed.

C. An explanation of the current level of resources and capacity for reviewing health insurance rates: information technology (IT) and system capacity

All rate filings are required to be made electronically and via SERFF. The Department does not have any additional IT resources available to support its rate review capacity. The State of Vermont has established the Vermont Healthcare Claims Uniform Reporting and Evaluation System ("VHCURES"), "to continuously review health care utilization, expenditures, and performance in Vermont." 18 V.S.A. § 9410. VHCURES is administered by the Department, and includes de-identified eligibility records and medical and pharmacy claims for over 330,000 privately insured Vermonters or about 80 percent of the privately insured population. The paid claims data includes diagnosis codes, procedures codes, facility codes, billing and service provider information, charges, and amount paid including insurer payments and member payments (deductible, copayments, coinsurance).[2] In its current form, VHCURES cannot be utilized to support Vermont's rate review process, but there is substantial potential for enhancing the rate review process by integrating the review process with VHCURES.

D. An explanation of the current level of resources and capacity for reviewing health insurance rates: budget and staffing

The annual overall total budget for the Division of Health Care Administration for State fiscal Year 2011 is $4,741,907. This funding supports a number of programs in addition to the rate review program, including: hospital budget approval; the Certificate of Need program; quality assurance; consumer services; public service outreach; data analysis, market conduct; and enforcement.

The Division's annual budget allocated for rate review is $501,580. Of this amount, approximately $401,264 is allocated for review of health insurance rates in the individual and small group/association markets.

Vermont currently has a full time person reviewing all rate increase requests. The one rate reviewer closed 516 filings in the past year ending May 12, 2010. The number of closed rate

[2] The VHCURES report on expenditures and utilization published in January 2010 is attached as Appendix 2.

filings does not take into account that each rate filing averages three reviews by the analyst, because the initial carrier filings can be insufficient or cannot be approved. Thus, on average, the 516 closed rate filings represent 1,548 actual reviews. The Department's rate analyst has approximately twenty-two years of experience in the insurance field, including work as senior actuarial analyst and Director of Rates and Forms (Life & PC). The rate analyst has a Bachelor of Science (BS) degree in Mathematics and Management. $87,000 is budgeted to support the rate analyst.

The Director of Rates and Forms supervises and manages the rate review process, along with other duties, and provides legal support. The Director of Rates and Forms has a law degree, a MPH degree, and a BS degree. In addition to the present position, the Director of Rates and Forms has served as staff attorney at Vermont Legal Aid and had a supervisory position for two community based epidemiology studies while on staff at the University of Minnesota's School of Public Health. $14,580 is budgeted from the Department's Administration Division (General Counsel's Office) to support the rate review functions of the Director of Rates and Form.

The Department also contracts with Oliver Wyman for actuarial services. The principal contracted actuary has over twenty-five years of experience and has earned both a FCA and MAAA. $400,000 is budgeted to support this contract.

E. Consumer Protections

All rate filings made with the Department are open to the public pursuant to the Vermont Public Records Law (1 V.S.A. Chapter 5, Subchapter 3). A carrier may request the Department to keep portions of the rate filing confidential, upon a proper showing that the material is a trade secret. 1 V.S.A. § 317(c)(9). Rate filings can be reviewed on the Department's public computer, via a read-only access to SERFF system. The Department also produces a **Consumer Tips**

publication, which contains small-group and individual rates for specific companies and specific plans.[3]

Layperson summaries of rate changes are currently not offered for consumers, but the Department anticipates this can be accomplished as part of the Vermont Rate Review Enhancement Project.

F. Examination and oversight

The State of Vermont requires prior approval before any proposed rate increase can take effect. Over the past two years, there have been multiple instances when the Department has denied a health insurer's request for a rate increase. In most of these instances, the health insurer has voluntarily lowered the proposed rate increase. The Department is unable to quantify the exact number of policyholders affected, however, it is safe to conclude that a significant number of Vermont policyholders have been impacted by these proactive determinations.

On occasion, a health insurer has appealed the Department's determination to deny a rate increase, pursuant to 8 V.S.A § 4062. Over the past two years, carrier appeals have led to two formal hearings, following which the Commissioner issued written decisions denying the appeals. One such decision included a Supplemental Order, pursuant to the Commissioner's authority under 8 V.S.A. § 4513(c), directing the carrier to engage in additional cost containment activities, and ordering a ratepayer refund of excessive executive compensation amounts.[4]

Section 2. Proposed rate review enhancements for health insurance

Introduction

As described in Section 1, above, the Department administers a comprehensive, rigorous health insurance rate review process. Nevertheless, the Department can enhance its current rate review process by means of the following initiatives.

A. Expanding the scope of current review and approval activities.

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[3] See Appendix 3
[4] See Appendix 4.

The Department proposes an appropriate level of rate review for all carriers, in all markets.

Large group market rates are not filed for review and approval; rather, the Department reviews and approves a rating formula included within the carrier's "rate manual", and the Department reviews and approves a medical trend factor and other factors that are incorporated into the carrier's rate manual. For minor lines of health insurance such as student health insurance policies, which are filed as "blanket" health insurance, the Department's rate review process is an abbreviated one.

Ratepayers in the large group market and in minor lines markets would benefit from a more thorough rate review approval process.

Proposed enhancements:

1. Goal: Effective rate review in all insurance markets. Measurable objective, timeline, and milestone for change: By September 30, 2011 the Department will establish procedures for annual rate reviews of rates in the large group market. The Department anticipates review of large group rates beginning for calendar year 2012 rates. Resources needed: allocate time of existing staff, and hire and/or contract for additional professional and clerical services, as further described in Section 2 (D). Estimated cost: $83,111.[5]
2. Goal: Rate review of minor lines of insurance. Measurable objective, timeline and milestone for change: By July 1, 2011 the Department will establish procedures for rate reviews of minor lines of insurance such as student health insurance. The Department anticipates review of rates for minor lines insurance beginning with rate filings made after October 1, 2011. Resources needed: allocate time of existing staff, and hire and/or contract for additional professional and clerical services, as further described in Section 2 (D). Estimated cost: $83,110.

B. Improving rate filing requirements.

[5] All cost estimates are for the Cycle 1 time period.

The Department proposes to standardize rate filing requirements, in order to strengthen the rate review process, and to improve communications with ratepayers. The Department also proposes to collect rate and benefit plan information for all Vermont markets, in order to increase the Department's capacity to analyze market trends, and thereby strengthen the rate review process.

Carriers include different information, in different formats, when filing rate requests with the Department. As a result, comparison between rate filings of each carrier is difficult. Some filings do not include information concerning the benefit plan (cost sharing, network limitations and coverage) for which a specific rate increase is sought. In addition, carriers' rate filings are written in technical language, and therefore are difficult for the layperson ratepayer to understand.

The Department also proposes to require Third Party Administrators to make information-only filings relating to benefits, coverages, enrollment and costs so that the Department will have a better understanding of the Vermont health insurance market as a whole, and thus be better able to review and analyze rates in the regulated health insurance markets.

Proposed enhancements:

1. Goal: Adopt standards for carrier rate filings. Measurable objectives, timeline and milestone for change: By July 1, 2011, the Department will establish and publish standards for carrier rate filings, including a requirement that a description of each benefit plan be linked with the rate request for that plan, and a requirement of narrative, layperson summary of the rate increase request. The Department anticipates that its filing standards will be applicable to rate filings beginning for calendar year 2012. Resources needed: allocate time of existing staff, and hire and/or contract for additional professional and clerical services, as further described in Section 2 (D). Estimated cost: $83,110.
2. Goal: Informational filings by Third Party Administrators. Measurable objectives, timeline and milestone for change: By September 30, 2011, the Department will establish

and publish standards for annual, informational filings by Third Party Administrators of benefits, coverages, enrollment and costs for each benefit plan administered. The Department anticipates that its TPA filing standards will be effective on and after January 1, 2012. Resources needed: allocate time of existing staff, and hire and/or contract for additional professional and clerical services, as further described in Section 2 (D). Estimated cost: $83,111.

C. Enhanced review process – verification of filed rate information.

The Department proposes to enhance the accuracy and credibility of the rate review process by conducting periodic examinations of carriers' claims experience. This capacity is particularly important with respect to Vermont's Catamount Health premium subsidy program for the uninsured, and with respect to benefit and coverage changes required by the Patient Protection and Affordable Care Act ("PPACA"). Anecdotal observations have suggested that considerable migration takes place between Catamount Health[6] and VHAP[7] because of differences in eligibility and pre-existing condition limitations of the two programs. Carriers will be making assumptions about the cost of implementing the benefit and coverage requirements of the PPACA without significant experience upon which to base those assumptions.

Proposed enhancements:

1. Goal: Examine claims experience based on new federal requirements. Measurable objectives, timeline and milestone for change: By July 1, 2011 the Department will collect early claims experience in order to validate or change the estimated rate increments which have been included by carriers to account for changes in benefits and coverages required by federal law. Resources needed: allocate time of existing staff, and

[6] Catamount Health is a premium subsidy program for the uninsured with household income between 150-300% FPL, with a policy issued by a private carrier. It is funded by state and federal funds in accordance with a Section 115 Medicaid waiver.
[7] VHAP is a Medicaid-administered Section 115 waiver program for Vermont residents with household income under 150% FPL.

hire and/or contract for additional professional and clerical services, as further described in Section 2 (D). Estimated cost: $98,213.

2. Goal: Migration analysis. Measurable objectives, timeline and milestone for change: By July 1, 2011, the Department will collect information on the relationship between the Catamount Health program and the VHAP, in order to validate or change the estimated claims costs assumed by carriers for Catamount Health insureds. Resources needed: allocate time of existing staff, and hire and/or contract for additional professional and clerical services, as further described in Section 2 (D). Estimated cost: $98,214.
3. Goal: Targeted data verification examinations. Measurable objectives, timeline and milestone for change: By July 1, 2011, the Department will begin to conduct targeted examinations to validate or change the assumptions used by carriers in their rate filings. Resources needed: allocate time of existing staff, and hire and/or contract for additional professional and clerical services, as further described in Section 2 (D). Estimated cost: $70,152.

D. Enhance rate review process – staffing.

The Department proposes to increase its professional staffing and/or contracted resources allocated to the health insurance rate review process.

The enhancements in the scope and depth of rate review and analysis contemplated by the Department and described in this Application will require professional resources in addition to current staffing and contracting resources.

Proposed enhancements:

Goal: Increase professional resources for rate review. Measurable objectives, timeline and milestone for change: Throughout the course of the Cycle 1 time period, beginning in September, 2010, the Department proposes to increase its professional resources for health insurance rate review functions, as set forth below, and as described further in Section 2 (A), (B), (C), (E) and

(F). The options for increasing professional resources will be either by hiring Department employees, or by contracting for professional services, or both. Staff may be hired to either temporary or permanent positions. The options chosen will be based in part on whether the Department will be authorized to hire for new positions and what type of positions will be authorized, and in part on the Department's judgment as to the availability of funds to support these additional resources in future years. It is anticipated that acquisition of additional actuarial resources will be accomplished by contract.

1. Two (2) professional actuaries. Estimated cost: $225,800.
2. Two (2) rate analysts with actuarial experience. Estimated cost: $180,000.
3. One (1) data entry clerks. Estimated cost: $50,000.
4. One (1) claims analyst. Estimated cost: $90,000.
5. One (1) grant administrator. Estimated cost: $68,500.

E. Enhanced rate review process – IT capacity.

(a) Rate filings.

The Department proposes to enhance its rating filing IT infrastructure (1) to report on current rate filing components in Vermont in accordance with the information required to be reported to the Secretary of HHS (see Section 3 below), and (2) to integrate the reporting of current data with the collection and reporting on historical rate filing components. Both current and historical data is critical for the Department's understanding and analysis of trends in health insurance markets and health insurance rates, as well as for the Department's ability to communicate with essential constituencies, including but not limited to the HHS Secretary, the Vermont Legislative and Executive Branches, business and individual ratepayers, carriers, hospitals, physicians, and other health care providers.

(b) Rate review supported by claims data.

The Department proposes to customize use of claims data to provide a powerful tool for rate review, in order to improve information symmetry between the regulator and regulated entities, and to enhance the Department's flexibility and effectiveness in analyzing insurance markets, and in reviewing carrier rate requests.

The State of Vermont has established VHCURES; an all payer claims database intended "to continuously review health care utilization, expenditures, and performance" in Vermont. 18 V.S.A. § 9410. Vermont is one of a very few states in the country to have established such an all payer claims database.

VHCURES can make available to the rate review process actual eligibility, product, provider and claims data, which will allow the Department to critically analyze assumptions used by insurers to set proposed rates, including demographics and health status ("My members are older and/or sicker"); reimbursement ("My members use more expensive facilities and providers"); and cost drivers ("My members use more services and/or more expensive services"). The Department proposes to utilize the VHCURES IT program in a manner specifically customized to support the rate review process.

Strengthening of the Department's rate view process through enhanced IT capacity and resources will be accomplished by means of four VHCURES IT initiatives, as follows:

First: the Department proposes to customize VHCURES reporting to support rate review. In reviewing trends in health insurance utilization and expenditures, actuaries use regional and national averages and benchmarks for specified categories of expenditures such as hospital inpatient, hospital outpatient, physician office visits including primary and specialty care consultation, prescription drugs, durable medical equipment, etc. VHCURES reporting currently categorizes utilization and expenditures in close alignment with the National Health Expenditures categories published by the Centers for Medicare and Medicaid Services (CMS) as applicable to commercial health insurance. This first IT initiative will enable the rate review process to

compare the VHCURES categorization to the categorization used traditionally by actuaries, resulting in greater accuracy in assessing carrier utilization and expenditures, and in identifying cost drivers.

Second, the Department proposes to consolidate carrier "carve-out" data to permit better analysis of filed rate information. Most major insurers with carve-outs submit a consolidated file for medical members, including a single eligibility file for medical, mental health, and pharmacy claims. Benefits covered by one major carrier are also carved-out, but three separate companies submit eligibility and claims records to VHCURES. This VHCURES IT enhancement will consolidate expenditure and utilization reports, thereby strengthening the rate review process for the plans issued by this carrier.

Third, the Department proposes to increase the depth of rate analysis by providing claims reporting by product type. VHCURES currently reports expenditures and utilization at the major insurer level, accounting for over 90 percent of the privately insured market including the insured market and self-insured employer market for comprehensive health benefits. The data is also reported at the hospital service area level to support population-based comparison of rates. Within the VHCURES data set for every insurer, every member eligibility record and claim is coded with Insurance Product Type that for comprehensive major medical benefits includes HMO, PPO, POS, EPO, and indemnity. After the appropriate categories are developed for reporting expenditures and utilization as discussed above, reports by insurance product type would be generated by major insurer to aid in rate review of products by insurance type.

Fourth, the Department proposes to identify claims by provider, thereby creating the capacity to identify and analyze cost drivers, and to compare carrier effectiveness in addressing those cost drivers. Health services and actuarial research and literature have identified cost drivers in health care with robust trends in increased utilization and contribution to rising cost with potentially marginal health benefits. Insurers, payers, purchasers, and providers are interested in

understanding trends in utilization of cost drivers such as advanced imaging, potentially avoidable hospital admissions, readmissions, and emergency department use, and use of prescription drugs. The capability to drill down on cost drivers and identify facilities and providers associated with significant expenditures and utilization would bring a valuable perspective and refinement to the rate review process. To develop this capability requires development and maintenance of an accurate Master Provider Index ("MPI") of both facility claims and professional claims.

Proposed enhancements:

1. Goal: Enhanced rate data collection and reporting. Measurable objectives, timeline and milestone for change: Within three months (initial enhancement), and within eight months (additional enhancement) following the receipt of HHS reporting requirements, the Department will collaborate with other states through the NAIC and its SERFF program in order to improve the IT, analysis and reporting capacity of the Department with respect to rate review. Vermont already requires carriers to file their proposed rates with SERFF.[8] Estimated cost: $18,808.[9]
2. Goal. Integration of historical and current rate data. Measurable objectives, timeline and milestone for change: By September 30, 2011 the Department will collect and integrate historical rate information with the current information reported through SERFF, in order to better understand rate and market trends over time, and to better communicate with consumers and other stakeholders. Resources needed: allocate time of existing staff, and hire and/or contract for additional professional and clerical services. Estimated cost: $20,000.
3. Goal: Customize VHCURES reporting to support rate review. Measurable objectives, timeline and milestone for change: By September 30, 2011, the Department will establish

[8] The SERFF proposal is submitted as Appendix 5.
[9] The cost to the Department to duplicate the IT functions and reporting capability of SERFF have not been estimated, but are anticipated to be many multiples of the estimated cost utilizing the SERFF program.

a collaborative relationship between VHCURES staff and the Department's actuarial consultant and rate analysts to identify alternative claims data categorizations, and thereby support enhanced evaluation of carrier filing data, trends and cost drivers. Resources needed: contract for VHCURES enhancements. Estimated cost: $99,372.

4. Goal: Consolidate carrier "carve-out" data. Measurable objectives, timeline and milestone for change: By September 30, 2011 the Department will contract for changes to the VHCURES system in order to support the consolidation of carrier "carve-out" data. Resources needed: contract for VHCURES enhancements. Estimated cost: $10,000.
5. Goal: Claims reporting by product type. By September 30, 2011 the Department will contract for a VHCURES IT enhancement to permit a review of rate filings in collaboration with the Rate and Form Unit's consultants by product type. Resources needed: allocation of current staff time, hiring or contracting for a claims analyst, and increased VHCURES contractual resources. Estimated cost: $145,845.
6. Goal. Claims reporting by provider. Measurable objectives, timeline and milestone for change: By September 30, 2011, the Department will contract for a VHCURES IT enhancement to permit a linkage between claims and providers, thereby enhancing the rate review process by identifying cost drivers in the health care system. Resources needed: develop and maintain an accurate Master Provider Index ("MPI") for both facility claims and professional claims. Estimated cost: $85,000.

F. Enhancing consumer protection standards.

Under Vermont law, the rate review process is a public, open process. Carrier rate filings are public records subject to disclosure to consumers (other than proprietary, trade secret information), and Vermont law requires 45 days advance notice to ratepayers before the proposed effective date of a rate. The Department proposes additional measures to enhance its existing consumer protection standards.

Proposed enhancements:

1. Goal. Layperson summaries of rate filings. Measurable objectives, timeline and milestone for change: By July 1, 2011 the Department will establish requirements for carriers to file layperson-friendly summaries of rate filings. Beginning for calendar year 2012 rate requests, the Department will post these summaries on the Department's website. Resources needed: allocation of existing staff time. Estimated cost: $9,440.
2. Goal. Ratepayer comment opportunity. Measurable objectives, timeline and milestone for change: By July 1, 2011 the Department will design its website to offer a ratepayer comment and/or forum opportunity for carrier rate increase requests. Beginning for calendar year 2012 rate requests, the Department proposes to incorporate these website functionalities on the health insurance rate portion of its website. Resources needed: allocation of existing staff time. Estimated cost: $12,514.

Section 3. Reporting to the Secretary on rate increase patterns

The Department attests that it will comply with the requirements of the PPACA with respect to required reporting to the Secretary of HHS. As described in Section 3(E), above, the Department intends to collaborate with other states through the NAIC and its SERFF program in order to improve the IT, analysis and reporting capacity of the Department with respect to rate review.

Section 4. Optional data center funding

The Department does not intend to request optional data center funding for compiling and publishing fee schedule information, as described in the grant Announcement.

Rate Review Grant – Vermont Application – Proposed Budget (Justification/Narrative)

The Budget plan depends upon 5 new full time staff and a variety of contracted services to complete the work. The staff are considered to be limited term staff that will be funded by the grant through its completion. Travel, equipment, supplies, and some rental funds have been estimated in order to support the staff. The budget costs reflect the costs for one year.

Contractual costs have been budgeted to provide technical support in the three key areas of claims analysis, actuarial analysis, and selected research activities that are highly technical and require unique skills. Besides the actuarial services, the most notable amount of funds will be dedicated to enhancing analysis of the VCHURES data base and determining how it can best be used to support new health care reform activities in Vermont. This database is quite complex and the Department needs to improve its ability to understand, manage, and analyze the information to support rate review activities.

The Department currently has existing contracts for actuarial services and claims analysis and those contracts will continue to support the standard reporting and review done by the Department. Further, existing staff will work directly with various contractors to enhance their skills and assist with the unique circumstances the contractors may encounter.

There are five main cost centers and the budget reflects the allocation of costs for each:

I) Expanding the scope of current rate review activities ($166,221);
II) Improving rate filing requirements ($166,221),
III) Enhancing and verifying filed rate data ($266,579),
V) Enhancing the IT capacity of the rate review process ($379,025), and
VI) Enhancing consumer protection ($21,954).
(Note: Cost center IV is the staff used to support the other cost centers)

Federal Rate Review Grant

7/6/2010

Project number				I	II	III	V	VI
			Total Budget	25%	25%	35%	10%	5%
Personnel	$	149,650	$ 299,300	$ 74,825	$ 74,825	$ 104,755	$ 29,930	$ 14,965
Fringe benefits	$	46,392	$ 92,783	$ 23,196	$ 23,196	$ 32,474	$ 9,278	$ 4,639
Travel	$	1,000	$ 2,000	$ 500	$ 500	$ 700	$ 200	$ 100
Equipment	$	8,750	$ 17,500	$ 4,375	$ 4,375	$ 6,125	$ 1,750	$ 875
Supplies	$	3,750	$ 7,500	$ 1,875	$ 1,875	$ 2,625	$ 750	$ 375
Space/rental	$	10,000	$ 20,000	$ 5,000	$ 5,000	$ 7,000	$ 2,000	$ 1,000
Contracts/sub-contractors	$	-						
Actuarial services	$	112,900	$ 225,800	$ 56,450	$ 56,450	$ 112,900		
Update SERF	$	-	$ 18,808				$ 18,808	
Enhance IT	$	-	$ 316,309				$ 316,309	
Construction	$	-	$ -					
Other	$	-	$ -					
Total direct	$	332,442	$ 1,000,000	$ 166,221	$ 166,221	$ 266,579	$ 379,025	$ 21,954
Indirect staff time*								
Grand Totals			$ 1,000,000	$ 166,221	$ 166,221	$ 266,579	$ 379,025	$ 21,954

*Department staff will support activities above but no funds have been requested in the grant.

Personnel detail

2 Rate analysts	$ 145,000	Travel, equip, & supplies based on number of people employed.
1 Data entry & support staff	$ 40,000	Fringe budgeted at 31% of salary.
1 Claims analyst	$ 62,300	
1 Grant Adminstrator	$ 52,000	
	$ 299,300	

Appendix 1

Vermont's Rate Review Statutory and Regulatory Authority

I. 8 V.S.A. § 4062. Filing and approval of policy forms and premiums
II. 8 V.S.A. § 4080a. Small group health benefit plans
III. 8 V.S.A. § 4080b. Nongroup health benefit plans
IV. 8 V.S.A. § 4513(b). Permit to engage in business; foreign corporations
V. 8 V.S.A. § 4584(a). Application for permit
VI. REGULATION 91-4b MINIMUM REQUIREMENTS FOR COMPLIANCE WITH 8 V.S.A. SECTION 4080a
VII. REGULATION 93-5 (Amended Rule) MINIMUM REQUIREMENTS FOR COMPLIANCE WITH TITLE 8 V.S.A., SECTION 4080b
VIII. REGULATION H-99-4 COMMUNITY RATING AND APPROVAL OF COMMUNITY RATING FORMULAS

§ 4062. Filing and approval of policy forms and premiums

No policy of health insurance or certificate under a policy not exempted by subdivision 3368(a)(4) of this title shall be delivered or issued for delivery in this state nor shall any endorsement, rider, or application which becomes a part of any such policy be used, until a copy of the form, premium rates and rules for the classification of risks pertaining thereto have been filed with the commissioner of banking, insurance, securities, and health care administration; nor shall any such form, premium rate or rule be so used until the expiration of 30 days after having been filed, unless the commissioner shall sooner give his or her written approval thereto. The commissioner shall notify in writing the insurer which has filed any such form, premium rate or rule if it contains any provision which is unjust, unfair, inequitable, misleading, or contrary to the law of this state. In such notice, the commissioner shall state that a hearing will be granted within 20 days upon written request of the insurer. In all other cases, the commissioner shall give his or her approval. After the expiration of such 30 days from the filing of any such form, premium rate or rule, or at any time after having given written approval, the commissioner may, after a hearing of which at least 20 days written notice has been given to the insurer using such form, premium rate or rule, withdraw approval on any of the grounds stated in this section. Such disapproval shall be effected by written order of the commissioner which shall state the ground for disapproval and the date, not less than 30 days after such hearing when the withdrawal of approval shall become effective. (Amended 1983, No. 238 (Adj. Sess.), § 4; 1989, No. 106, § 3; 1989, No. 106, § 3; 1989, No. 225 (Adj. Sess.), § 25(b); 1995, No. 180 (Adj. Sess.), § 38(a).)

8 V.S.A. § 4080a. Small group health benefit plans

§ 4080a. Small group health benefit plans

(a) Definitions. As used in this section:

(1) "Small employer" means an employer who, on at least 50 percent of its working days during the preceding calendar quarter, employs at least one and no more than 50 employees. The term includes self-employed persons. Calculation of the number of employees of a small employer shall not include a part-time employee who works less than 30 hours per week. The provisions of this section shall continue to apply until the plan anniversary date following the date the employer no longer meets the requirements of this subdivision.

(2) "Small group" means:

(A) a small employer; or

(B) an association, trust or other group issued a health insurance policy subject to regulation by the commissioner under subdivisions 4079(2), (3), or (4) of this title.

(3) "Small group plan" means a group health insurance policy, a nonprofit hospital or medical service corporation service contract or a health maintenance organization health benefit plan offered or issued to a small group, including but not limited to common health care plans approved by the commissioner under subsection (e) of this section. The term does not include disability insurance policies, accident indemnity or expense policies, long-term care insurance policies, student or athletic expense or indemnity policies, dental policies, policies that supplement the Civilian Health and Medical Program of the Uniformed Services, or Medicare supplemental policies.

(4) "Registered small group carrier" means any person, except an insurance agent, broker, appraiser or adjuster, who issues a small group plan and who has a registration in effect with the commissioner as required by this section.

(b) No person may provide a small group plan unless the plan complies with the provisions of this section.

(c) No person may provide a small group plan unless such person is a registered small group carrier. The commissioner, by rule, shall establish the minimum financial, marketing, service and other requirements for registration. Such registration shall be effective upon approval by the

commissioner and shall remain in effect until revoked or suspended by the commissioner for cause or until withdrawn by the carrier. A small group carrier may withdraw its registration upon at least six months prior written notice to the commissioner. A registration filed with the commissioner shall be deemed to be approved unless it is disapproved by the commissioner within 30 days of filing.

(d)(1) A registered small group carrier shall guarantee acceptance of all small groups for any small group plan offered by the carrier. A registered small group carrier shall also guarantee acceptance of all employees or members of a small group, and each dependent of such employees or members, for any small group plan it offers.

(2) Notwithstanding subdivision (1) of this subsection, a health maintenance organization shall not be required to cover:

(A) a small employer which is not physically located in the health maintenance organization's approved service area; or

(B) a small employer or an employee or member of the small group located or residing within the health maintenance organization's approved service area for which the health maintenance organization:

(i) is not providing coverage; and

(ii) reasonably anticipates, and demonstrates to the satisfaction of the commissioner, that it will not have the capacity within its network of providers to deliver adequate service because of its existing group contract obligations, including contract obligations subject to the provisions of this section and any other group contract obligations.

(e) A registered small group carrier shall offer one or more common health care plans approved by the commissioner. The commissioner, by rule, shall adopt standards and a process for approval of common health care plans that ensure that consumers may compare the cost of plans offered by carriers and that ensure the development of an affordable common health care plan, providing for deductibles, coinsurance arrangements, managed care, cost containment provisions, and any other term, not inconsistent with the provisions of this title, deemed useful in making the plan affordable. A health maintenance organization may add limitations to a common health care plan if the commissioner finds that the limitations do not unreasonably restrict the insured from access to the benefits covered by the plans.

(f) A registered small group carrier shall offer a small group plan rate structure which at least differentiates between single person, two person and family rates.

(g) For a 12-month period from the effective date of coverage, a registered small group carrier may limit coverage of preexisting conditions which exist during the six-month period before the effective date of coverage; provided that a registered small group carrier shall waive any preexisting condition provisions for all new employees or members of a small group, and their dependents, who produce evidence of continuous health benefit coverage during the previous nine months substantially equivalent to the common health care plan of the carrier approved by the commissioner. Credit shall be given for prior coverage that occurred without a break in coverage of 90 days or more.

(h)(1) A registered small group carrier shall use a community rating method acceptable to the commissioner for determining premiums for small group plans. Except as provided in subdivision (2) of this subsection, the following risk classification factors are prohibited from use in rating small groups, employees, or members of such groups, and dependents of such employees or members:

(A) demographic rating, including age and gender rating;

(B) geographic area rating;

(C) industry rating;

(D) medical underwriting and screening;

(E) experience rating;

(F) tier rating; or

(G) durational rating.

(2)(A) The commissioner shall, by rule, adopt standards and a process for permitting registered small group carriers to use one or more risk classifications in their community rating method, provided that the premium charged shall not deviate above or below the community rate filed by the carrier by more than 20 percent, and provided further that the commissioner's rules may not permit any medical underwriting and screening.

(B) The commissioner's rules shall permit a carrier, including a hospital or medical service corporation and a health maintenance organization, to

establish rewards, premium discounts, split benefit designs, rebates, or otherwise waive or modify applicable co-payments, deductibles, or other cost-sharing amounts in return for adherence by a member or subscriber to programs of health promotion and disease prevention. The commissioner shall consult with the commissioner of health, the director of the Blueprint for Health, and the director of the office of Vermont health access in the development of health promotion and disease prevention rules that are consistent with the Blueprint for Health. Such rules shall:

(i) limit any reward, discount, rebate, or waiver or modification of cost-sharing amounts to not more than a total of 15 percent of the cost of the premium for the applicable coverage tier, provided that the sum of any rate deviations under subdivision (A) of this subdivision (2) does not exceed 30 percent;

(ii) be designed to promote good health or prevent disease for individuals in the program and not be used as a subterfuge for imposing higher costs on an individual based on a health factor;

(iii) provide that the reward under the program is available to all similarly situated individuals and shall comply with the nondiscrimination provisions of the federal Health Insurance Portability and Accountability Act of 1996; and

(iv) provide a reasonable alternative standard to obtain the reward to any individual for whom it is unreasonably difficult due to a medical condition or other reasonable mitigating circumstance to satisfy the otherwise applicable standard for the discount and disclose in all plan materials that describe the discount program the availability of a reasonable alternative standard.

(C) The commissioner's rules shall include:

(i) standards and procedures for health promotion and disease prevention programs based on the best scientific, evidence-based medical practices as recommended by the commissioner of health;

(ii) standards and procedures for evaluating an individual's adherence to programs of health promotion and disease prevention; and

(iii) any other standards and procedures necessary or desirable to carry out the purposes of this subdivision (2).

(3) The commissioner may exempt from the requirements of this section an association as defined in subdivision 4079(2) of this title which:

(A) offers a small group plan to a member small employer which is community rated in accordance with the provisions of subdivisions (1) and (2) of this subsection. The plan may include risk classifications in accordance with subdivision (2) of this subsection;

(B) offers a small group plan that guarantees acceptance of all persons within the association and their dependents; and

(C) offers one or more of the common health care plans approved by the commissioner under subsection (e) of this section.

(4) The commissioner may revoke or deny the exemption set forth in subdivision (3) of this subsection if the commissioner determines that:

(A) because of the nature, size, or other characteristics of the association and its members, the employees, or members are in need of the protections provided by this section; or

(B) the association exemption has or would have a substantial adverse effect on the small group market.

(i) A registered small group carrier shall file with the commissioner an annual certification by a member of the American Academy of Actuaries of the carrier's compliance with this section. The requirements for certification shall be as the commissioner by rule prescribes.

(j) A registered small group carrier shall provide, on forms prescribed by the commissioner, full disclosure to a small group of all premium rates and any risk classification formulas or factors prior to acceptance of a small group plan by the group.

(k) A registered small group carrier shall guarantee the rates on a small group plan for a minimum of six months.

(l)(1) A registered small group carrier may require that 75 percent or less of the employees or members of a small group with more than 10 employees participate in the carrier's plan. A registered small group carrier may require that 50 percent or less of the employees or members of a small group with 10 or fewer employees or members participate in the carrier's plan. A small group carrier's rules established pursuant to this subsection shall be applied to all small groups participating in the carrier's plans in a consistent and nondiscriminatory manner.

(2) For purposes of the requirements set forth in subdivision (1) of this subsection (l), a registered small group carrier shall not include in its calculation an employee or member who is already covered by another

group health benefit plan as a spouse or dependent or who is enrolled in Catamount Health, Medicaid, the Vermont health access plan, or Medicare. Employees or members of a small group who are enrolled in the employer's plan and receiving premium assistance under chapter 19 of Title 33 shall be considered to be participating in the plan for purposes of this section. If the small group is an association, trust, or other substantially similar group, the participation requirements shall be calculated on an employer-by-employer basis.

(3) A small group carrier may not require recertification of compliance with the participation requirements set forth in this section more often than annually at the time of renewal. If, during the recertification process, a small group is found not to be in compliance with the participation requirements, the small group shall have 120 days to become compliant prior to termination of the plan.

(m) This section shall apply to the provisions of small group plans. This section shall not be construed to prevent any person from issuing or obtaining a bona fide individual health insurance policy; provided that no person may offer a health benefit plan or insurance policy to individual employees or members of a small group as a means of circumventing the requirements of this section. The commissioner shall adopt, by rule, standards and a process to carry out the provisions of this subsection.

(n) The guaranteed acceptance provision of subsection (d) of this section shall not be construed to limit an employer's discretion in contracting with his or her employees for insurance coverage.

(o) Registered small group carriers, except nonprofit medical and hospital service organizations and nonprofit health maintenance organizations, shall form a reinsurance pool for the purpose of reinsuring small group risks. This pool shall not become operative until the commissioner has approved a plan of operation. The commissioner shall not approve any plan which he or she determines may be inconsistent with any other provision of this section. Failure or delay in the formation of a reinsurance pool under this subsection shall not delay implementation of this section. The participants in the plan of operation of the pool shall guarantee, without limitation, the solvency of the pool, and such guarantee shall constitute a permanent financial obligation of each participant, on a pro rata basis. (Added 1991, No. 52, § 1; amended 1993, No. 71, § 2; 1997, No. 24, §§ 2, 3; 2005, No. 191 (Adj. Sess.), § 50; 2007, No. 203 (Adj. Sess.), §§ 3, 12.)

8 V.S.A. § 4080b. Nongroup health benefit plans

§ 4080b. Nongroup health benefit plans

(a) As used in this section:

(1) "Individual" means a person who is not eligible for coverage by group health insurance as defined by section 4079 of this title.

(2) "Nongroup plan" means a health insurance policy, a nonprofit hospital or medical service corporation service contract or a health maintenance organization health benefit plan offered or issued to an individual, including but not limited to common health care plans approved by the commissioner under subsection (e) of this section. The term does not include disability insurance policies, accident indemnity or expense policies, long-term care insurance policies, student or athletic expense or indemnity policies, Medicare supplemental policies, and dental policies. The term also does not include hospital indemnity policies or specified disease indemnity or expense policies, provided such policies are sold only as supplemental coverage when a common health care plan or other comprehensive health care policy is in effect. By July 1, 1993, the commissioner shall review and approve or disapprove, according to the provisions of section 4062 of this title, any supplemental health insurance policy form offered or issued to an individual within the state of Vermont.

(3) "Registered nongroup carrier" means any person, except an insurance agent, broker, appraiser or adjuster, who issues a nongroup plan and who has a registration in effect with the commissioner as required by this section.

(b) No person may provide a nongroup plan unless the plan complies with the provisions of this section.

(c) No person may provide a nongroup plan unless such person is a registered nongroup carrier. The commissioner, by rule, shall establish the minimum financial, marketing, service and other requirements for registration. Registration under this section shall be effective upon approval by the commissioner and shall remain in effect until revoked or suspended by the commissioner for cause or until withdrawn by the carrier. A nongroup carrier may withdraw its registration upon at least six months' prior written notice to the commissioner. A registration filed with the commissioner shall be deemed to be approved unless it is disapproved by the commissioner within 30 days of filing.

(d)(1) A registered nongroup carrier shall guarantee acceptance of any individual for any nongroup plan offered by the carrier. A registered

nongroup carrier shall also guarantee acceptance of each dependent of such individual for any nongroup plan it offers.

(2) Notwithstanding subdivision (1) of this subsection, a health maintenance organization shall not be required to cover:

(A) an individual who is not physically located in the health maintenance organization's approved service area; or

(B) an individual residing within the health maintenance organization's approved service area for which the health maintenance organization:

(i) is not providing coverage; and

(ii) reasonably anticipates, and demonstrates to the satisfaction of the commissioner, that it will not have the capacity within its network of providers to deliver adequate service because of its existing contract obligations, including contract obligations subject to the provisions of this section and any other group contract obligations.

(e) A registered nongroup carrier shall offer two or more common health care plans approved by the commissioner. The commissioner, by rule, shall adopt standards and a process for approval of common health care plans that ensure that consumers may compare the cost of plans offered by carriers. At least one plan shall be a low-cost common health care plan that may provide for deductibles, coinsurance arrangements, managed care, cost-containment provisions, and any other term, not inconsistent with the provisions of this title, deemed useful in making the plan affordable. A health maintenance organization may add limitations to a common health care plan if the commissioner finds that the limitations do not unreasonably restrict the insured from access to the benefits covered by the plans.

(f) A registered nongroup carrier shall offer a nongroup plan rate structure which at least differentiates between single-person, two-person and family rates.

(g) For a 12-month period from the effective date of coverage, a registered nongroup carrier may limit coverage of preexisting conditions which exist during the 12-month period before the effective date of coverage; provided that a registered nongroup carrier shall waive any preexisting condition provisions for all individuals, and their dependents, who produce evidence of continuous health benefit coverage during the previous nine months substantially equivalent to the common health care plan of the carrier approved by the commissioner. If an individual has a preexisting condition excluded under a subsequent policy, such exclusion shall not continue

longer than the period required under the original contract, or 12 months, whichever is less. Credit shall be given for prior coverage that occurred without a break in coverage of 63 days or more. For an eligible individual, as such term is defined in Section 2741 of Title XXVII of the Public Health Service Act, a registered nongroup carrier shall not limit coverage of preexisting conditions.

(h)(1) A registered nongroup carrier shall use a community rating method acceptable to the commissioner for determining premiums for nongroup plans. Except as provided in subdivision (2) of this subsection, the following risk classification factors are prohibited from use in rating individuals and their dependents:

(A) demographic rating, including age and gender rating;

(B) geographic area rating;

(C) industry rating;

(D) medical underwriting and screening;

(E) experience rating;

(F) tier rating; or

(G) durational rating.

(2)(A) The commissioner shall, by rule, adopt standards and a process for permitting registered nongroup carriers to use one or more risk classifications in their community rating method, provided that the premium charged shall not deviate above or below the community rate filed by the carrier by more than 20 percent, and provided further that the commissioner's rules may not permit any medical underwriting and screening and shall give due consideration to the need for affordability and accessibility of health insurance.

(B) The commissioner's rules shall permit a carrier, including a hospital or medical service corporation and a health maintenance organization, to establish rewards, premium discounts, rebates, or otherwise waive or modify applicable co-payments, deductibles, or other cost-sharing amounts in return for adherence by a member or subscriber to programs of health promotion and disease prevention. The commissioner shall consult with the commissioner of health and the director of the office of Vermont health access in the development of health promotion and disease prevention rules. Such rules shall:

(i) limit any reward, discount, rebate, or waiver or modification of cost-sharing amounts to not more than a total of 15 percent of the cost of the premium for the applicable coverage tier, provided that the sum of any rate deviations under subdivision 4080a(2)(A) of this title does not exceed 30 percent;

(ii) be designed to promote good health or prevent disease for individuals in the program and not be used as a subterfuge for imposing higher costs on an individual based on a health factor;

(iii) provide that the reward under the program is available to all similarly situated individuals; and

(iv) provide a reasonable alternative standard to obtain the reward to any individual for whom it is unreasonably difficult due to a medical condition or other reasonable mitigating circumstance to satisfy the otherwise applicable standard for the discount and disclose in all plan materials that describe the discount program the availability of a reasonable alternative standard.

(C) The commissioner's rules shall include:

(i) standards and procedures for health promotion and disease prevention programs based on the best scientific, evidence-based medical practices as recommended by the commissioner of health;

(ii) standards and procedures for evaluating an individual's adherence to programs of health promotion and disease prevention; and

(iii) any other standards and procedures necessary or desirable to carry out the purposes of this subdivision (2).

(i) Notwithstanding subdivision (h)(2) of this section, the commissioner shall not grant rate increases, including increases for medical inflation, for individuals covered pursuant to the provisions of this section that exceed 20 percent in any one year; provided that the commissioner may grant an increase that exceeds 20 percent if the commissioner determines that the 20 percent limitation will have a substantial adverse effect on the financial safety and soundness of the insurer. In the event that this limitation prevents implementation of community rating to the full extent provided for in subsection (h) of this section, the commissioner may permit insurers to correspondingly limit community rating provisions from applying to individuals who would otherwise be entitled to rate reductions.

(j) A registered nongroup carrier shall file with the commissioner an annual certification by a member of the American Academy of Actuaries

of the carrier's compliance with this section. The requirements for certification shall be as the commissioner by rule prescribes.

(k) A registered nongroup carrier shall guarantee the rates on a nongroup plan for a minimum of 12 months.

(l) Registered nongroup carriers, except nonprofit medical and hospital service organizations and nonprofit health maintenance organizations, shall form a reinsurance pool for the purpose of reinsuring nongroup risks. This pool shall not become operative until the commissioner has approved a plan of operation. The commissioner shall not approve any plan which he or she determines may be inconsistent with any other provision of this section. Failure or delay in the formation of a reinsurance pool under this subsection shall not delay implementation of this section. The participants in the plan of operation of the pool shall guarantee, without limitation, the solvency of the pool, and such guarantee shall constitute a permanent financial obligation of each participant, on a pro rata basis.

(m) The commissioner shall disapprove any rates filed by any registered nongroup carrier, whether initial or revised, for nongroup insurance policies unless the anticipated loss ratios for the entire period for which rates are computed are at least 70 percent. For the purpose of this section, "anticipated loss ratio" shall mean a comparison of earned premiums to losses incurred plus a factor for industry trend where the methodology for calculating trend shall be determined by the commissioner by rule.

(n) The commissioner shall ensure that any rates filed by any registered nongroup carrier, whether initial or revised, for nongroup insurance policies reflect the reduction in claims costs attributable to the nongroup market security trust established in section 4062d of this title. (Added 1991, No. 160 (Adj. Sess.), § 41, eff. July 1, 1993; amended 1993, No. 71, § 1; 1997, No. 24, § 4; 2005, No. 191 (Adj. Sess.), §§ 28, 51.)

8 V.S.A. § 4513. Permit to engage in business; foreign corporations

§ 4513. Permit to engage in business; foreign corporations

(a) At least three-fourths of the board of directors of a corporation organized under this chapter shall be composed of subscribers and members of the public. The remainder may be providers. The subscriber members of the board shall comprise at least a majority of the board. A corporation organized under this chapter shall provide for the election of its board of directors at a publicly announced meeting. For the purposes of this section, "provider" means any person who is a provider of hospital or medical services, or who is an employee, director, trustee or representative of a provider of such services.

(b) A hospital service corporation shall not enter into a contract with a subscriber until it has obtained from the commissioner of banking, insurance, securities, and health care administration a permit so to do. A permit may be issued by the commissioner upon the receipt of an application in form to be prescribed by him. Such application shall include a statement of the territory in which such corporation proposes to seek subscribers, the service to be rendered by it and the rates to be charged therefor. Such application shall also include a statement of the number of subscribers for hospital service. Before issuing such permit, the commissioner may make such examination or investigation as he deems necessary. The commissioner may refuse such permit if he finds that the rates submitted are excessive, inadequate or unfairly discriminatory. A hospital service corporation organized under the laws of another state or country shall not be licensed to do business in this state except as provided by section 4520 of this title.

(c) In connection with a rate decision, the commissioner may also make reasonable supplemental orders to the corporation and may attach reasonable conditions and limitations to such orders as he finds, on the basis of competent and substantial evidence, necessary to insure that benefits and services are provided at minimum cost under efficient and economical management of the corporation. The commissioner shall not set the rate of payment or reimbursement made by the corporation to any physician, hospital or other health care provider.

(d) The commissioner shall permit rates for a hospital service corporation designed to enable the corporation to accumulate and maintain a reserve fund which shall from time to time during the calendar year be increased in an amount equal to at least two percent of the annual premium income of the corporation until the reserve fund is equal to at least eight percent of the annual premium income of the corporation. However, if the liabilities

of the corporation exceed its assets, the commissioner shall permit the corporation to charge rates that enable the corporation to accumulate a reserve fund at the rate of at least five percent of annual premium income of the corporation until the corporation's assets equal its liabilities. Nothing herein shall require the commissioner to permit a corporation to accumulate a reserve fund until the law of the state of incorporation of that corporation is substantially similar to this subsection with respect to the reserve fund. (Amended 1975, No. 69, § 2, eff. April 18, 1975; 1983, No. 166 (Adj. Sess.); 1989, No. 225 (Ajd. Sess.), § 25(b); 1995, No. 180 (Adj. Sess.), § 38(a).)

8 V.S.A. § 4584. Application for permit

§ 4584. Application for permit

(a) A corporation incorporated under this chapter shall immediately, after filing its articles of association, apply to the commissioner of banking, insurance, securities, and health care administration for a permit to operate. Such application shall be made to the commissioner upon forms to be prescribed by him. Such application shall include a statement of the territory in which such corporation proposed to operate, the services to be furnished and rendered by it, and the rates to be charged therefor. Such application shall be accompanied by two copies of any contract for medical services which the corporation proposes to make with its subscriber. Before issuing such permit, the commissioner may make such examination or investigation as he deems necessary. The commissioner may refuse such permit if he finds that the rates submitted are excessive, inadequate or unfairly discriminatory.

(b) A corporation organized under the provisions of this chapter shall not enter into a contract with a subscriber to furnish medical services until it has obtained from such commissioner a permit to do so.

(c) In connection with a rate decision, the commissioner may also make reasonable supplemental orders to the corporation and may attach reasonable conditions and limitations to such orders as he finds, on the basis of competent and substantial evidence, necessary to insure that benefits and services are provided at minimum cost under efficient and economical management of the corporation. The commissioner shall not set the rate of payment or reimbursement made by the corporation to any physician, hospital or other health care provider.

(d) The commissioner shall permit rates for a medical service corporation designed to enable the corporation to accumulate and maintain a reserve fund which shall from time to time during the calendar year be increased in an amount equal to at least two percent of the annual premium income of the corporation until the reserve fund is equal to at least eight percent of the annual premium income of the corporation. However, if the liabilities of the corporation exceed its assets, the commissioner shall permit the corporation to charge rates that enable the corporation to accumulate a reserve fund at the rate of at least five percent of annual premium income of the corporation until the corporation's assets equal its liabilities. Nothing herein shall require the commissioner to permit a corporation to accumulate a reserve fund until the law of the state of incorporation of that corporation is substantially similar to this subsection with respect to the reserve fund. (Amended 1975, No. 69, § 4, eff. April 18, 1975; 1989, No. 225 (Adj. Sess.), § 25(b); 1995, No. 180 (Adj. Sess.), § 38(a).)

VERMONT DEPARTMENT OF BANKING, INSURANCE AND SECURITIES
REGULATION 91-4b
MINIMUM REQUIREMENTS FOR COMPLIANCE
WITH 8 V.S.A. SECTION 4080a

Table of Contents

Section 1. Purpose

The purpose of this regulation is to set forth the rules for registration of small group carriers, requirements for the sale of individual insurance and the standards and process for approval of common health care plans.

Section 2. Authority

This regulation is issued pursuant to the authority vested in the Commissioner of the Department of Banking, Insurance and Securities ("Commissioner") by Title 8 V.S.A. Section 4080a.

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Section 3. Registration

No person may offer a small group plan unless such person is a registered small group carrier as defined by 8 V.S.A. Section 4080a(a)(4). Pursuant to 8 V.S.A. Section 4080a(c), the following are the minimum requirements for registration as a small group carrier:

1. The carrier must apply to the Commissioner to be a registered small group carrier.
2. The carrier must be licensed or authorized to provide health insurance in Vermont.

3. The carrier shall have all small group rates, common health care plans and forms approved by the Department of Banking, Insurance and Securities ("Department") prior to their use in Vermont.
4. The carrier must have licensed or employee sales representatives in Vermont.
5. The carrier must designate, in writing, the name and address of a representative responsible for answering questions and responding to complaints about underwriting and claims.
6. The carrier must provide insureds with a toll free number for claims handling and customer service.
7. All advertising material about small group insurance must clearly identify the product advertised as a "Small Group Health Insurance Plan." All advertising material must be filed with the Department of Banking, Insurance and Securities prior to use.
8. The carrier must provide access to prior group experience, including gross premium (gross premium means written direct premium) earned premium and incurred claims, if collected, upon written request from any group policyholder.
9. The carrier must file annually the following information with the Department for the preceding calendar year no later than April 1:

a. the number of employers covered under each small group plan;
b. the number of employees and an estimate of the number of lives covered under each small group plan;
c. the gross premium for each small group plan;
d. the earned premium for each small group plan;
e. the incurred claims for each small group plan;
f. the number of employers with rates deviating above and below the community rate for each small group plan;
g. the amount of gross premium above, below and at the community rate for each small group plan; and
h. the same information required in lines a-g must be provided for any business underwritten with or through an association or trust, to include the name and address of each association or trust.

10. A carrier who intends to withdraw from the small group market must notify the Commissioner in writing at least six (6) months prior to canceling or nonrenewing any coverage. This notice must include the following information:

a. a description of the plans offered by the carrier;
b. the number of employers and the total number of lives insured under each contract; and
c. the planned termination date(s).

11. A registered carrier who qualifies under the provisions of Section 6(c), 1991, Act 52 must certify in writing by April 1 of each year that it continues to qualify and that in the preceding calendar year, it has not written more than $100,000.00 in annual gross premium for small group business covering individuals residing in this state.

Section 4. Individual Insurance

This section sets forth the standards and process for the sale of individual insurance as required by 8 V.S.A. Section 4080a(m).

1. No person may sell, offer or provide a health care benefit plan or insurance policy to individual employees or members of a small group as a means of circumventing the requirements of 8 V.S.A. Section 4080a.

2. No person may replace, offer or solicit the replacement of an existing group contract offered by an employer by selling or offering to sell or provide individual policies to employees of that employer.

3. Any person offering to sell or provide individual insurance must satisfy the following requirements:

a. Obtain a written statement from each individual that the purchase of individual health insurance coverage was not initiated, sponsored or subsidized by the individual's employer or any affiliate or agent of the employer.

b. Obtain a written statement from each agent or broker selling an individual policy that the sale was not made as a means of circumventing small group health insurance and that the purchase was not initiated, sponsored or subsidized by the individual's employer or any affiliate or agent of the employer.

c. Retain and make available for the Department's inspection all documentation required in subsections 3(a) and (b) for at least three (3) years.

d. Provide to the Department no later than April 1 of each year the following information for the preceding calendar year:

i. the number of individuals covered under all policies;

ii. the total gross premium for all policies;

iii. the total earned premium;

iv. the total incurred claims;

v. the percentage increase or decrease in new policies issued and existing policies renewed; and

vi. the total number of policies issued.

Section 5. Common Health Care Plans

This section sets forth the standards and process for approval of common health care plans as required by 8 V.S.A. Section 4080a(e).

1. Standards and Criteria.

The following standards and criteria shall be considered by the Commissioner in approving common health care plans. The standards and criteria are to be used as guidelines. They are not intended to establish minimum benefit levels or outlines of policy coverage that must be included in a common health care plan.

a. Comparable – a common health care plan shall permit comparison of the costs and relative benefits of all plans available to consumers.

b. Affordable – a common health care plan shall balance specific benefits and benefit levels with their impact on the plan cost. Cost containment

features such as deductibles; co-insurance and managed care should be considered.

c. Style and terms of policy – a common health care plan shall be easy for a consumer to read and understand. It shall contain a clear description of benefits, exclusions and conditions. A carrier may use its own format and style of type, subject to the Department's approval.

d. Exceptions and reductions – any exceptions or reductions of coverage shall be clearly labeled as such in a separate section of the plan. Each specific exclusion shall be listed and identified by number. Appropriate notice and explanation for each reduction or exclusion shall be provided to certificateholders.

e. Managed benefits – the suitability of requiring managed benefits shall be considered for each plan. Managed benefits may include but are not limited to pre-admission certification, admission certification of emergency admissions, concurrent review and individual case management.

f. Preventative care – each plan shall consider the use of preventative care benefits to promote the general health of certificateholders.

g. Benefit component – each benefit plan shall weigh the needs of Vermonters for the broadest benefit package possible, considering the constraints imposed by the cost of each benefit on the overall plan.

h. Feasibility – each plan will be considered in light of the technical and logistical requirements imposed on registered small group carriers.

2. Required Policy Provisions

Each common health care plan must satisfy the following minimum policy provisions:

a. Cancellation and Nonrenewal.

i. A carrier who cancels or nonrenews a group health insurance policy or subscriber contract shall:

(a) notify the group policyholder or other entity involved, and each of its employees or members covered under the policy or subscriber contract of the date of termination of the policy or contract. The notice shall advise the employees or members that, unless otherwise provided for in the policy or contract, the carrier shall not be liable for claims for losses incurred after the termination date and shall direct employees or members to refer to their certificates or contracts in order to determine their rights. The obligation to notify employees or members shall not apply to associations, trusts, and groups other than employer groups if the addresses of the employees and members are not reasonably available to the carrier. A carrier is not obligated to provide notice to employees and members if the termination of the policy or contract is due to replacement coverage subject to the provisions of this subchapter.

(b) advise, in any instance in which the plan involves employee contributions, that if the policyholder or other entity continues to collect contributions for coverage beyond the date of termination, the policyholder or other entity may be held solely liable for the benefits with respect to which the contributions have been collected.

ii. Except for cases pursuant to subsection (a) of this section, whenever the carrier is obligated to give any notice to employees and members directly, the carrier shall prepare and furnish to the policyholder or other entity a supply of notice forms to be distributed to covered employees or members. The forms shall state the fact of termination and the effective date of termination. The forms shall contain a statement directly employees or member to refer to their certificates or contracts in order to determine their rights. The notice forms shall be provided at the time the carrier gives its notice of termination to the policyholder or other entity.

b. Pre-existing Conditions.

For a 12-month period from the effective date of coverage, a registered small group carrier may limit coverage for pre-existing conditions which existed during the 12-month period preceding the effective date of coverage except that a registered small group carrier shall waive any preexisting conditions for all new employees or members of a small group, and their dependents, who produce evidence of continuous health benefit coverage (whether group or non-group) during the previous nine months which is substantially equivalent to the common health care plan of the carrier approved by the Commissioner.

c. Continuation and Conversion.

Any employee or member whose insurance under a group policy would terminate because of the termination of employment or the death of a covered employee shall be entitled to continue coverage under the policy as provided in Chapter 107, Subchapter 2 of Title 8. In addition, such person shall be entitled to have a converted policy as provided in Chapter 107, Subchapter 2 of Title 8. The converted policy shall cover any person who was covered by the continued group policy. At the option of the insurer, a separate, converted policy may be issued to cover any dependent. Premiums charged shall not exceed 102 percent (102%) of the group rate.

d. Termination and Replacement.

Carriers must comply with Title 8 V.S.A., Chapter 107, Subchapter 3 for the termination and replacement of coverage.

e. Mandated Benefits.

Except as stated in the model plan, no policy can be issued or delivered or advertised unless the following minimum benefits are available:

i. Mental health care, with the minimums stated in 8 V.S.A., Section 4089 must be offered as an option.

ii. Dependent children coverage must be provided where coverage would otherwise end for a child at a limiting age. There shall be no limit or coverage restriction for a child who is incapable of employment and dependent on the employee or member for support and maintenance. See 8 V.S.A. Section 4090.

iii. Newborn coverage must be provided without notice or additional premiums for 31 days after birth. Coverage shall include well baby care, injury, sickness, necessary care and treatment of medically diagnosed congenital defects and birth abnormalities as provided at 8 V.S.A. Section 4092

iv. Home health care coverage with the minimums provided in 8 V.S.A., Sections 4095 and 4096 must be offered as an option.

v. Alcoholism treatment must be provided for the necessary care and treatment of alcohol dependency as required by 8 V.S.A. Section 4098.

vi. Coverage for screening by low-dose mammography must be provided according to 8 V.S.A. Section 4100a.

vii. Maternity coverage must be provided and shall be treated as any other sickness for all insureds covered by the policy as required under Regulation 89-1.

f. Process for Approval of Common Health Care Plans.

i. Advisory Committee.

(a) The Commissioner shall appoint at least seven members to a small group health plan advisory committee. The committee shall include individuals representing business, the general public, the insurance industry, and the medical community. To the greatest extent possible, committee members will have technical expertise in health care insurance or regulation.

(b) The Commissioner shall consult with the small group advisory committee in the development of small group benefit plans revision of existing plans and review of plan suitability.

(c) The Committee will review all proposed plans for compliance with the standards set forth in Section 1.

ii. Review of suitability.
The Commissioner, in consultation with the advisory committee, will annually review the suitability of all approved common health care plans. This review will consider the number of policies sold during the prior year, the cost of the plan(s) and the need for any amendments to the plan(s). Any plan deemed unsuitable will be withdrawn, as required by the Commissioner.

iii. Process of approval.

(a) Upon approval of a common health care plan, the Commissioner shall:

(1) notify all registered small group carriers and supply a copy of the common health care plan;

(2) prepare a consumer guide to the benefit plan within six months of approval; and

(3) publish semi-annually the rates charged by carriers for each common health care plan.

(b) A registered small group carrier shall offer all approved common health care plans within six months of approval of the plan by the Commissioner.

Effective: November 1, 1992

VERMONT DEPARTMENT OF BANKING, INSURANCE AND SECURITIES
REGULATION 93-5 (Amended Rule)
MINIMUM REQUIREMENTS FOR COMPLIANCE
WITH TITLE 8 V.S.A., SECTION 4080b

Table of Contents

Section 1. Purpose

The purpose of this regulation is to set forth rules for the enrollment of registered non-group carriers, requirements for the sale of individual insurance, requirements for the filing of rates, and standards and the process for approval of common health care plans.

Section 2. Authority

This regulation is issued pursuant to the authority vested in the Commissioner of Banking, Insurance and Securities ("Commissioner") by Title 8 V.S.A., Sections 75, 4071, and 4080b(c).

Section 3. Applicability and Scope

This regulation applies to any person who issues a non-group plan. A non-group plan includes a health insurance policy, a nonprofit hospital or medical service contract or a health maintenance organization health benefit plan offered or issued to an individual. The term does not include disability insurance policies, long-term care insurance policies, Medicare supplement insurance policies, civilian

health and medical program of the uniformed services supplement policies, accident indemnity or expense policies, student or athletic expense or indemnity policies or dental policies. The term also does not include hospital indemnity policies or specified disease policies, provided such policies are sold only as supplemental coverage when a common health care plan or other comprehensive health care policy is in effect. This regulation applies to any contract issued to or renewed by a Vermont resident.

Section 4. Definitions

A. "Community rating" means a rating process that produces average rates for a defined community of insureds in the state of Vermont for the given policy period. The averaging process includes various geographic rating areas, if any, within Vermont, ages and genders of the Vermont insureds, industrial classifications within Vermont, if any, Vermont claims experience and duration of coverage. Different community rates are appropriate for the different insurance models which may be represented by indemnity coverage, indemnity coverage with managed care, preferred provider organizations and any other health insurance models approved by the Commissioner.

B. "Credibility" means a measure of the degree of statistical significance that can be assigned to the claims experience of a plan when it is used as a basis for projecting a future rate.

C. "Demographic rating" means a rating process that adjusts the community rate for a specific plan, based on that plan's deviation from the average age and gender in the community rate.

D. "Department" means the Department of Banking, Insurance and Securities.

E. "Deviation plan" means a plan, subject to the Commissioner's approval, which describes how the premium shall deviate from a filed community rate as provided in Title 8 V.S.A. § 4080b(h)(2).

F. "Durational rating" means a rating process that adjusts the community rate for a specific non-group, based on the individual's deviation from the average claims experience assumed in the community rate due to the period of time the policy has been in force.

G. "Experience rating" means a rating process that adjusts the community rate for a specific plan issued to an individual or group of individuals. The experience rating plan changes the individual's premium or rates based upon a deviation of the individual's or group of individuals' claims experience from an average claims experience.

H. "Geographic area rating" means a rating process that adjusts the community rate for a specific plan based on the deviation of the claims experience in the area where the insured person lives from the average claims experience in the community rate.

I. "Health insurance trend factor" means a projection factor that is an estimate of the unit cost increases and utilization increases that are expected to be incurred in a health benefits plan. The estimate of unit cost increases and utilization increases may include consideration of erosion of deductibles, medical technology, general inflation and cost shifting.

J. "Industry rating" means a rating process that adjusts the community rate for a specific plan, based upon the deviation of the experience of the industrial classification of the insured from the average experience in the community rate.

K. "Non-group plan" or "plan" has the same meaning as found in Title 8 V.S.A., Section 4080b(a)(2). The term "non-group plan" also includes any exempt plans listed in Section 4080b(a)(2), if coverage enhancements to those exempt plans make them substantially similar to any approved non-group plan.

L. "Pre-existing condition" means the existence of symptoms which would cause an ordinary, prudent person to seek diagnosis, care or treatment or those conditions for which medical advice or treatment was recommended by or received from a physician or other medical professional during the 12-month period preceding the effective date of coverage.

M. "Tier rating" means a rating process that assigns rates of a set of plans to one of a series of rating tiers, based upon claims experience of the set of plans, or based upon one or a combination of demographic, industry, and geographic rating factors.

N. "Rating manual rule" includes, but is not limited to, any procedures, manuals, rules, or rating plans used to develop a premium from a filed community rate.

O. "Registered non-group carrier" ("carrier") means any person, except an insurance agent, broker, appraiser, or adjuster, who issues a non-group plan and who is registered and approved as such by the Commissioner.

P. "Resident" means a person as defined in Title 18 V.S.A., Section 9402(8). A resident also includes a dependent as defined in Title 8 V.S.A., Section 4090 and a dependent child attending school outside Vermont.

Section 5. Registration

No carrier may offer a non-group plan as defined in Section 3(B) of this regulation unless such carrier registers as a non-group carrier as required by Title 8 V.S.A., Section 4080b(c) and is approved by the Commissioner. The following are the minimum requirements for registration as a non-group carrier:

A. The carrier must apply in writing to the Commissioner to be a registered non-group carrier.

B. The carrier must either be licensed or authorized to provide health insurance in Vermont, be a nonprofit hospital service corporation, nonprofit medical service corporation or be a health maintenance organization.

C. The carrier shall have all non-group rates, health care plans and forms approved by the Department prior to using them in Vermont.
D. The carrier must have licensed representatives in Vermont. The carrier must identify the representatives in the written application. If the carrier is a health maintenance organization, it shall have a sales representative in each of its service areas. The service areas shall be designated in the initial application.
E. The carrier must designate, in writing, the name and address of a representative responsible for answering questions and responding to complaints about underwriting and claims.
F. The carrier must provide insureds with a toll-free number for claims handling and customer service and supply this number to the Department in its application.
G. All advertising material about non-group insurance must clearly identify the product advertised as a "Non-group Health Insurance Plan." In addition, all registered nongroup insurers shall identify the common plan(s) by name (i.e., plan "A" etc). All advertising material must be filed with the Department prior to use. The carrier may use the advertising material after receipt by the Department.
H. A registered non-group carrier who qualifies under the provisions of Title 8 V.S.A., Section 4080b, and this regulation must certify in writing by April 1 of each year that it continues to qualify. The certification shall be signed by a member of the American Academy of Actuaries.

Section 6. Withdrawal

A carrier who intends to withdraw from the non-group market must notify the Commissioner in writing at least six (6) months prior to canceling or nonrenewing any policies. This notice must include the following information:

A. a description of the plans offered by the carrier;
B. the number of policies and the total number of lives insured under each plan; and
C. the planned termination date(s).

Section 7. Common Health Care Plans

This Section sets forth the standards and process for approval of common health care plans as required by Title 8 V.S.A., 4080b(e).

A. The standards and criteria outlined in Regulation 91-4b,Section 5(1)(a) through (h) shall be the standards adopted by this regulation. Any changes to the standards and criteria in Regulation 91-4b shall also apply to this regulation. Where Regulation 91-4b

refers to certificate holder, the reader should substitute "policy holder."

B. Each common health care plan must satisfy the following minimum policy provisions:

1. A policy offered for sale after the effective date of this regulation shall not be canceled except for nonpayment of premium and eligibility for Medicare coverage due to age.

2. The policy may be nonrenewed only for the following reasons: the insured is no longer a resident of Vermont or will not be a resident on or after the renewal date, the carrier has withdrawn from the nongroup market after notification as required by this regulation, the carrier has withdrawn an approved plan and/or the insured is eligible for Medicare coverage due to age.

3. The notice of cancellation for nonpayment of premium shall provide for at least 15 days notice from the date of mailing.

4. The notice of nonrenewal shall provide for at least 30 days notice from the date of mailing. If the carrier has withdrawn an approved plan, it shall provide the reasons for nonrenewal in the notice and offer to replace the plan with an approved plan.

5. A policy providing coverage for a spouse or members of a family shall not terminate because of the death of the insured. The insurer may issue a replacement policy providing substantially the same benefits to cover the surviving spouse or other dependents.

6. Termination or nonrenewal of the policy for any reason other than non-payment of premium shall provide for the payment of covered expenses from a continuous loss which started while the policy was in force, not to exceed 12 months from the date of termination or nonrenewal. The payment of benefits under the policy may be conditioned upon total disability of the covered person and the coverage limits of the policy. Policies providing pregnancy benefits shall provide for an extension of benefits as to pregnancy commencing while the policy is in force and for which benefits would have been payable had the policy remained in force.

C. For a 12-month period from the effective date of coverage a registered non-group carrier may limit coverage for preexisting conditions. A registered non-group carrier shall waive any pre-existing conditions for a11 new policyholders and their dependents, who produce evidence of continuous health benefit coverage (whether group or non-group) during the previous nine

months. This waiver may be conditioned upon the prior policy having provided substantially equivalent coverage to the coverage provided by the new policy.

D. No policy which is the subject of this regulation, can be issued, delivered, renewed or advertised unless the following minimum benefits are available:

1. Dependent children coverage must be provided where coverage would otherwise end for a child at a limiting age as required by Title 8 V.S.A., Section 4090.
2. Newborn coverage for routine and other care must be provided without notice or additional premiums for 31 days after birth. Coverage shall include well baby care, injury, sickness, necessary care and treatment of medically diagnosed congenital defects and birth abnormalities as provided by Title 8 V.S.A., Section 4092.
3. Home health care coverage with the minimum coverage described in Title 8 V.S.A., Section 4095 and 4096 must be offered as an option.
4. Alcoholism treatment must be provided for the necessary care and treatment of alcohol dependency as required by Title 8 V.S.A., Section 4098.
5. Coverage for screening by low-dose mammography must be provided as required by Title 8 V.S.A., Section 4100a.
6. Maternity coverage must be provided and shall be treated as any other sickness for all insureds covered by the policy as required under Regulation 89-1.

Section 8. Other Non-Group Plans

All non-group plans must satisfy the minimum policy provisions provided in Section 7(B),(C) and (D) of this regulation.

Section 9. Health Care Advisory Committee

A. The process for the approval of the Common Health Care Plan shall be as outlined in Regulation 91-4b, Section 5(2)(f). Any changes to Section 5(2)(f) shall be incorporated into this regulation. Language in Section 5(2)(f) referring to group carrier shall be interpreted to mean non-group carrier when applying it to this regulation.

Section 10. Solicitation

A registered non-group carrier shall make available to each resident of Vermont all non-group plans approved by the Commissioner. A registered non-group carrier shall not take any action that would prevent or discourage a resident from

purchasing any plan offered by the carrier. The carrier must list all plans that it is offering for sale in Vermont in any rate filing covered by this regulation to the Commissioner. A registered non-group carrier which is also a health maintenance organization may limit applications for approved plans to residents in its service area. The health maintenance organization must state in its rate filing the service area for the plans approved by the Commissioner and how the sale may be limited.

Section 11. Community Rating Methodology

A. To be considered acceptable by the Commissioner, the community rates submitted by a registered non-group carrier must be effective for at least a twelve-month policy period.

B. Premiums shall be submitted for "single," "two person," (two adults or one adult and one child) and "family" membership classifications. Other or different classifications may be filed and used, provided they are approved by the Commissioner.

C. Community rates shall be calculated in such a manner that appropriate and separate rates are available for each insurance model for each month in which accounts renew or new accounts are written. Compliance with this requirement can be accomplished in many ways, some of which are listed here:

1. A set of community rates are calculated for a twelve month period. The rates are to be effective for at least twelve months for accounts renewing in that month. Monthly trend factors may be applied to community rates for the remaining eleven months of renewals, all of which are to be effective for twelve months. Filings should be made no more frequently than twice a year.

2. Other methodologies that are submitted to and approved by the Commissioner, but filings should be made no more frequently than quarterly.

D. Medical underwriting and screening to exclude or individually rate non-group insureds is not allowed. Therefore, the community rating plan for a registered nongroup carrier may not contain any provisions for adjustments that are based upon medical underwriting and/or medical screening.

E. Proposed community rates should be based upon reasonable projections of Vermont non-group experience that has been incurred by the registered non-group carrier. To the extent that the carrier's Vermont claims experience is not deemed to be fully credible, it can be combined with the carrier's non-group experience from other states, if that experience is adjusted to reflect Vermont benefit differences,

demographic differences, geographic differences, etc., that, if not otherwise made, would render the out-of-state experience invalid for Vermont insureds. Carriers may be required to provide such Vermont-based data as the Commissioner deems necessary.
Projections of the base claims experience forward to the period for which the proposed community rates are designed to be effective should be accomplished with the use of an appropriate health insurance trend factor.
F. In addition to the expected claims cost, the carrier's community rates may contain appropriate allowances for administrative expenses, taxes, profit and the cost for reinsurance, if any, and other elements used by the carrier.
G. The approved community rates for a given benefit package may be adjusted for the following rating classifications upon approval of a deviation plan by the Commissioner:

1. demographics;
2. geographic area;
3. industrial class;
4. experience;
5. tier rating;
6. durational rating; and
7. other classifications approved by the Commissioner. After July 1, 1993, the premium charged shall not deviate above or below the community rate filed by the carrier by more than 40 percent (40%) for two years and thereafter, 20 percent (20%).

H. The registered carrier must file and request approval from the Commissioner of all rating manual rules.

Section 12. Restrictions Relating to Premium Increases

A. The percentage of increase in the premium charged to an individual account for the same coverage for a new rating period may not exceed twenty percent (20%).
B. Notwithstanding Section A of this paragraph, a carrier may seek relief from the premium increase limitation by requesting a determination from the Commissioner that such a limitation will have a substantial adverse effect on the financial soundness and safety of the carrier.

Section 13. Approval of Community Rates, Deviation Plans and Rating Methodology

A. Each registered carrier shall file its community rates and the method used to derive them at least sixty days prior to their first intended use. The rates filed may not be used until approved by the Commissioner.

B. The filing should contain, at a minimum, the following information:

1. a description of the base claims experience data;
2. actuarial support for the health insurance trend factor used to project the base claims experience data forward to the rating period and a copy of the data used to calculate the trend factors;
3. a description of each element of retention;
4. a description of all other adjustments or elements included in or used to calculate the rates;
5. an identification of the effective date that the rates were designed for and the effective period of the rates. One way to appropriately make this identification would be to include a statement in the filing similar to the following:

> "These rates have been designed to apply to (identify the plans), renewing on or after XX/XX/XX and will remain in effect for twelve months for each renewal."; and

6. a description of the rating classifications and rating rules that make up the rating plan, including a demonstration of how the requirement that the premium for any given insured shall not deviate by more than 40% from the carrier's approved community rate. After July 1, 1995, the above information shall be submitted based on a deviation of not more than 20 percent.

C. The following statements by a qualified actuary who is a member of the American Academy of Actuaries must be included with each filing:

1. that the rates and proposed rating methodology meet all the requirements of this regulation;
2. that the rates are reasonable in relation to the benefits provided, and that they are neither excessive, deficient, nor unfairly discriminatory; and
3. that the proposed rates anticipate at least a 70% loss ratio for the period of time the rates will remain in effect.

D. Filings made after the initially-approved filing should also identify what changes, if any, are made in the use of rating classification factors as compared to the last filing. Similarly, if no changes are proposed in the use of rating classification factors as compared to the last filing, this should also be noted. The

rating factors shall be applied in their entirety without exception or adjustment.

E. Once a rating plan with rating classifications has been approved, a carrier must apply the rating factors or rating manual rules in a uniform manner to all accounts.

F. The filing form shown in Attachment 1 shall be used for each rate submission to the Commissioner.

Section 14. Underwriting Standards for Registered Non-Group Carriers

A. A registered non-group carrier shall guarantee acceptance of all applicants who are residents of Vermont for any approved plan offered by the carrier. A registered non-group carrier shall, upon application by a resident of Vermont who is currently insured by another carrier, accept the application and provide a policy of insurance under an approved plan without imposing any additional restrictions for preexisting conditions or waiting periods. The carrier may restrict coverage only to the extent provided in Title 8 V.S.A., Section 4080b(g). A registered non-group carrier shall also guarantee acceptance for each spouse of an applicant and dependent children including disabled children.

B. Insurers may gather medical information from insured persons in order to make informed decisions concerning reinsurance or for other non-underwriting purposes.

C. Medical underwriting or screening to exclude or limit coverage is not allowed. The community rating plan for a registered non-group carrier may not contain any provisions for adjustments that are based on medical underwriting and/or medical screening.

D. Registered non-group carriers must accept all applications for non-group coverage from residents of Vermont. The carrier may require proof of current Vermont residency. In addition, the carrier may require appropriate records which demonstrate bona fide residency in Vermont. (The intention is to protect the financial integrity of registered nongroup carriers from adverse selection.)

E. Registered non-group carriers are required to renew each plan as the policy anniversary date comes due. In addition, all dependents must be renewed, unless the insured or dependent is no longer a resident of Vermont or ceases to be a qualified dependent pursuant to Title 8 V.S.A., Section 4090. If the registered non-group carrier has the necessary information, it shall confirm in writing, at least 30 days prior to renewal, the premium at which the policy is to be renewed.

Section 15. Agent/Broker Reimbursement

Agent/broker reimbursement may not be based on or related to the case characteristics or experience of an account. Commission levels of a carrier must be uniform for all accounts.

Section 16. Separability

Should a court hold any provision of this regulation invalid in any circumstances, the invalidity shall not affect any other provisions or circumstances.

Section 17. Effective Date

This regulation initially became effective April 1, 1994 and these amendments will become effective March 16, 1998.

Attachment 1
WORKSHEET

The purpose of this worksheet is to provide the Commissioner with appropriate information to judge the reasonableness of premium rates submitted by registered non group carriers. While it can be used by the carrier to actually determine its premium rates, it need not be. The carrier is free to use its own techniques. However, the carrier is required to then provide the base claims cost information requested, as well as the expected claims cost for the period of the proposed rates. The resulting trend factor will be reviewed by the Commissioner for reasonableness. The carrier is required to file for approval each time any rate for non group coverage is proposed to change. The worksheet should be filled out with information for the coverage offered by the registered non group carrier. If other coverage produce health care trend factors different than the trend factor shown in Item 6, the coverage and associated trend factors should be identified on a separate sheet of paper, and attached to the worksheet. Space is provided in Item 10 for different trend factors for the same coverage with different deductibles and/or coinsurance. In Item 1, please insert the incurred claims for a recent 12 month period for this coverage. Ideally, the 12 month incurred claims would have 3 months of runout and would then be completed to the fully incurred level with an estimate of unpaid claims. In Item 2, the amount of claims in excess of any medical stop loss attachment point are posted. Item 3 is the difference between Item 1 and Item 2. The earned contract months exposed to risk for the coverage during the 12 month incurred period should be entered at Item 4. The incurred claims cost per contract month (monthly pure premium) in Item 5 is calculated by dividing Item 3 by the "Total" contract months in Item 4. Carriers who use this form to actually calculate their rates will enter their average

annual trend factor at Item 6, and compound it for the appropriate number of months in the projection span in Item 7. The compounded trend factor is applied to the base claims cost in Item 5, and the resulting expected claims cost is entered at Item 8.

Carriers who develop their expected claims cost using some other method should fill in Item 8, and then develop the trends that result from their process, and fill them in at Items 6 and 7.
The carrier's allocation of the total claims cost in Item 8 into single, two person, and family components is shown in Item 9. If, for example, the primary product is a $100 deductible comprehensive major medical coverage, other deductible coverage claims costs are filled in at Item 10, along with average annual trend factors comparable to the one reported in Item 6.

Retention elements are reported in Item 11 b through g, both on a dollar basis and a percent of premium basis.
The total premium rates are filled in at Item 12. The claims cost in Item 9 and the retention in Item 11 are combined to produce these premium rates. Premium rates for the same period for the same coverage one year earlier are inserted at Item 13, and the annual rate increase is entered at Item 14.

Registered Carrier _____
Coverage _____
Effective Date _____
1. Base incurred claims* for the 12 month
_____
period _____.
2. Incurred claims in excess of
reinsurance_____
attachment point, if applicable **
3. Incurred claims adjusted for the
removal_____
of claims in excess of reinsurance attachment point (1)-(2)

4. Earned contract months exposed to a) Single _____
risk during the same 12 month b) 2 Person _____
experience period. c) Family _____
d) Total _____
5. Incurred claims cost per contract month
_____
(pure premium) for the 12 month period,
excluding claims in excess of the
reinsurance attachment point. (3) ÷ (4d)
* State this on a fully incurred basis. This is a combined statistic for single, two person, family, and other types of membership classifications.

** This refers to the reinsurance attachment point for the period of the rates discounted at the health insurance trend factor to the base experience period.

6. Health insurance trend factor*** _____
stated on an average annual basis.

7. Health insurance trend factor compounded _____
as necessary for the projection span
from the base experience period to the
period of the proposed rates.

a) State the period of the proposed rates.

· First effective date _____
· Last effective date _____
· Length of rate guarantee _____

b) State the projection span from
the base experience period to the
period of the rates in terms of
numbers of months. _____

8. Expected claims cost per contract (pure
premium)_____
for the period of the proposed rates, excluding
claims in excess of the reinsurance attachment
point. (5 x 7)

9. Allocation of the expected claims cost into
single, two person and family classifications:

Single _____
Two Person _____
Family _____

*** The trend factor should include the effects of the fixed deductibles under a comprehensive major medical product, and the fixed reinsurance attachment point under all coverage.

10. Expected claims costs trends for other deductible and coinsurance combinations.

Average Annual Health Insurance Coverage	Single	Two Person	Family	Trend Factor
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

11. Elements of the proposed composite rate expressed as a percent of total rate and as a dollar amount.

	Amount	%
a. Expected claims cost (Item 8)	_____	____
b. Administrative expense	_____	____
c. Commissions	_____	____
d. Taxes	_____	____
e. Profit or contribution to reserves/surplus	_____	____
f. Reinsurance expense	_____	____
g. Other	_____	____
Total	_____	100%

12. Premium rates (Item 9 loaded with Item 11, b through g)
Single _____
Two Person _____
Family _____

13. Premium rates for the same period one year earlier.
Single _____
Two Person _____
Family _____

14. Annual rate increase
Single _____
Two Person _____
Family _____

15. Please list all plans being offered for sale in Vermont. Please list the form number and the product name. Use other sheets of paper, if you need more room.

_____
_____
_____
_____

Attachment 2
Worksheet

The purpose of this work sheet is to provide the Commissioner with the information required in Section 11, G, H and Sections 13, B.4 about adjustments to the Community Rates. Adjustments based on medical underwriting and health status are not allowed.
However, adjustments for demographics, geographic area, industry, claims experience, experience of the tier to which the individual is assigned, the duration of the individual's policy and other adjustments that may be approved by the Commissioner are allowed, as long as the total adjustment falls within the limiting bands.

1. Please identify the specific types or adjustments that will be used by your company by placing a check next to the appropriate adjustment.

AGE/GENDER _____
AREA _____
INDUSTRY _____
EXPERIENCE _____
TIER _____
DURATION _____
OTHER _____

2. If "OTHER" has been checked, please describe the adjustment in full.

3. For each adjustment that is checked, please demonstrate how the factor was determined and what sources were used.

4. For each adjustment that is checked, please show what adjustment factors will be used and demonstrate how they will be applied. Please provide tables of adjustment factors for each type of adjustment.

5. Please demonstrate how the use of the adjustment factors will be controlled to produce no more than a 40% variation in the community rate for two years.

Eff. 10/28/99

REGULATION H-99-4
COMMUNITY RATING
AND APPROVAL OF COMMUNITY RATING FORMULAS

TABLE OF CONTENTS

A. DEFINITIONS

"COMMUNITY RATING" means a rating process that produces average premium rates for a defined community of insureds in the State of Vermont for the given policy period. The averaging process includes various geographic rating areas, if any, within Vermont, ages and genders of the Vermont insureds, industrial classifications within Vermont, if any, Vermont claims experience, size of group within the small group definition, and duration of coverage.

Different community rates are appropriate for the different insurance models which may be represented by indemnity coverage, indemnity coverage with managed care, preferred provider organizations and any other health insurance model as approved by the Commissioner.

"DEMOGRAPHIC RATING" means a rating process that adjusts the community rate for a specific small group, based on that small group's deviation from the average age and gender in the community rate.

"EXPERIENCE RATING" means a rating process that adjusts the community rate for a specific small group, based on the deviation of the group's own claim experience from the average claim experience in the community rate. The definition recognizes that an experience rating formula for small groups may give only partial credit to the group's own experience in any experience rating plan.

"GEOGRAPHIC AREA RATING" means a rating process that adjusts the community rate for a specific small group, based on the deviation of the claims experience in the area in which the group is located from the average claims experience in the community rate.

"INDUSTRY RATING" means a rating process that adjusts the community rate for a specific small group, based upon the deviation of the experience of its industrial classification from the average experience in the community rate.

"PRE-EXISTING CONDITION" means a condition that exists during the twelve-month period before the effective date of coverage.

"DURATIONAL RATING" means a rating process that adjusts the community rate for a specific small group, based on the group's deviation from the average claims experience assumed in the community rate due to the period of time the policy has been in force.

"TIER RATING" means a rating process that assigns small groups to one of a series of rating tiers, based upon claims experience of the group, or based upon one or a combination of demographic, industry, and geographic rating factors.

"CREDIBILITY" means a measure of the degree of statistical significance that can be assigned to the claims experience of a small group when it is used as a basis for projecting a future rate.

"HEALTH INSURANCE TREND FACTOR"means a projection factor that is an estimate of the unit cost increases and utilization increases that are expected to be incurred in a health benefits plan. The estimate of unit cost increases and utilization increases may include consideration of erosion of deductibles, medical technology, general inflation and cost shifting.

"SMALL GROUP PLAN"means a Small Group Plan as defined in Title 8 V.S.A., Section 4080a.

"SMALL EMPLOYER" means a Small Employer as defined in Title 8 V.S.A., Section 4080a.

"REGISTERED SMALL GROUP CARRIER" means a Small Group carrier as defined in Title 8 V.S.A., Section 4080a.

B. COMMUNITY RATING METHODOLOGY

1. This community rating regulation applies to registered small group carriers providing small group health plans to small groups. For purposes of this regulation, Multiple Employer Trusts, Multiple Employer Welfare Associations and other associations that are made up of a collection of small groups are included (Section B9 refers to certain conditions under which general associations may be excluded).
2. To be considered acceptable by the Commissioner, the community rates submitted by a registered small group carrier must be effective for at least a six- month policy period.
3. Premiums shall be submitted for "single", "two person" (two adults or one adult and one child) and "family" membership classifications. Other or different classifications may be filed and used, provided they are approved by the Commissioner.
4. Community rates shall be calculated in such a manner that appropriate and separate rates are available for each insurance model for each month in which small groups renew policies or new small group business is written by a carrier. Compliance with this regulation can be accomplished in many ways, some of which are listed here:

4.1 a set of community rates is calculated for a calendar quarter, and applies to the renewals in that quarter. The rates are to be effective for at least six months.
4.2 a set of community rates is calculated for the first month of a six-month period. The rates are designed to be effective for at least six months for accounts renewing in that month. Monthly trend factors are supplied that, when applied, provide community rates for the remaining five months of renewals, all of which are to be effective for a minimum of six months.
4.3 other methodologies that are submitted and approved by the Commissioner, but filings should be made no more frequently than once a quarter.

5. Medical underwriting and screening to exclude or individually rate small group insureds is not allowed. Therefore, the community rating plan for a registered small group carrier may not contain any provisions for adjustments that are based on medical underwriting and/or medical screening.

6. Proposed community rates should be based upon reasonable projections of Vermont small group experience that has been incurred by the registered small group carrier. To the extent that the carrier's Vermont claims experience is not deemed to be fully credible, it can be combined with the carrier's small group experience from other states, if that experience is adjusted to reflect Vermont benefit differences, demographics differences, geographic differences, etc., that, if not otherwise made, would render the out-of-state experience invalid for Vermont insureds. Carriers may be required to provide such Vermont-based data as the Commissioner deems necessary. Projection of the base claims experience forward to the period for which the proposed community rates are designed to be effective should be accomplished with the use of an appropriate health insurance trend factor.

7. In addition to the expected claims costs, the carrier's community rates may contain appropriate allowances for administrative expense, taxes, profit, the cost for reinsurance, if any, and the other elements used by the carrier.

8. For a particular small group, the approved community rates for a given benefit package may be adjusted for the following rating classifications:
8.1 demographics
8.2 geographic area
8.3 industrial class
8.4 the group's experience
8.5 durational rating
8.6 tier rating
8.7 other factors that the Commissioner would approve

The total premium charged shall not deviate above or below the community rate filed by the carrier by more than twenty percent (20%) except for hospital or medical service corporations that qualify for tax-exempt status, pursuant Title 8 V.S.A., Section 4516.

8A. Notwithstanding the above, as of January 1, 2000, no small group carrier may deviate from the community rate when writing new business. Additionally, small group carriers must phase out deviations in business existing as of January 1, 2000, according to the following schedule:
All renewals of business with anniversary dates on or after January 1, 2000 through

December 31, 2000: reduce deviation to 15%.
All renewals of business with anniversary date on or after January 1, 2001 through December 31, 2001: reduce deviation to 10%.
All renewals of business with anniversary dates on or after January 1, 2002 through December 31, 2002: reduce deviation to 5%.
All renewals of business with anniversary dates on or after January 1, 2003: no deviations.

9. The percentage increase in the premium charged to a small employer for a new 12-month period may not exceed the sum of the following:

a. the percentage change in the community rate for a new rating period; and any adjustment, not to exceed fifteen percent (15%) annually, due to a change in the deviation calculated for a new rating period based on a change in the case characteristics of the group as permitted under paragraph B(8) of this regulation.

b. Notwithstanding Section 9a of this paragraph, a carrier may seek relief from the premium increase limitation by requesting a determination from the Commissioner that such a limitation will have a substantial adverse effect on the financial soundness and safety of the carrier.

10. The Commissioner may exempt from the requirements of Title 8 V.S.A., Section 4080a(d)(1) an association as defined in Section 4079(2) of this title which:

10.1 offers a small group plan to a member small employer which is community rated in accordance with the provisions of this section. The plan may include rating classifications in accordance with this section;
10.2 offers a small group plan that guarantees acceptance of all persons within the association and their dependents; and
10.3 offers one or more of the common health care plans approved by the Commissioner.

The exemption referred to in this paragraph consists of allowing an association to restrict access to small group accident and health insurance to members of the association or a class of members of the association with the approval of the Commissioner. The Commissioner may revoke or deny the exemption if it is determined that because of the nature, size or other characteristics of the association and its members, the employees or members are in need of the protection provided by this section or the exemption would have a substantial adverse effect on the small group market.

C. APPROVAL OF COMMUNITY RATES AND RATING METHODOLOGY

1. Each registered small group carrier shall file its community rates, and the method used to derive them, at least sixty days prior to their first intended use. The rates filed may not be used until approved by the Commissioner.
2. This filing should contain, at a minimum, the following information:
2.1 A description of the base claims experience data.

2.2 Actuarial support for the health insurance trend factor used to project the base claims experience data forward to the rating period.
2.3 A description of the elements of retention.
2.4 A description of other adjustments or elements included in the rates.
2.5 An identification of the exact effective date that the rates were designed for and the effective period of the rates. One way to appropriately make this identification would be to include a statement in the filing similar to the following:

> "These premium rates have been designed to apply to all small groups renewing in the third calendar quarter of 1992, and will remain in effect for twelve months for each renewal,"

2.6 A description of the rating classifications that are part of the rating plan, including a demonstration of how the requirement that the premium for any given group should not deviate by more than twenty percent (20%) from the carriers approved community rate is being met.

Filings made after the initial approved filing should also identify what changes, if any, are made in the use of rating classification factors as compared to the last filing. Similarly, if no changes are proposed in the use of rating classification factors as compare to the last filing, this should also be noted. The rating factors shall be applied in their entirety without exception or adjustment.

Once the rating plan together with rating classifications has been approved, the carrier shall not selectively apply the rating factors: every approved rating factor contained in the rating plan shall be applied in respect to every small group without any adjustment unless such adjustment has been approved by the Commissioner.

2.7 A statement by a qualified actuary who is a member of the American Academy of Actuaries that the rates and proposed rating methodology meet the requirements of this section, that they are reasonable in relation to the benefits provided, and that they are neither excessive, deficient, nor unfairly discriminatory.
2.8 The filing form shown in Attachment 1 shall be used for each premium rate submission to the Commissioner.

D. UNDERWRITING STANDARDS FOR REGISTERED SMALL GROUP CARRIERS

1. A registered small group carrier shall guarantee acceptance of all small groups as defined in Title 8 V.S.A., Section 4080a(1) for any small group plan offered by the carrier. A registered small group carrier shall, upon application by any small group which is currently insured by another carrier, accept such small group and grant insurance under a plan with substantially comparable benefits without imposing any additional restrictions for pre-existing conditions and may restrict coverage only to the extent provided in Title 8 V.S.A., Section 4080a(g).
2. A registered small group carrier shall also guarantee acceptance of all employees or

members of a small group, each spouse of an employee or member and dependent children, including disabled children. Insurers may gather medical information from employees of small employers in order to make informed decisions concerning reinsurance or for other non-underwriting purposes.

3. Registered small group carriers are required to accept groups of one, who are selfemployed persons. The carrier may require proof of current Vermont residency and that such residency has endured for a continuous period of at least one year. In addition, the carrier may require appropriate federal tax records which demonstrate bona fide selfemployment. (The intention is the protection of the financial integrity of small group health plans against adverse selection).

4. The provisions of these regulations shall not be construed to prevent any person from issuing or obtaining a bona fide individual health insurance policy; provided that no person may offer a health benefit plan or insurance policy to individual employees or members of a small group as a means of circumventing the requirements of this section. The Commissioner shall adopt standards and a process to carry out the provisions of this section.

5. A registered small group carrier which is not a nonprofit health maintenance organization shall require that at least 75 percent of the employees or members of a small group participate in the carrier's plan, provided that if a nonprofit health maintenance organization provides a small group plan to more than 25 percent of the employees or members of the small group, a registered small group carrier may offer or continue to provide its small group plan to the remaining employees or members.

6. For the purpose of calculating whether or not a small group meets the minimum enrollment requirements, the number of eligible employees shall be counted as the total number of full-time employees and part-time employees who work thirty hours per week or more. Any full-time or part-time employee who is covered as a spouse or a dependent on another health insurance plan are excluded from the count.

7. The minimum participation requirements shall be calculated on an employer-by employer basis if the small group is part of an association, trust or other substantially similar arrangement.

8. In performing the computation to determine the actual enrollment required for qualification as a small group plan, the registered small group carrier must calculate seventy-five percent (75%) of the actual number of eligible employees and round any fractional number to the higher integer.

9. Registered small group carriers are required to renew every small group plan as the policy anniversary comes due. In addition, all employees or members and their dependents must be renewed. If the insurer has the necessary information to renew, it shall confirm in writing at least forty-five days prior to renewal, the premium at which the policy is to be renewed.

10. If the small group health plan falls below the seventy-five percent (75%) minimum enrollment or if it fails to pay its premiums on a timely basis or if it provides fraudulent information to the registered small group carrier or if the small employer ceases to exist, the small group carrier may cancel the policy with thirty days written notice that provides for a time period of at least thirty days. If, during a policy period, an employer no longer satisfies the minimum enrollment requirements, coverage must be continued to the end of that rate period.

11. Separability. Should a court hold any provision of this regulation invalid in any circumstances, the invalidity shall not affect any other provisions or circumstances.
12. This regulation shall become effective upon passage and supersedes Regulation 91-4A.

ATTACHMENT 1
WORKSHEET

The purpose of this worksheet is to provide the Commissioner with appropriate information to judge the reasonableness of premium rates submitted by registered small group carriers. While it can be used by the carrier to actually determine its premium rates, it need not be. The carrier is free to use its own techniques. However, the carrier is required to then provide the base claims cost information requested, as well as the expected claims cost for the period of the proposed rates. The resulting trend factor will be reviewed by the Commissioner for reasonableness.

The carrier is required to file for approval each time any rate for small group coverage is proposed to change.

The worksheet should be filled out with information for the most popular coverage offered by the registered small group carrier. If other coverages produce health care trend factors different than the trend factor shown in Item 6, the coverages and associated trend factors should be identified on a separate sheet of paper, and attached to the worksheet. Space is provided in Item 10 for different trend factors for the same coverage with different deductibles and/orcoinsurance.

In Item 1, please insert the incurred claims for a recent 12 month period for this coverage. Ideally, the 12 month incurred claims would have 3 months of runout and would then be completed to the fully incurred level with an estimate of unpaid claims.

In Item 2, the amount of claims in excess of any medical stop loss attachment point are posted.

Item 3 is the difference between Item 1 and Item 2.
The earned contract months exposed to risk for the coverage during the 12 month incurred period should be entered at Item 4.
The incurred claims cost per contract month (monthly pure premium) in Item 5 is calculated by dividing Item 3 by the "Total" contract months in Item 4.
Carriers who use this form to actually calculate their rates will enter their average annual trend factor at Item 6, and compound it for the appropriate number of months in the projection span in Item 7. The compounded trend factor is applied to the base claims cost in Item 5, and the resulting expected claims cost is entered at Item 8.

Carriers who develop their expected claims cost using some other method should fill in Item 8, and then develop the trends that result from their process, and fill them in at Items 6 and 7. The carrier's allocation of the total claims cost in Item 8 into single, two person, and family components is shown in Item 9.

If, for example, the primary product is a $100 deductible comprehensive major medical coverage, other deductible coverage claims costs are filled in at Item 10, along with average annual trend factors comparable to the one reported in Item 6.

Retention elements are reported in Item 11 b through g, both on a dollar basis and a percent of premium basis.
The total premium rates are filled in at Item 12. The claims cost in Item 9 and the retention in Item 11 are combined to produce these premiums rates.
Premium rates for the same period for the same coverage one year earlier are inserted at Item 13, and the annual rate increase is entered at Item 14.

* Registered Small Group Carrier _____
Coverage _____
Effective Date _____
1. Base incurred claims* for the 12 month _____
period _____.
2. Incurred claims in excess of reinsurance _____
attachment point, if applicable **
3. Incurred claims adjusted for the removal _____
of claims in excess of reinsurance
attachment point (1)-(2)
4. Earned contract months exposed to risk a) Single _____
during the same 12 month experience b) 2 Person _____
period. c) Family _____
d) Total _____
5. Incurred claims cost per contract month _____
(pure premium) for the 12 month period,
excluding claims in excess of the
reinsurance attachment point. (3) ÷ (4d)
6. Health insurance trend factor *** _____
stated on an average annual basis.
7. Health insurance trend factor compounded _____
as necessary for the projection span from
the base experience period to the period of
the proposed rates.
a) State the period of the proposed rates.
- First effective date _____
- Last effective date _____
- Length of rate guarantee _____

b) State the projection span from the
base experience period to the
period of the rates in terms of
numbers of months _____.
8. Expected claims cost per contract (pure premium) _____
for the period of the proposed rates, excluding
claims in excess of the reinsurance attachment
point. (5 x 7)
9. Allocation of the expected claims cost into
single, two person and family classifications:
Single _____

Two Person _____
Family _____
10. Expected claims costs trends for other
deductible and coinsurance combinations.
Average Annual
Health Insurance
Coverage Single Two Person Family _Trend Factor__

_____ _____ _____ _____ _____
_____ _____ _____ _____ _____
_____ _____ _____ _____ _____
_____ _____ _____ _____ _____
_____ _____ _____ _____ _____
_____ _____ _____ _____ _____

11. Elements of the proposed composite rate expressed as a percent of total rate and as a dollar amount.
Amount __%__
a. Expected claims cost (Item 8) _____ _____
b. Administrative expense _____ _____
c. Commissions _____ _____
d. Taxes _____ _____
e. Profit or contribution to reserves/surplus _____ _____
f. Reinsurance expense _____ _____
g. Other _____ _____
Total _____ 100%
12. Premium rates (Item 9 loaded with Item 11 b through g)
Single _____
Two Person _____
Family _____
13. Premium rates for the same period one year earlier.
Single _____
Two Person _____
Family _____

14. Annual rate increase
Single _____
Two Person _____
Family _____
* State this on a fully incurred basis. This is a combined statistic for single, two person, family, and other types of membership classifications.
** This refers to the reinsurance attachment point for the period of the rates discounted at the health insurance trend factor to the base experience period.
*** The trend factor should include the effects of the fixed deductibles under a comprehensive major medical product, and the fixed reinsurance attachment point under all coverages.

Appendix 2

I. VHCURES report on expenditures and utilization

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

Vermont Healthcare Utilization and Expenditure Report: 2008 Incurred Major Medical Claims for Commercially Insured Residents Under the Age of 65

Prepared by Onpoint Health Data

TABLE OF CONTENTS

INTRODUCTION

About the Vermont Healthcare Claims Uniform Reporting & Evaluation System (VHCURES)

The Department of Banking, Insurance, Securities & Health Care Administration (BISHCA) has a statutory mandate to collect health insurance claims data from health insurers through the Vermont Healthcare Claims Uniform Reporting & Evaluation System (VHCURES). The purpose of VHCURES is to provide information that can be used to evaluate and improve the quality and cost-effectiveness of healthcare. To the extent allowed by federal and state law, this data shall be made available as a resource for the continuous review of healthcare utilization, expenditures, and performance in Vermont.

Under state law, the definition of health insurer also includes third party administrators (TPAs), pharmacy benefit managers (PBMs), any entity conducting administrative services for business, and any other similar entity with claims data, eligibility data, provider files, and other information relating to healthcare provided to Vermont residents and healthcare provided by Vermont healthcare providers and facilities. TPAs and PBMs are required to register with BISHCA.

As established in Regulation H-2008-01 for VHCURES, all health insurers, including TPAs and PBMs, are required to register with the Department's designated claims data collection contractor, currently Onpoint Health Data (formerly known as the Maine Health Information Center). After registering, health insurers will be notified about whether they need to submit claims data to VHCURES depending on enrollment thresholds. Since the commercial health insurance market in Vermont for major medical benefits is concentrated among a relatively small number of large companies, VHCURES data collection includes claims for the vast majority of insured Vermont residents. Submissions will be made via Onpoint CDM (Claims Data Manager).

Onpoint Health Data, a nonprofit independent organization, has provided reporting from the VHCURES eligibility and claims data. This reporting is based on the eligibility and claims data generated through Onpoint CDM (formerly the National Claims Data Management System, or NCDMS). Onpoint Health Data also has provided additional value-added work on the eligibility and claims data required for this and other reports generated for BISHCA.

About the Healthcare Utilization and Expenditure Report

The Healthcare Utilization and Expenditure Report is a standard report developed by Onpoint Health Data to meet the needs of BISHCA. In addition, the report was developed to meet the needs of a business model developed for Vermont Blueprint Medical Home project. With Onpoint research staff, representatives from both BISHCA and Vermont Blueprint participated in the review and development of the reporting categories. The report is one of four reports for inclusion in the initial Onpoint Health Data project with BISHCA.

The report is based on commercial medical and pharmacy claims data and eligibility data as well as on an incurred (date of service) basis. The report is restricted to members under the age of 65 to ensure that members with Medicare, for whom claims in VHCURES are incomplete, are not included incorrectly in the report.

This report provides several views of the commercially insured population of Vermont receiving major medical benefits including the aggregate statewide total, all commercially insured Vermonters by hospital service area (HSA), and all commercially insured by company. Hospital service areas are defined by the State and assign Vermont residents to service areas where the majority of residents receive care provided by certain health care facilities.

The report provides measures of service utilization and payments by major category (hospital inpatient, hospital outpatient, professional, pharmacy, and others) using categorization similar to that used in the annual Vermont Health Care Expenditure Report & 3-Year Forecast series that can be found on the Department's website at:

http://www.bishca.state.vt.us/health-care/hospitals-health-care-practitioners/hospital-financial-health-care-reports

Services related to mental health and substance abuse are separated throughout the reporting. The definitions of mental health and substance abuse are based on the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data Information Set (HEDIS) reporting specification (ICD-9 coding 290-316), which does not include mental retardation (ICD-9 317-319).

For each category of provider or service type, the count of unique members using the service, the count of total visits, the plan's payments, and member payments are reported. Member payments include deductible, coinsurance, and copayment as reported on the claims.

Rates reported in this report include the visit rates per 1,000 as well as payments PMPM (per member per month). All rates use a denominator of member months or average members (member months/12). Using member months is the industry standard for a denominator for calculating rates, adjusting for the fact that a significant proportion of members will not be covered by a plan continuously for an entire year. Using member months is consistent with the use of person-time as a denominator in medical epidemiological studies.

The report was developed to allow for separate tabulation by Vermont Hospital Service Area and payer.

Each section of this report is documented below.

HEALTHCARE UTILIZATION AND EXPENDITURE REPORT DOCUMENTATION

Hospital Inpatient

The hospital inpatient section reports mental health and substance abuse, maternity-related and newborns, surgical, and medical inpatient care separately. At the request of BISHCA, private psychiatric hospitals are reported separately from other hospitals providing mental or substance care. The determination of which claims are hospital inpatient is developed by Onpoint Health Data. Diagnosis and revenue coding are used to determine the subcategories in this section.

Hospital Outpatient

The hospital outpatient section provides utilization and expenditure reporting for mental health and substance abuse, observation bed, emergency room, outpatient surgery, outpatient radiology, outpatient lab, hospital-dispensed pharmacy, outpatient physical therapy, outpatient other therapy, and other outpatient. Visits are assigned to mutually exclusive categories in a hierarchical manner in the following order: mental health and substance abuse, observation bed, emergency room, outpatient surgery, outpatient radiology, outpatient lab, hospital-dispensed pharmacy, outpatient physical therapy, outpatient other therapy, and other outpatient. If a member visits an emergency room and has a lab test during the visit, the visit and all payments during the visit are assigned to emergency room visit, not to outpatient lab. Mental health and substance abuse are assigned based on diagnostic coding (ICD-9 290-316); all other categories are assigned on revenue codes. The logic for determining which claims are hospital outpatient was developed by Onpoint Health Data using accepted methods in claims analyses.

Non-Mental Health Professional Services

This section reports professional services that are not associated with a mental health or substance abuse diagnosis (ICD-9 290-316). The logic for determining which claims are professional services was developed by Onpoint Health Data using accepted methods in claims analyses.

Physician services are further distinguished by the setting of service as indicated on the claims. This includes physician services in inpatient setting, outpatient setting, office setting, or other setting. Other setting could include claims where setting was not identified. Representative from various agencies in the State of Vermont with a variety of reporting needs requested reporting by setting of care.

Other professional services are further distinguished by the specialty of the provider such as nurse practitioners, physician assistants, physical therapists, chiropractors, podiatrists, and other professional services. These are based on provider specialty coding assigned by Onpoint Health Data. Other professional services may include claims where the specialty of the provider cannot be determined. Initial work for the Vermont project did not include a budget for provider linkage, which might reduce the volume of claims reported as "other."

Non-Hospital Mental Health Professional Services

This section reports on mental health and substance abuse professional services. Only professional claims with a primary diagnosis indicating a mental health or substance abuse disorder (ICD-9 290-316) are included.

The logic for determining which claims are professional services was developed by Onpoint Health Data using accepted methods in claims analyses.

This section includes claims for psychiatrists, psychologists, social workers (including MSWs, LICSW, LCSW), and other non-hospital mental health professionals. These are based on provider specialty coding assigned by Onpoint Health Data.

Other non-hospital mental health professional claims may include visits to primary care physicians who reported a primary diagnosis of mental health or substance abuse on the claims or could include claims for which the specialty of the professional could not be determined.

Visits that are identified as a mental health clinic facility are not reported in this section; they instead appear in the All Other Services section later in the report.

Pharmacy

This section of the report provides information on pharmacy use and payments.

Most pharmacy claims are supplied into the VHCURES system by insurers and PBMs through a separate pharmacy data file. These claims are reported as "pharmacy in pharmacy claims". These types of claims include detailed information, such as national drug codes (NDCs), about what type of medication was dispensed.

In some cases, medication or other items purchased at a pharmacy may be billed and paid directly to the pharmacy by the insurer or TPA. These claims appear in the medical claims file submitted by the insurer but not in the pharmacy claims file. They are reported as "pharmacy in medical claims." For these types of claims, there is a lack of detailed information such as NDC coding.

For other projects and reports, Onpoint Health Data utilizes the Red Book® to assign NDC coding to therapeutic and brand and generic categories.

All Other Services

This section of the report provides information about services that are not hospital, professional, or pharmacy. The section includes claims paid for mental health clinics, free-standing ambulatory surgery centers, nursing homes, home-based care, and durable medical equipment. These are based on provider specialty coding assigned by Onpoint Health Data. The "other" category in this section will report on all claims that were unable to be assigned in any previous reporting category.

Vermont HealthCare Utilization and Expenditure 2008
Statewide Total - Major Medical Members Under 65

Member Months	Average Members (member months / 12)	Expenditure Category	Expenditure Category Description	Count of Unique Members Using Service	Count of Visits	Plan Paid	Member Paid	Plan + Member Paid	Visits per 1,000 Members	Plan + Member Paid Per Member Per Month
3,208,205	267,350	0	Total	324,649	4,504,268	$979,752,295	$154,672,384	$1,134,424,678	16,847.8	$354
3,208,205	267,350	1	Hospital Inpatient	10,881	13,787	$159,575,730	$4,867,243	$164,442,973	51.6	$51
3,208,205	267,350	2	Mental/Susbstance Inpatient	662	1,095	$6,539,853	$407,347	$6,947,199	4.1	$2
3,208,205	267,350	3	Private Psych Hospital	164	310	$1,870,104	$91,233	$1,961,338	1.2	$1
3,208,205	267,350	4	Other Hospitals	526	785	$4,669,748	$316,114	$4,985,862	2.9	$2
3,208,205	267,350	5	Maternity-related and newborns	4,491	4,592	$20,936,544	$1,376,717	$22,313,260	17.2	$7
3,208,205	267,350	6	Surgical	3,208	3,609	$85,327,824	$1,332,628	$86,660,451	13.5	$27
3,208,205	267,350	7	Medical	3,483	4,491	$46,771,511	$1,750,552	$48,522,062	16.8	$15
3,208,205	267,350	8	Hospital Outpatient	164,269	527,390	$357,040,851	$41,894,950	$398,935,802	1,972.7	$124
3,208,205	267,350	9	Mental/Substance Hospital Outpatient	4,046	6,840	$2,518,651	$537,623	$3,056,274	25.6	$1
3,208,205	267,350	10	Observation Bed	2,217	2,399	$15,863,805	$668,521	$16,532,326	9.0	$5
3,208,205	267,350	11	Emergency Room	36,042	47,089	$36,223,109	$7,438,286	$43,661,395	176.1	$14
3,208,205	267,350	12	Outpatient Surgery	17,967	21,233	$78,189,708	$6,368,090	$84,557,798	79.4	$26
3,208,205	267,350	13	Outpatient Radiology	46,858	78,937	$107,415,907	$8,685,715	$116,101,622	295.3	$36
3,208,205	267,350	14	Outpatient Lab	116,907	252,792	$54,151,465	$10,539,453	$64,690,918	945.5	$20
3,208,205	267,350	15	Hospital-Dispensed Pharmacy	6,857	8,494	$16,462,386	$1,548,733	$18,011,120	31.8	$6
3,208,205	267,350	16	Outpatient Physical Therapy	7,370	15,995	$6,988,735	$1,084,415	$8,073,150	59.8	$3
3,208,205	267,350	17	Outpatient Other Therapy	1,787	3,500	$1,283,187	$192,034	$1,475,221	13.1	$0
3,208,205	267,350	18	Other Outpatient Hospital	60,592	90,111	$37,943,897	$4,832,081	$42,775,978	337.1	$13
3,208,205	267,350	19	Non-Mental Health Professional Services	243,339	1,741,971	$270,284,959	$51,522,219	$321,807,178	6,515.7	$100
3,208,205	267,350	20	Physician Services	229,341	1,258,852	$225,691,432	$37,680,279	$263,371,710	4,708.6	$82
3,208,205	267,350	21	Physician Inpatient Setting	12,336	62,464	$36,567,741	$2,455,270	$39,023,011	233.6	$12
3,208,205	267,350	22	Physician Outpatient Setting	108,152	280,034	$73,538,095	$9,502,806	$83,040,901	1,047.4	$26
3,208,205	267,350	23	Physician Office Setting	218,105	867,119	$106,874,167	$24,463,209	$131,337,376	3,243.4	$41
3,208,205	267,350	24	Physician Other Setting	32,179	49,235	$8,711,429	$1,258,994	$9,970,422	184.2	$3
3,208,205	267,350	25	Other Professional Services	120,619	483,119	$44,678,129	$13,863,923	$58,542,052	1,807.1	$18
3,208,205	267,350	26	Nurse Practitioners or Physician Assistants	63,937	116,928	$14,508,012	$3,405,546	$17,913,558	437.4	$6
3,208,205	267,350	27	Physical Therapists	18,033	127,919	$11,416,676	$3,626,428	$15,043,104	478.5	$5
3,208,205	267,350	28	Chiropractors	26,302	153,468	$8,662,819	$4,090,134	$12,752,953	574.0	$4
3,208,205	267,350	29	Podiatrists	6,828	15,065	$1,691,346	$504,134	$2,195,479	56.3	$1
3,208,205	267,350	30	Other Professional Services	46,442	69,739	$8,399,276	$2,237,681	$10,636,957	260.9	$3
3,208,205	267,350	31	Non-Hospital Mental Health Professional Services	33,831	189,767	$17,387,544	$6,077,789	$23,465,333	709.8	$7
3,208,205	267,350	32	Psychiatrists	3,254	14,552	$1,704,902	$425,963	$2,130,865	54.4	$1
3,208,205	267,350	33	Psychologists	6,493	42,830	$3,980,229	$1,489,644	$5,469,873	160.2	$2
3,208,205	267,350	34	Social Workers (including MSWs, LICSW, LCSW)	8,212	54,709	$4,097,593	$1,939,164	$6,036,757	204.6	$2
3,208,205	267,350	36	Other non-hospital Mental	22,502	77,676	$7,520,218	$2,201,036	$9,721,254	290.5	$3
3,208,205	267,350	37	Pharmacy	232,481	1,767,681	$155,783,960	$47,443,240	$203,227,200	6,611.9	$63
3,208,205	267,350	38	Pharmacy in pharmacy claims	230,951	1,668,957	$152,982,631	$41,945,094	$194,927,726	6,242.6	$61
3,208,205	267,350	39	Pharmacy in medical claims	17,291	98,724	$2,801,329	$5,498,145	$8,299,474	369.3	$3
3,208,205	267,350	40	All Other Services	21,737	28,756	$19,679,250	$2,866,943	$22,546,193	107.6	$7
3,208,205	267,350	41	Free-standing Ambulatory Surgery Center	122	131	$165,583	$18,582	$184,164	0.5	$0
3,208,205	267,350	44	Nursing Home	10	21	$10,320	$654	$10,974	0.1	$0
3,208,205	267,350	45	Home Based Care	3,673	10,973	$5,829,067	$385,673	$6,214,741	41.0	$2
3,208,205	267,350	46	Durable Medical Equipment	6,712	17,150	$5,616,469	$939,976	$6,556,445	64.1	$2
3,208,205	267,350	47	Mental Health Clinics	123	481	$77,292	$22,586	$99,877	1.8	$0
3,208,205	267,350	48	Other	13,379	24,950	$7,980,519	$1,499,473	$9,479,992	93.3	$3

Vermont HealthCare Utilization and Expenditure 2008
Total By Barre Hospital Service Area- Major Medical Members Under 65

Member Months	Average Members (member months / 12)	Expenditure Category	Expenditure Category Description	Count of Unique Members Using Service	Count of Visits	Plan Paid	Member Paid	Plan + Member Paid	Visits per 1,000 Members	Plan + Member Paid Per Member Per Month
399,202	33,267	0	Total	42,683	558,649	$121,300,305	$18,425,664	$139,725,970	16,793	$350
399,202	33,267	1	Hospital Inpatient	1,333	1,676	$18,666,937	$552,953	$19,219,890	50	$48
399,202	33,267	2	Mental/Susbstance Inpatient	84	122	$650,207	$58,992	$709,199	4	$2
399,202	33,267	3	Private Psych Hospital	16	24	$159,550	$9,959	$169,509	1	$0
399,202	33,267	4	Other Hospitals	73	98	$490,657	$49,034	$539,691	3	$1
399,202	33,267	5	Maternity-related and newborns	530	539	$2,416,633	$170,849	$2,587,482	16	$6
399,202	33,267	6	Surgical	391	448	$9,902,848	$146,408	$10,049,256	13	$25
399,202	33,267	7	Medical	445	567	$5,700,086	$176,391	$5,876,478	17	$15
399,202	33,267	8	Hospital Outpatient	21,677	73,331	$46,963,031	$5,526,783	$52,489,814	2,204	$131
399,202	33,267	9	Mental/Substance Hospital Outpatient	551	939	$260,783	$58,358	$319,141	28	$1
399,202	33,267	10	Observation Bed	344	376	$2,409,211	$75,055	$2,484,266	11	$6
399,202	33,267	11	Emergency Room	5,201	6,983	$4,754,384	$1,012,093	$5,766,477	210	$14
399,202	33,267	12	Outpatient Surgery	2,107	2,606	$10,397,790	$805,224	$11,203,014	78	$28
399,202	33,267	13	Outpatient Radiology	5,985	10,048	$14,039,614	$1,082,152	$15,121,766	302	$38
399,202	33,267	14	Outpatient Lab	16,381	36,524	$7,552,124	$1,432,615	$8,984,739	1,098	$23
399,202	33,267	15	Hospital-Dispensed Pharmacy	1,138	1,313	$2,197,473	$278,758	$2,476,230	39	$6
399,202	33,267	16	Outpatient Physical Therapy	1,307	2,663	$834,338	$178,268	$1,012,606	80	$3
399,202	33,267	17	Outpatient Other Therapy	261	468	$157,949	$30,841	$188,790	14	$0
399,202	33,267	18	Other Outpatient Hospital	7,563	11,411	$4,358,774	$573,615	$4,932,389	343	$12
399,202	33,267	19	Non-Mental Health Professional Services	30,131	207,276	$32,935,094	$5,880,178	$38,815,272	6,231	$97
399,202	33,267	20	Physician Services	28,221	149,422	$27,839,395	$4,292,864	$32,132,259	4,492	$80
399,202	33,267	21	Physician Inpatient Setting	1,577	7,880	$4,508,621	$262,421	$4,771,042	237	$12
399,202	33,267	22	Physician Outpatient Setting	12,345	30,948	$8,970,062	$955,549	$9,925,610	930	$25
399,202	33,267	23	Physician Office Setting	27,057	104,801	$13,306,596	$2,960,575	$16,267,171	3,150	$41
399,202	33,267	24	Physician Other Setting	3,910	5,793	$1,053,783	$114,319	$1,168,102	174	$3
399,202	33,267	25	Other Professional Services	15,772	57,854	$5,114,689	$1,590,595	$6,705,284	1,739	$17
399,202	33,267	26	Nurse Practitioners or Physician Assistants	7,715	12,686	$1,478,701	$359,300	$1,838,002	381	$5
399,202	33,267	27	Physical Therapists	2,379	15,598	$1,202,495	$407,493	$1,609,989	469	$4
399,202	33,267	28	Chiropractors	3,069	17,172	$1,001,043	$467,184	$1,468,226	516	$4
399,202	33,267	29	Podiatrists	723	1,517	$164,149	$46,859	$211,007	46	$1
399,202	33,267	30	Other Professional Services	7,413	10,881	$1,268,301	$309,759	$1,578,060	327	$4
399,202	33,267	31	Non-Hospital Mental Health Professional Services	4,382	23,116	$2,348,252	$732,304	$3,080,555	695	$8
399,202	33,267	32	Psychiatrists	370	1,706	$222,922	$46,303	$269,225	51	$1
399,202	33,267	33	Psychologists	854	5,272	$526,088	$195,998	$722,086	158	$2
399,202	33,267	34	Social Workers (including MSWs, LICSW, LCSW)	998	5,631	$523,644	$238,988	$762,632	169	$2
399,202	33,267	36	Other non-hospital Mental	2,986	10,507	$1,066,797	$247,603	$1,314,400	316	$3
399,202	33,267	37	Pharmacy	30,127	216,956	$18,039,701	$5,448,045	$23,487,746	6,522	$59
399,202	33,267	38	Pharmacy in pharmacy claims	29,907	200,646	$17,611,791	$4,577,048	$22,188,839	6,031	$56
399,202	33,267	39	Pharmacy in medical claims	2,764	16,310	$428,349	$871,036	$1,299,386	490	$3
399,202	33,267	40	All Other Services	2,589	3,828	$2,347,290	$285,403	$2,632,693	115	$7
399,202	33,267	41	Free-standing Ambulatory Surgery Center	4	4	$23,915	$415	$24,330	0	$0
399,202	33,267	45	Home Based Care	585	1,503	$714,060	$42,608	$756,668	45	$2
399,202	33,267	46	Durable Medical Equipment	1,053	2,258	$674,697	$107,812	$782,509	68	$2
399,202	33,267	47	Mental Health Clinics	28	63	$27,348	$2,457	$29,805	2	$0
399,202	33,267	48	Other	1,243	2,026	$902,721	$131,913	$1,034,634	61	$3

Vermont HealthCare Utilization and Expenditure 2008
Total By Bennington Hospital Service Area- Major Medical Members Under 65

Member Months	Average Members (member months / 12)	Expenditure Category	Expenditure Category Description	Count of Unique Members Using Service	Count of Visits	Plan Paid	Member Paid	Plan + Member Paid	Visits per 1,000 Members	Plan + Member Paid Per Member Per Month
171,498	14,292	0	Total	20,170	275,485	$60,851,610	$9,619,324	$70,470,934	19,276	$411
171,498	14,292	1	Hospital Inpatient	713	991	$12,199,442	$378,167	$12,577,609	69	$73
171,498	14,292	2	Mental/Susbstance Inpatient	51	84	$463,845	$45,630	$509,475	6	$3
171,498	14,292	3	Private Psych Hospital	21	38	$233,230	$13,748	$246,978	3	$1
171,498	14,292	4	Other Hospitals	32	46	$230,615	$31,882	$262,497	3	$2
171,498	14,292	5	Maternity-related and newborns	253	259	$1,543,287	$70,112	$1,613,399	18	$9
171,498	14,292	6	Surgical	226	253	$6,032,784	$105,470	$6,138,255	18	$36
171,498	14,292	7	Medical	257	395	$4,159,526	$156,954	$4,316,480	28	$25
171,498	14,292	8	Hospital Outpatient	9,497	31,819	$22,303,817	$2,827,420	$25,131,237	2,226	$147
171,498	14,292	9	Mental/Substance Hospital Outpatient	219	348	$133,336	$30,573	$163,909	24	$1
171,498	14,292	10	Observation Bed	80	80	$405,263	$51,573	$456,836	6	$3
171,498	14,292	11	Emergency Room	1,935	2,524	$3,017,067	$530,629	$3,547,696	177	$21
171,498	14,292	12	Outpatient Surgery	1,408	1,667	$6,021,196	$519,036	$6,540,232	117	$38
171,498	14,292	13	Outpatient Radiology	2,637	4,175	$5,951,905	$584,376	$6,536,282	292	$38
171,498	14,292	14	Outpatient Lab	7,225	16,554	$3,472,812	$658,153	$4,130,965	1,158	$24
171,498	14,292	15	Hospital-Dispensed Pharmacy	240	275	$425,798	$60,987	$486,786	19	$3
171,498	14,292	16	Outpatient Physical Therapy	197	512	$338,419	$36,149	$374,568	36	$2
171,498	14,292	17	Outpatient Other Therapy	57	140	$70,856	$11,627	$82,483	10	$0
171,498	14,292	18	Other Outpatient Hospital	3,649	5,544	$2,466,933	$344,316	$2,811,248	388	$16
171,498	14,292	19	Non-Mental Health Professional Services	13,245	95,417	$14,752,443	$2,875,365	$17,627,809	6,676	$103
171,498	14,292	20	Physician Services	12,606	75,372	$13,047,914	$2,266,467	$15,314,382	5,274	$89
171,498	14,292	21	Physician Inpatient Setting	791	4,299	$2,161,376	$159,914	$2,321,290	301	$14
171,498	14,292	22	Physician Outpatient Setting	5,948	15,327	$3,641,482	$494,777	$4,136,259	1,072	$24
171,498	14,292	23	Physician Office Setting	12,090	52,672	$6,734,347	$1,553,080	$8,287,428	3,686	$48
171,498	14,292	24	Physician Other Setting	1,891	3,074	$510,709	$58,696	$569,405	215	$3
171,498	14,292	25	Other Professional Services	5,864	20,045	$1,707,529	$610,359	$2,317,889	1,403	$14
171,498	14,292	26	Nurse Practitioners or Physician Assistants	2,666	5,366	$568,009	$160,562	$728,571	375	$4
171,498	14,292	27	Physical Therapists	787	4,426	$448,372	$137,328	$585,700	310	$3
171,498	14,292	28	Chiropractors	1,332	6,224	$268,769	$166,840	$435,609	436	$3
171,498	14,292	29	Podiatrists	363	1,009	$110,924	$33,153	$144,077	71	$1
171,498	14,292	30	Other Professional Services	2,218	3,020	$311,456	$112,476	$423,932	211	$2
171,498	14,292	31	Non-Hospital Mental Health Professional Services	1,829	9,753	$832,709	$294,159	$1,126,867	682	$7
171,498	14,292	32	Psychiatrists	134	588	$70,181	$16,223	$86,403	41	$1
171,498	14,292	33	Psychologists	448	3,210	$258,953	$97,659	$356,611	225	$2
171,498	14,292	34	Social Workers (including MSWs, LICSW, LCSW)	403	2,172	$167,280	$73,579	$240,859	152	$1
171,498	14,292	36	Other non-hospital Mental	1,189	3,783	$333,355	$105,846	$439,201	265	$3
171,498	14,292	37	Pharmacy	15,727	123,035	$9,472,837	$3,085,768	$12,558,605	8,609	$73
171,498	14,292	38	Pharmacy in pharmacy claims	15,605	115,932	$9,283,635	$2,689,878	$11,973,513	8,112	$70
171,498	14,292	39	Pharmacy in medical claims	1,229	7,103	$189,202	$395,890	$585,092	497	$3
171,498	14,292	40	All Other Services	1,020	1,700	$1,290,362	$158,445	$1,448,807	119	$8
171,498	14,292	41	Free-standing Ambulatory Surgery Center	14	17	$28,273	$3,966	$32,239	1	$0
171,498	14,292	45	Home Based Care	220	732	$231,820	$21,217	$253,037	51	$1
171,498	14,292	46	Durable Medical Equipment	354	949	$368,642	$61,960	$430,601	66	$3
171,498	14,292	47	Mental Health Clinics	2	2	$156	$103	$259	0	$0
171,498	14,292	48	Other	586	995	$661,472	$71,199	$732,670	70	$4

Vermont HealthCare Utilization and Expenditure 2008
Total By Brattleboro Hospital Service Area- Major Medical Members Under 65

Member Months	Average Members (member months / 12)	Expenditure Category	Expenditure Category Description	Count of Unique Members Using Service	Count of Visits	Plan Paid	Member Paid	Plan + Member Paid	Visits per 1,000 Members	Plan + Member Paid Per Member Per Month
144,912	12,076	0	Total	16,228	219,028	$43,732,123	$7,387,825	$51,119,948	18,137	$353
144,912	12,076	1	Hospital Inpatient	421	568	$7,239,266	$225,574	$7,464,840	47	$52
144,912	12,076	2	Mental/Susbstance Inpatient	43	96	$562,960	$26,165	$589,124	8	$4
144,912	12,076	3	Private Psych Hospital	23	34	$173,064	$10,832	$183,896	3	$1
144,912	12,076	4	Other Hospitals	24	62	$389,895	$15,333	$405,228	5	$3
144,912	12,076	5	Maternity-related and newborns	137	139	$512,487	$57,464	$569,951	12	$4
144,912	12,076	6	Surgical	133	148	$4,109,016	$64,655	$4,173,671	12	$29
144,912	12,076	7	Medical	152	185	$2,059,604	$77,802	$2,137,406	15	$15
144,912	12,076	8	Hospital Outpatient	7,463	25,747	$17,366,062	$2,117,607	$19,483,669	2,132	$134
144,912	12,076	9	Mental/Substance Hospital Outpatient	163	275	$111,899	$26,367	$138,267	23	$1
144,912	12,076	10	Observation Bed	32	34	$308,463	$9,480	$317,942	3	$2
144,912	12,076	11	Emergency Room	1,453	1,795	$1,337,148	$310,797	$1,647,946	149	$11
144,912	12,076	12	Outpatient Surgery	660	770	$3,667,046	$253,305	$3,920,351	64	$27
144,912	12,076	13	Outpatient Radiology	2,701	4,647	$6,111,414	$503,795	$6,615,209	385	$46
144,912	12,076	14	Outpatient Lab	5,197	11,790	$3,012,262	$599,977	$3,612,239	976	$25
144,912	12,076	15	Hospital-Dispensed Pharmacy	312	425	$494,921	$80,311	$575,232	35	$4
144,912	12,076	16	Outpatient Physical Therapy	412	1,194	$552,848	$65,190	$618,038	99	$4
144,912	12,076	17	Outpatient Other Therapy	119	294	$116,658	$18,982	$135,640	24	$1
144,912	12,076	18	Other Outpatient Hospital	3,023	4,523	$1,653,404	$249,642	$1,903,047	375	$13
144,912	12,076	19	Non-Mental Health Professional Services	10,940	76,150	$10,265,557	$2,208,629	$12,474,186	6,306	$86
144,912	12,076	20	Physician Services	10,246	54,056	$8,501,079	$1,594,947	$10,096,026	4,476	$70
144,912	12,076	21	Physician Inpatient Setting	534	2,347	$1,348,605	$84,751	$1,433,356	194	$10
144,912	12,076	22	Physician Outpatient Setting	4,842	12,195	$2,603,704	$349,510	$2,953,215	1,010	$20
144,912	12,076	23	Physician Office Setting	9,816	37,828	$4,355,747	$1,124,411	$5,480,158	3,132	$38
144,912	12,076	24	Physician Other Setting	1,232	1,686	$193,023	$36,274	$229,298	140	$2
144,912	12,076	25	Other Professional Services	5,334	22,094	$1,768,601	$614,646	$2,383,247	1,830	$16
144,912	12,076	26	Nurse Practitioners or Physician Assistants	2,166	4,338	$462,852	$116,551	$579,403	359	$4
144,912	12,076	27	Physical Therapists	873	5,608	$537,403	$175,175	$712,578	464	$5
144,912	12,076	28	Chiropractors	1,317	6,769	$279,985	$180,391	$460,376	561	$3
144,912	12,076	29	Podiatrists	381	903	$90,774	$27,648	$118,422	75	$1
144,912	12,076	30	Other Professional Services	2,728	4,476	$397,587	$114,882	$512,468	371	$4
144,912	12,076	31	Non-Hospital Mental Health Professional Services	1,935	10,874	$917,202	$389,509	$1,306,711	900	$9
144,912	12,076	32	Psychiatrists	383	1,546	$99,311	$39,136	$138,447	128	$1
144,912	12,076	33	Psychologists	382	2,115	$207,187	$83,727	$290,914	175	$2
144,912	12,076	34	Social Workers (including MSWs, LICSW, LCSW)	510	3,248	$271,476	$134,599	$406,075	269	$3
144,912	12,076	36	Other non-hospital Mental	1,138	3,965	$335,957	$130,997	$466,954	328	$3
144,912	12,076	37	Pharmacy	12,098	87,423	$7,055,455	$2,303,328	$9,358,783	7,239	$65
144,912	12,076	38	Pharmacy in pharmacy claims	11,993	82,262	$6,939,865	$2,003,647	$8,943,512	6,812	$62
144,912	12,076	39	Pharmacy in medical claims	932	5,161	$115,647	$299,720	$415,367	427	$3
144,912	12,076	40	All Other Services	877	1,425	$888,581	$143,178	$1,031,759	118	$7
144,912	12,076	41	Free-standing Ambulatory Surgery Center	5	5	$3,486	$1,608	$5,095	0	$0
144,912	12,076	45	Home Based Care	144	432	$148,406	$17,795	$166,201	36	$1
144,912	12,076	46	Durable Medical Equipment	325	953	$310,601	$52,672	$363,272	79	$3
144,912	12,076	47	Mental Health Clinics	11	35	$3,183	$1,851	$5,034	3	$0
144,912	12,076	48	Other	529	1,220	$422,905	$69,252	$492,157	101	$3

Vermont HealthCare Utilization and Expenditure 2008
Total By Burlington Hospital Service Area- Major Medical Members Under 65

Member Months	Average Members (member months / 12)	Expenditure Category	Expenditure Category Description	Count of Unique Members Using Service	Count of Visits	Plan Paid	Member Paid	Plan + Member Paid	Visits per 1,000 Members	Plan + Member Paid Per Member Per Month
1,074,899	89,575	0	Total	112,231	1,424,155	$291,405,338	$47,271,030	$338,676,368	15,899	$315
1,074,899	89,575	1	Hospital Inpatient	3,472	4,154	$40,763,468	$1,436,701	$42,200,169	46	$39
1,074,899	89,575	2	Mental/Susbstance Inpatient	185	300	$1,792,515	$104,264	$1,896,779	3	$2
1,074,899	89,575	3	Private Psych Hospital	34	78	$439,039	$17,662	$456,702	1	$0
1,074,899	89,575	4	Other Hospitals	158	222	$1,353,476	$86,602	$1,440,077	2	$1
1,074,899	89,575	5	Maternity-related and newborns	1,699	1,734	$7,535,437	$485,278	$8,020,715	19	$7
1,074,899	89,575	6	Surgical	925	1,025	$20,816,322	$361,024	$21,177,346	11	$20
1,074,899	89,575	7	Medical	893	1,095	$10,619,503	$485,858	$11,105,362	12	$10
1,074,899	89,575	8	Hospital Outpatient	49,857	140,598	$89,147,475	$9,793,348	$98,940,822	1,570	$92
1,074,899	89,575	9	Mental/Substance Hospital Outpatient	1,366	2,230	$794,123	$172,930	$967,053	25	$1
1,074,899	89,575	10	Observation Bed	359	373	$2,036,276	$93,268	$2,129,545	4	$2
1,074,899	89,575	11	Emergency Room	8,700	10,884	$9,392,535	$1,907,264	$11,299,798	122	$11
1,074,899	89,575	12	Outpatient Surgery	5,878	6,741	$19,337,569	$1,805,927	$21,143,496	75	$20
1,074,899	89,575	13	Outpatient Radiology	12,304	20,810	$27,931,152	$1,933,404	$29,864,556	232	$28
1,074,899	89,575	14	Outpatient Lab	35,131	69,884	$12,322,885	$2,103,221	$14,426,106	780	$13
1,074,899	89,575	15	Hospital-Dispensed Pharmacy	1,601	2,044	$5,452,802	$389,078	$5,841,880	23	$5
1,074,899	89,575	16	Outpatient Physical Therapy	1,252	2,485	$1,018,351	$170,052	$1,188,404	28	$1
1,074,899	89,575	17	Outpatient Other Therapy	574	967	$323,351	$47,488	$370,839	11	$0
1,074,899	89,575	18	Other Outpatient Hospital	17,437	24,180	$10,541,354	$1,171,074	$11,712,428	270	$11
1,074,899	89,575	19	Non-Mental Health Professional Services	81,044	601,733	$98,313,780	$18,825,551	$117,139,331	6,718	$109
1,074,899	89,575	20	Physician Services	76,761	417,932	$80,097,450	$13,436,953	$93,534,402	4,666	$87
1,074,899	89,575	21	Physician Inpatient Setting	3,687	17,692	$11,441,502	$804,510	$12,246,012	198	$11
1,074,899	89,575	22	Physician Outpatient Setting	35,253	91,873	$26,517,112	$3,576,300	$30,093,412	1,026	$28
1,074,899	89,575	23	Physician Office Setting	73,509	296,634	$38,742,090	$8,527,387	$47,269,477	3,312	$44
1,074,899	89,575	24	Physician Other Setting	8,256	11,733	$3,397,575	$528,792	$3,926,367	131	$4
1,074,899	89,575	25	Other Professional Services	39,450	183,801	$18,245,975	$5,396,527	$23,642,502	2,052	$22
1,074,899	89,575	26	Nurse Practitioners or Physician Assistants	23,173	40,719	$5,601,170	$1,256,416	$6,857,586	455	$6
1,074,899	89,575	27	Physical Therapists	7,605	62,620	$5,866,628	$1,738,711	$7,605,339	699	$7
1,074,899	89,575	28	Chiropractors	8,971	59,991	$3,610,260	$1,608,032	$5,218,293	670	$5
1,074,899	89,575	29	Podiatrists	1,730	3,290	$400,986	$121,268	$522,253	37	$0
1,074,899	89,575	30	Other Professional Services	11,537	17,181	$2,767,157	$672,112	$3,439,269	192	$3
1,074,899	89,575	31	Non-Hospital Mental Health Professional Services	11,766	77,105	$6,965,999	$2,478,872	$9,444,871	861	$9
1,074,899	89,575	32	Psychiatrists	924	4,621	$594,144	$140,123	$734,268	52	$1
1,074,899	89,575	33	Psychologists	2,719	19,980	$1,785,268	$658,254	$2,443,522	223	$2
1,074,899	89,575	34	Social Workers (including MSWs, LICSW, LCSW)	3,141	24,576	$1,675,381	$813,080	$2,488,461	274	$2
1,074,899	89,575	36	Other non-hospital Mental	7,359	27,928	$2,876,885	$860,179	$3,737,064	312	$3
1,074,899	89,575	37	Pharmacy	81,370	521,863	$49,745,614	$13,809,449	$63,555,063	5,826	$59
1,074,899	89,575	38	Pharmacy in pharmacy claims	80,850	496,485	$49,043,750	$12,333,226	$61,376,976	5,543	$57
1,074,899	89,575	39	Pharmacy in medical claims	4,813	25,378	$701,930	$1,476,292	$2,178,222	283	$2
1,074,899	89,575	40	All Other Services	6,519	8,090	$6,469,002	$927,110	$7,396,112	90	$7
1,074,899	89,575	41	Free-standing Ambulatory Surgery Center	10	14	$30,111	$399	$30,510	0	$0
1,074,899	89,575	45	Home Based Care	1,122	3,678	$2,593,241	$126,669	$2,719,910	41	$3
1,074,899	89,575	46	Durable Medical Equipment	1,833	4,385	$1,650,889	$266,966	$1,917,856	49	$2
1,074,899	89,575	47	Mental Health Clinics	4	13	$750	$708	$1,458	0	$0
1,074,899	89,575	48	Other	4,115	8,409	$2,193,910	$532,368	$2,726,278	94	$3

Vermont HealthCare Utilization and Expenditure 2008
Total By Middlebury Hospital Service Area- Major Medical Members Under 65

Member Months	Average Members (member months / 12)	Expenditure Category	Expenditure Category Description	Count of Unique Members Using Service	Count of Visits	Plan Paid	Member Paid	Plan + Member Paid	Visits per 1,000 Members	Plan + Member Paid Per Member Per Month
167,744	13,979	0	Total	17,674	233,820	$48,406,500	$8,409,913	$56,816,414	16,727	$339
167,744	13,979	1	Hospital Inpatient	570	696	$9,071,476	$262,740	$9,334,216	50	$56
167,744	13,979	2	Mental/Susbstance Inpatient	29	43	$261,860	$23,269	$285,129	3	$2
167,744	13,979	3	Private Psych Hospital	6	9	$51,276	$5,310	$56,586	1	$0
167,744	13,979	4	Other Hospitals	23	34	$210,584	$17,959	$228,543	2	$1
167,744	13,979	5	Maternity-related and newborns	243	247	$812,160	$86,827	$898,987	18	$5
167,744	13,979	6	Surgical	150	175	$5,349,499	$52,389	$5,401,888	13	$32
167,744	13,979	7	Medical	191	231	$2,648,482	$101,099	$2,749,581	17	$16
167,744	13,979	8	Hospital Outpatient	8,744	26,869	$14,864,748	$2,415,582	$17,280,330	1,922	$103
167,744	13,979	9	Mental/Substance Hospital Outpatient	201	332	$95,267	$34,361	$129,628	24	$1
167,744	13,979	10	Observation Bed	53	55	$376,840	$10,075	$386,915	4	$2
167,744	13,979	11	Emergency Room	1,931	2,505	$1,648,895	$382,441	$2,031,336	179	$12
167,744	13,979	12	Outpatient Surgery	796	912	$3,959,360	$328,321	$4,287,681	65	$26
167,744	13,979	13	Outpatient Radiology	2,218	3,368	$3,860,298	$526,789	$4,387,087	241	$26
167,744	13,979	14	Outpatient Lab	6,690	14,860	$2,858,242	$775,515	$3,633,757	1,063	$22
167,744	13,979	15	Hospital-Dispensed Pharmacy	306	361	$561,155	$86,443	$647,599	26	$4
167,744	13,979	16	Outpatient Physical Therapy	248	569	$188,207	$36,999	$225,207	41	$1
167,744	13,979	17	Outpatient Other Therapy	43	76	$23,245	$3,379	$26,624	5	$0
167,744	13,979	18	Other Outpatient Hospital	2,900	3,831	$1,294,173	$230,547	$1,524,720	274	$9
167,744	13,979	19	Non-Mental Health Professional Services	13,093	93,837	$15,032,996	$2,995,348	$18,028,344	6,713	$107
167,744	13,979	20	Physician Services	12,409	67,621	$12,690,078	$2,185,419	$14,875,497	4,837	$89
167,744	13,979	21	Physician Inpatient Setting	615	2,928	$2,066,954	$151,566	$2,218,521	209	$13
167,744	13,979	22	Physician Outpatient Setting	5,530	13,412	$3,645,998	$507,383	$4,153,381	959	$25
167,744	13,979	23	Physician Office Setting	11,959	48,526	$6,465,172	$1,465,424	$7,930,597	3,471	$47
167,744	13,979	24	Physician Other Setting	1,822	2,755	$512,189	$61,027	$573,216	197	$3
167,744	13,979	25	Other Professional Services	6,138	26,216	$2,352,005	$810,809	$3,162,814	1,875	$19
167,744	13,979	26	Nurse Practitioners or Physician Assistants	2,607	4,540	$637,881	$151,049	$788,930	325	$5
167,744	13,979	27	Physical Therapists	1,010	7,666	$626,401	$225,817	$852,218	548	$5
167,744	13,979	28	Chiropractors	1,557	8,949	$488,401	$226,993	$715,393	640	$4
167,744	13,979	29	Podiatrists	391	791	$99,103	$28,766	$127,868	57	$1
167,744	13,979	30	Other Professional Services	2,601	4,270	$500,219	$178,185	$678,404	305	$4
167,744	13,979	31	Non-Hospital Mental Health Professional Services	1,832	9,181	$932,457	$326,230	$1,258,687	657	$8
167,744	13,979	32	Psychiatrists	179	795	$102,434	$31,125	$133,560	57	$1
167,744	13,979	33	Psychologists	436	2,592	$272,855	$97,986	$370,841	185	$2
167,744	13,979	34	Social Workers (including MSWs, LICSW, LCSW)	388	2,284	$229,522	$87,536	$317,058	163	$2
167,744	13,979	36	Other non-hospital Mental	1,204	3,510	$321,403	$107,827	$429,230	251	$3
167,744	13,979	37	Pharmacy	12,732	88,003	$7,676,312	$2,264,907	$9,941,219	6,296	$59
167,744	13,979	38	Pharmacy in pharmacy claims	12,624	83,664	$7,559,917	$2,019,807	$9,579,724	5,985	$57
167,744	13,979	39	Pharmacy in medical claims	812	4,339	$116,394	$245,100	$361,495	310	$2
167,744	13,979	40	All Other Services	1,158	1,520	$828,511	$145,106	$973,617	109	$6
167,744	13,979	41	Free-standing Ambulatory Surgery Center	4	5	$7,805	$531	$8,336	0	$0
167,744	13,979	45	Home Based Care	175	604	$255,331	$20,081	$275,412	43	$2
167,744	13,979	46	Durable Medical Equipment	402	911	$205,313	$44,720	$250,032	65	$1
167,744	13,979	48	Other	675	1,180	$360,216	$79,774	$439,990	84	$3

Vermont HealthCare Utilization and Expenditure 2008
Total By Morrisville Hospital Service Area- Major Medical Members Under 65

Member Months	Average Members (member months / 12)	Expenditure Category	Expenditure Category Description	Count of Unique Members Using Service	Count of Visits	Plan Paid	Member Paid	Plan + Member Paid	Visits per 1,000 Members	Plan + Member Paid Per Member Per Month
119,544	9,962	0	Total	13,355	162,189	$36,923,009	$5,640,415	$42,563,424	16,281	$356
119,544	9,962	1	Hospital Inpatient	438	585	$6,965,592	$207,236	$7,172,828	59	$60
119,544	9,962	2	Mental/Susbstance Inpatient	20	37	$181,057	$7,878	$188,934	4	$2
119,544	9,962	3	Private Psych Hospital	2	7	$75,420	$0	$75,420	1	$1
119,544	9,962	4	Other Hospitals	19	30	$105,637	$7,878	$113,514	3	$1
119,544	9,962	5	Maternity-related and newborns	177	178	$675,356	$60,241	$735,598	18	$6
119,544	9,962	6	Surgical	138	167	$4,136,497	$62,861	$4,199,358	17	$35
119,544	9,962	7	Medical	142	203	$1,973,532	$76,593	$2,050,125	20	$17
119,544	9,962	8	Hospital Outpatient	6,192	19,855	$13,900,316	$1,631,841	$15,532,157	1,993	$130
119,544	9,962	9	Mental/Substance Hospital Outpatient	154	292	$82,026	$20,149	$102,174	29	$1
119,544	9,962	10	Observation Bed	115	126	$735,128	$44,561	$779,688	13	$7
119,544	9,962	11	Emergency Room	1,544	1,996	$977,080	$240,088	$1,217,168	200	$10
119,544	9,962	12	Outpatient Surgery	531	622	$3,290,584	$254,903	$3,545,488	62	$30
119,544	9,962	13	Outpatient Radiology	1,827	3,167	$3,525,509	$324,528	$3,850,037	318	$32
119,544	9,962	14	Outpatient Lab	4,272	9,047	$2,103,214	$424,235	$2,527,450	908	$21
119,544	9,962	15	Hospital-Dispensed Pharmacy	372	474	$686,781	$63,051	$749,832	48	$6
119,544	9,962	16	Outpatient Physical Therapy	444	950	$358,363	$55,313	$413,676	95	$3
119,544	9,962	17	Outpatient Other Therapy	60	96	$23,554	$2,832	$26,386	10	$0
119,544	9,962	18	Other Outpatient Hospital	2,138	3,085	$2,118,256	$202,412	$2,320,668	310	$19
119,544	9,962	19	Non-Mental Health Professional Services	9,318	62,972	$9,565,794	$1,939,970	$11,505,764	6,321	$96
119,544	9,962	20	Physician Services	8,697	46,346	$7,998,321	$1,428,601	$9,426,922	4,652	$79
119,544	9,962	21	Physician Inpatient Setting	471	2,641	$1,500,483	$113,789	$1,614,272	265	$14
119,544	9,962	22	Physician Outpatient Setting	4,192	10,988	$2,619,423	$383,080	$3,002,504	1,103	$25
119,544	9,962	23	Physician Office Setting	8,201	30,146	$3,577,491	$883,322	$4,460,813	3,026	$37
119,544	9,962	24	Physician Other Setting	1,547	2,571	$300,923	$48,411	$349,334	258	$3
119,544	9,962	25	Other Professional Services	4,854	16,626	$1,564,226	$512,504	$2,076,730	1,669	$17
119,544	9,962	26	Nurse Practitioners or Physician Assistants	2,871	5,200	$602,342	$163,083	$765,426	522	$6
119,544	9,962	27	Physical Therapists	648	3,603	$296,282	$109,595	$405,877	362	$3
119,544	9,962	28	Chiropractors	896	5,032	$348,238	$153,169	$501,407	505	$4
119,544	9,962	29	Podiatrists	106	209	$23,084	$8,128	$31,212	21	$0
119,544	9,962	30	Other Professional Services	1,784	2,582	$294,279	$78,529	$372,808	259	$3
119,544	9,962	31	Non-Hospital Mental Health Professional Services	1,225	6,509	$584,788	$217,767	$802,554	653	$7
119,544	9,962	32	Psychiatrists	86	282	$27,224	$11,196	$38,420	28	$0
119,544	9,962	33	Psychologists	176	1,131	$120,119	$49,100	$169,219	114	$1
119,544	9,962	34	Social Workers (including MSWs, LICSW, LCSW)	329	2,348	$195,454	$85,587	$281,042	236	$2
119,544	9,962	36	Other non-hospital Mental	832	2,748	$236,847	$70,657	$307,504	276	$3
119,544	9,962	37	Pharmacy	9,640	60,128	$5,190,617	$1,541,166	$6,731,783	6,036	$56
119,544	9,962	38	Pharmacy in pharmacy claims	9,543	56,305	$5,034,489	$1,342,791	$6,377,280	5,652	$53
119,544	9,962	39	Pharmacy in medical claims	667	3,823	$155,689	$198,335	$354,023	384	$3
119,544	9,962	40	All Other Services	637	1,171	$715,903	$102,435	$818,338	118	$7
119,544	9,962	41	Free-standing Ambulatory Surgery Center	5	5	$4,503	$1,305	$5,808	1	$0
119,544	9,962	45	Home Based Care	163	497	$224,263	$18,808	$243,071	50	$2
119,544	9,962	46	Durable Medical Equipment	232	658	$223,706	$30,567	$254,273	66	$2
119,544	9,962	47	Mental Health Clinics	5	11	$4,216	$473	$4,689	1	$0
119,544	9,962	48	Other	317	563	$259,215	$51,282	$310,497	57	$3

Vermont HealthCare Utilization and Expenditure 2008
Total By Newport Hospital Service Area- Major Medical Members Under 65

Member Months	Average Members (member months / 12)	Expenditure Category	Expenditure Category Description	Count of Unique Members Using Service	Count of Visits	Plan Paid	Member Paid	Plan + Member Paid	Visits per 1,000 Members	Plan + Member Paid Per Member Per Month
100,539	8,378	0	Total	10,798	129,795	$33,847,261	$5,112,064	$38,959,325	15,492	$388
100,539	8,378	1	Hospital Inpatient	345	453	$5,604,308	$199,083	$5,803,390	54	$58
100,539	8,378	2	Mental/Susbstance Inpatient	18	27	$179,115	$13,865	$192,979	3	$2
100,539	8,378	3	Private Psych Hospital	3	4	$13,311	$696	$14,007	0	$0
100,539	8,378	4	Other Hospitals	17	23	$165,804	$13,168	$178,972	3	$2
100,539	8,378	5	Maternity-related and newborns	121	126	$656,480	$61,995	$718,474	15	$7
100,539	8,378	6	Surgical	104	123	$3,066,168	$34,009	$3,100,178	15	$31
100,539	8,378	7	Medical	142	177	$1,697,501	$88,345	$1,785,846	21	$18
100,539	8,378	8	Hospital Outpatient	5,483	19,280	$15,867,825	$2,040,911	$17,908,736	2,301	$178
100,539	8,378	9	Mental/Substance Hospital Outpatient	107	197	$111,009	$14,492	$125,501	24	$1
100,539	8,378	10	Observation Bed	123	138	$1,229,557	$42,107	$1,271,664	16	$13
100,539	8,378	11	Emergency Room	1,443	1,945	$1,886,872	$343,642	$2,230,515	232	$22
100,539	8,378	12	Outpatient Surgery	868	1,030	$4,402,732	$374,583	$4,777,315	123	$48
100,539	8,378	13	Outpatient Radiology	1,736	2,799	$3,531,073	$383,533	$3,914,606	334	$39
100,539	8,378	14	Outpatient Lab	3,862	8,665	$2,195,012	$536,694	$2,731,706	1,034	$27
100,539	8,378	15	Hospital-Dispensed Pharmacy	130	288	$445,448	$27,482	$472,930	34	$5
100,539	8,378	16	Outpatient Physical Therapy	345	793	$408,657	$48,500	$457,157	95	$5
100,539	8,378	17	Outpatient Other Therapy	76	167	$93,460	$6,540	$99,999	20	$1
100,539	8,378	18	Other Outpatient Hospital	2,045	3,258	$1,564,230	$263,363	$1,827,593	389	$18
100,539	8,378	19	Non-Mental Health Professional Services	7,597	46,613	$6,882,715	$1,331,663	$8,214,378	5,564	$82
100,539	8,378	20	Physician Services	7,016	35,794	$5,802,083	$1,021,016	$6,823,099	4,272	$68
100,539	8,378	21	Physician Inpatient Setting	383	2,372	$1,272,229	$90,816	$1,363,045	283	$14
100,539	8,378	22	Physician Outpatient Setting	3,722	9,640	$2,119,702	$309,184	$2,428,886	1,151	$24
100,539	8,378	23	Physician Office Setting	6,465	22,511	$2,272,201	$597,391	$2,869,591	2,687	$29
100,539	8,378	24	Physician Other Setting	798	1,271	$137,952	$23,625	$161,577	152	$2
100,539	8,378	25	Other Professional Services	3,763	10,819	$1,083,960	$311,696	$1,395,656	1,291	$14
100,539	8,378	26	Nurse Practitioners or Physician Assistants	2,557	4,923	$527,289	$133,186	$660,475	588	$7
100,539	8,378	27	Physical Therapists	405	2,385	$272,208	$82,759	$354,966	285	$4
100,539	8,378	28	Chiropractors	321	1,100	$70,272	$31,433	$101,704	131	$1
100,539	8,378	29	Podiatrists	151	387	$47,584	$16,651	$64,235	46	$1
100,539	8,378	30	Other Professional Services	1,323	2,024	$166,607	$47,667	$214,275	242	$2
100,539	8,378	31	Non-Hospital Mental Health Professional Services	863	3,905	$318,840	$109,599	$428,439	466	$4
100,539	8,378	32	Psychiatrists	135	593	$61,722	$20,863	$82,585	71	$1
100,539	8,378	33	Psychologists	115	789	$59,324	$18,556	$77,879	94	$1
100,539	8,378	34	Social Workers (including MSWs, LICSW, LCSW)	198	1,067	$75,475	$30,388	$105,863	127	$1
100,539	8,378	36	Other non-hospital Mental	577	1,456	$120,019	$38,931	$158,950	174	$2
100,539	8,378	37	Pharmacy	7,602	51,069	$4,615,742	$1,349,125	$5,964,867	6,095	$59
100,539	8,378	38	Pharmacy in pharmacy claims	7,540	48,711	$4,528,991	$1,221,301	$5,750,293	5,814	$57
100,539	8,378	39	Pharmacy in medical claims	357	2,358	$86,751	$127,824	$214,575	281	$2
100,539	8,378	40	All Other Services	538	906	$557,832	$81,682	$639,514	108	$6
100,539	8,378	41	Free-standing Ambulatory Surgery Center	1	1	$217	$554	$771	0	$0
100,539	8,378	44	Nursing Home	1	1	$96	$24	$120	0	$0
100,539	8,378	45	Home Based Care	61	232	$168,519	$6,836	$175,355	28	$2
100,539	8,378	46	Durable Medical Equipment	217	672	$199,632	$32,286	$231,919	80	$2
100,539	8,378	48	Other	299	495	$189,367	$41,982	$231,349	59	$2

Vermont HealthCare Utilization and Expenditure 2008
Total By Randolph Hospital Service Area- Major Medical Members Under 65

Member Months	Average Members (member months / 12)	Expenditure Category	Expenditure Category Description	Count of Unique Members Using Service	Count of Visits	Plan Paid	Member Paid	Plan + Member Paid	Visits per 1,000 Members	Plan + Member Paid Per Member Per Month
70,999	5,917	0	Total	7,451	92,737	$22,942,521	$3,519,653	$26,462,174	15,674	$373
70,999	5,917	1	Hospital Inpatient	258	315	$3,899,311	$141,894	$4,041,205	53	$57
70,999	5,917	2	Mental/Susbstance Inpatient	7	8	$44,141	$4,460	$48,601	1	$1
70,999	5,917	3	Private Psych Hospital	1	1	$13,000	$1,000	$14,000	0	$0
70,999	5,917	4	Other Hospitals	6	7	$31,141	$3,460	$34,601	1	$0
70,999	5,917	5	Maternity-related and newborns	92	94	$534,571	$30,448	$565,019	16	$8
70,999	5,917	6	Surgical	77	88	$2,082,501	$51,457	$2,133,957	15	$30
70,999	5,917	7	Medical	109	125	$1,238,098	$55,529	$1,293,627	21	$18
70,999	5,917	8	Hospital Outpatient	4,116	15,453	$10,228,691	$1,246,788	$11,475,479	2,612	$162
70,999	5,917	9	Mental/Substance Hospital Outpatient	87	140	$79,260	$14,871	$94,131	24	$1
70,999	5,917	10	Observation Bed	98	108	$684,082	$23,673	$707,754	18	$10
70,999	5,917	11	Emergency Room	883	1,113	$777,223	$155,229	$932,451	188	$13
70,999	5,917	12	Outpatient Surgery	544	651	$2,391,092	$196,655	$2,587,748	110	$36
70,999	5,917	13	Outpatient Radiology	1,426	2,454	$2,938,113	$297,165	$3,235,278	415	$46
70,999	5,917	14	Outpatient Lab	3,012	6,664	$1,545,125	$291,111	$1,836,236	1,126	$26
70,999	5,917	15	Hospital-Dispensed Pharmacy	70	85	$145,594	$13,199	$158,793	14	$2
70,999	5,917	16	Outpatient Physical Therapy	443	1,000	$461,577	$91,186	$552,763	169	$8
70,999	5,917	17	Outpatient Other Therapy	79	163	$66,974	$9,770	$76,745	28	$1
70,999	5,917	18	Other Outpatient Hospital	1,684	3,075	$1,139,650	$153,931	$1,293,580	520	$18
70,999	5,917	19	Non-Mental Health Professional Services	5,292	33,467	$5,233,193	$985,722	$6,218,916	5,656	$88
70,999	5,917	20	Physician Services	5,009	26,637	$4,557,942	$779,721	$5,337,663	4,502	$75
70,999	5,917	21	Physician Inpatient Setting	290	1,640	$809,529	$46,180	$855,709	277	$12
70,999	5,917	22	Physician Outpatient Setting	2,575	7,057	$1,629,197	$195,915	$1,825,112	1,193	$26
70,999	5,917	23	Physician Office Setting	4,699	16,437	$1,942,708	$508,937	$2,451,646	2,778	$35
70,999	5,917	24	Physician Other Setting	989	1,503	$176,508	$28,688	$205,196	254	$3
70,999	5,917	25	Other Professional Services	2,239	6,830	$676,253	$206,498	$882,751	1,154	$12
70,999	5,917	26	Nurse Practitioners or Physician Assistants	1,163	1,995	$265,429	$61,183	$326,613	337	$5
70,999	5,917	27	Physical Therapists	120	685	$60,047	$22,041	$82,088	116	$1
70,999	5,917	28	Chiropractors	464	2,287	$104,825	$63,123	$167,949	387	$2
70,999	5,917	29	Podiatrists	249	644	$73,496	$20,153	$93,648	109	$1
70,999	5,917	30	Other Professional Services	849	1,219	$172,456	$39,998	$212,454	206	$3
70,999	5,917	31	Non-Hospital Mental Health Professional Services	644	2,991	$276,719	$107,526	$384,245	506	$5
70,999	5,917	32	Psychiatrists	101	437	$44,347	$13,282	$57,629	74	$1
70,999	5,917	33	Psychologists	106	563	$58,770	$26,414	$85,184	95	$1
70,999	5,917	34	Social Workers (including MSWs, LICSW, LCSW)	154	855	$70,835	$33,916	$104,752	145	$1
70,999	5,917	36	Other non-hospital Mental	407	1,136	$101,837	$33,425	$135,262	192	$2
70,999	5,917	37	Pharmacy	5,127	35,405	$2,877,465	$977,263	$3,854,728	5,984	$54
70,999	5,917	38	Pharmacy in pharmacy claims	5,004	32,836	$2,826,758	$824,431	$3,651,189	5,550	$51
70,999	5,917	39	Pharmacy in medical claims	479	2,569	$50,707	$152,822	$203,529	434	$3
70,999	5,917	40	All Other Services	418	690	$427,143	$60,459	$487,602	117	$7
70,999	5,917	41	Free-standing Ambulatory Surgery Center	2	2	$1,420	$0	$1,420	0	$0
70,999	5,917	45	Home Based Care	80	219	$56,745	$4,716	$61,461	37	$1
70,999	5,917	46	Durable Medical Equipment	155	347	$118,486	$26,305	$144,791	59	$2
70,999	5,917	47	Mental Health Clinics	20	122	$17,825	$7,733	$25,558	21	$0
70,999	5,917	48	Other	202	291	$232,668	$21,705	$254,372	49	$4

Vermont HealthCare Utilization and Expenditure 2008
Total By Rutland Hospital Service Area- Major Medical Members Under 65

Member Months	Average Members (member months / 12)	Expenditure Category	Expenditure Category Description	Count of Unique Members Using Service	Count of Visits	Plan Paid	Member Paid	Plan + Member Paid	Visits per 1,000 Members	Plan + Member Paid Per Member Per Month
324,451	27,038	0	Total	33,593	479,592	$119,918,574	$15,894,530	$135,813,104	17,738	$419
324,451	27,038	1	Hospital Inpatient	1,171	1,614	$23,805,551	$505,827	$24,311,378	60	$75
324,451	27,038	2	Mental/Susbstance Inpatient	100	182	$1,113,178	$40,004	$1,153,182	7	$4
324,451	27,038	3	Private Psych Hospital	28	65	$458,668	$9,643	$468,311	2	$1
324,451	27,038	4	Other Hospitals	76	117	$654,511	$30,360	$684,871	4	$2
324,451	27,038	5	Maternity-related and newborns	358	380	$2,417,621	$91,383	$2,509,004	14	$8
324,451	27,038	6	Surgical	411	452	$12,962,595	$182,352	$13,144,948	17	$41
324,451	27,038	7	Medical	428	600	$7,312,156	$192,089	$7,504,245	22	$23
324,451	27,038	8	Hospital Outpatient	16,929	53,138	$46,539,366	$4,204,992	$50,744,359	1,965	$156
324,451	27,038	9	Mental/Substance Hospital Outpatient	384	702	$340,121	$64,167	$404,288	26	$1
324,451	27,038	10	Observation Bed	359	393	$2,450,360	$76,017	$2,526,377	15	$8
324,451	27,038	11	Emergency Room	4,391	5,734	$4,339,447	$781,308	$5,120,755	212	$16
324,451	27,038	12	Outpatient Surgery	1,622	1,913	$9,281,885	$474,986	$9,756,871	71	$30
324,451	27,038	13	Outpatient Radiology	4,963	7,951	$15,259,080	$888,097	$16,147,177	294	$50
324,451	27,038	14	Outpatient Lab	11,147	24,625	$7,374,425	$1,154,995	$8,529,421	911	$26
324,451	27,038	15	Hospital-Dispensed Pharmacy	1,157	1,338	$3,079,859	$245,556	$3,325,415	49	$10
324,451	27,038	16	Outpatient Physical Therapy	325	658	$419,082	$51,718	$470,801	24	$1
324,451	27,038	17	Outpatient Other Therapy	109	269	$93,777	$11,223	$105,000	10	$0
324,451	27,038	18	Other Outpatient Hospital	6,458	9,555	$3,901,023	$456,540	$4,357,563	353	$13
324,451	27,038	19	Non-Mental Health Professional Services	25,106	188,617	$28,105,596	$5,053,616	$33,159,213	6,976	$102
324,451	27,038	20	Physician Services	23,863	138,993	$23,818,848	$3,766,943	$27,585,791	5,141	$85
324,451	27,038	21	Physician Inpatient Setting	1,503	7,584	$4,175,757	$240,020	$4,415,777	280	$14
324,451	27,038	22	Physician Outpatient Setting	11,400	30,186	$7,883,910	$838,123	$8,722,033	1,116	$27
324,451	27,038	23	Physician Office Setting	22,940	95,694	$11,029,135	$2,600,849	$13,629,984	3,539	$42
324,451	27,038	24	Physician Other Setting	3,815	5,529	$730,045	$87,951	$817,997	204	$3
324,451	27,038	25	Other Professional Services	13,094	49,624	$4,291,504	$1,288,391	$5,579,895	1,835	$17
324,451	27,038	26	Nurse Practitioners or Physician Assistants	5,992	11,402	$1,228,758	$297,055	$1,525,812	422	$5
324,451	27,038	27	Physical Therapists	1,744	10,095	$816,310	$256,216	$1,072,526	373	$3
324,451	27,038	28	Chiropractors	3,113	16,002	$995,881	$432,410	$1,428,291	592	$4
324,451	27,038	29	Podiatrists	1,191	2,952	$256,843	$89,669	$346,511	109	$1
324,451	27,038	30	Other Professional Services	6,095	9,173	$993,712	$213,041	$1,206,753	339	$4
324,451	27,038	31	Non-Hospital Mental Health Professional Services	3,219	16,470	$1,463,901	$483,789	$1,947,690	609	$6
324,451	27,038	32	Psychiatrists	257	984	$114,512	$26,524	$141,036	36	$0
324,451	27,038	33	Psychologists	467	3,077	$270,453	$93,887	$364,339	114	$1
324,451	27,038	34	Social Workers (including MSWs, LICSW, LCSW)	709	4,171	$302,390	$154,532	$456,921	154	$1
324,451	27,038	36	Other non-hospital Mental	2,331	8,238	$770,866	$206,855	$977,721	305	$3
324,451	27,038	37	Pharmacy	25,336	191,748	$17,589,764	$5,292,875	$22,882,639	7,092	$71
324,451	27,038	38	Pharmacy in pharmacy claims	25,161	178,826	$17,201,185	$4,574,462	$21,775,647	6,614	$67
324,451	27,038	39	Pharmacy in medical claims	2,151	12,922	$389,255	$718,702	$1,107,957	478	$3
324,451	27,038	40	All Other Services	3,963	3,520	$2,414,396	$353,429	$2,767,825	130	$9
324,451	27,038	41	Free-standing Ambulatory Surgery Center	7	7	$7,060	$467	$7,527	0	$0
324,451	27,038	44	Nursing Home	6	12	$8,607	$600	$9,207	0	$0
324,451	27,038	45	Home Based Care	368	977	$560,637	$37,921	$598,558	36	$2
324,451	27,038	46	Durable Medical Equipment	954	2,514	$787,923	$125,357	$913,280	93	$3
324,451	27,038	47	Mental Health Clinics	2	10	$1,356	$626	$1,982	0	$0
324,451	27,038	48	Other	3,050	5,313	$1,048,814	$188,458	$1,237,271	197	$4

Vermont HealthCare Utilization and Expenditure 2008
Total By Springfield Hospital Service Area- Major Medical Members Under 65

Member Months	Average Members (member months / 12)	Expenditure Category	Expenditure Category Description	Count of Unique Members Using Service	Count of Visits	Plan Paid	Member Paid	Plan + Member Paid	Visits per 1,000 Members	Plan + Member Paid Per Member Per Month
133,204	11,100	0	Total	15,996	196,346	$44,210,196	$7,015,961	$51,226,157	17,688	$385
133,204	11,100	1	Hospital Inpatient	464	607	$7,092,652	$217,181	$7,309,833	55	$55
133,204	11,100	2	Mental/Susbstance Inpatient	35	54	$275,350	$10,632	$285,982	5	$2
133,204	11,100	3	Private Psych Hospital	12	23	$120,755	$1,000	$121,755	2	$1
133,204	11,100	4	Other Hospitals	24	31	$154,595	$9,632	$164,227	3	$1
133,204	11,100	5	Maternity-related and newborns	155	157	$536,161	$58,305	$594,466	14	$4
133,204	11,100	6	Surgical	146	160	$4,070,223	$70,767	$4,140,990	14	$31
133,204	11,100	7	Medical	183	236	$2,208,050	$77,469	$2,285,519	21	$17
133,204	11,100	8	Hospital Outpatient	7,226	25,093	$18,664,372	$2,090,876	$20,755,248	2,261	$156
133,204	11,100	9	Mental/Substance Hospital Outpatient	160	285	$124,384	$29,794	$154,178	26	$1
133,204	11,100	10	Observation Bed	141	150	$1,168,795	$39,458	$1,208,253	14	$9
133,204	11,100	11	Emergency Room	1,705	2,305	$2,126,595	$398,468	$2,525,063	208	$19
133,204	11,100	12	Outpatient Surgery	571	690	$2,622,350	$211,227	$2,833,576	62	$21
133,204	11,100	13	Outpatient Radiology	2,453	4,325	$6,301,307	$468,687	$6,769,993	390	$51
133,204	11,100	14	Outpatient Lab	5,094	11,658	$2,991,369	$530,014	$3,521,383	1,050	$26
133,204	11,100	15	Hospital-Dispensed Pharmacy	417	518	$1,031,196	$86,331	$1,117,527	47	$8
133,204	11,100	16	Outpatient Physical Therapy	371	825	$332,581	$45,236	$377,817	74	$3
133,204	11,100	17	Outpatient Other Therapy	74	157	$58,862	$8,511	$67,373	14	$1
133,204	11,100	18	Other Outpatient Hospital	2,827	4,180	$1,904,324	$272,977	$2,177,301	377	$16
133,204	11,100	19	Non-Mental Health Professional Services	10,121	70,101	$9,816,647	$1,914,822	$11,731,468	6,315	$88
133,204	11,100	20	Physician Services	9,237	48,086	$7,969,162	$1,332,250	$9,301,411	4,332	$70
133,204	11,100	21	Physician Inpatient Setting	553	2,907	$1,404,094	$97,276	$1,501,370	262	$11
133,204	11,100	22	Physician Outpatient Setting	4,661	11,513	$2,529,876	$326,324	$2,856,200	1,037	$21
133,204	11,100	23	Physician Office Setting	8,574	31,327	$3,710,572	$860,192	$4,570,764	2,822	$34
133,204	11,100	24	Physician Other Setting	1,521	2,339	$323,792	$48,420	$372,212	211	$3
133,204	11,100	25	Other Professional Services	5,661	22,015	$1,852,397	$583,426	$2,435,823	1,983	$18
133,204	11,100	26	Nurse Practitioners or Physician Assistants	3,603	7,872	$825,373	$204,374	$1,029,747	709	$8
133,204	11,100	27	Physical Therapists	644	3,858	$353,145	$108,314	$461,459	348	$3
133,204	11,100	28	Chiropractors	1,149	6,702	$302,422	$168,552	$470,975	604	$4
133,204	11,100	29	Podiatrists	336	792	$77,019	$26,125	$103,144	71	$1
133,204	11,100	30	Other Professional Services	1,899	2,791	$294,212	$76,049	$370,261	251	$3
133,204	11,100	31	Non-Hospital Mental Health Professional Services	1,399	6,478	$523,366	$206,735	$730,101	584	$5
133,204	11,100	32	Psychiatrists	209	783	$57,806	$18,084	$75,890	71	$1
133,204	11,100	33	Psychologists	240	1,251	$125,232	$46,301	$171,533	113	$1
133,204	11,100	34	Social Workers (including MSWs, LICSW, LCSW)	307	1,810	$124,463	$63,632	$188,095	163	$1
133,204	11,100	36	Other non-hospital Mental	955	2,634	$211,531	$77,727	$289,258	237	$2
133,204	11,100	37	Pharmacy	11,887	83,190	$7,260,142	$2,460,322	$9,720,463	7,494	$73
133,204	11,100	38	Pharmacy in pharmacy claims	11,779	77,739	$7,070,957	$2,160,884	$9,231,841	7,003	$69
133,204	11,100	39	Pharmacy in medical claims	821	5,451	$188,509	$299,148	$487,657	491	$4
133,204	11,100	40	All Other Services	964	1,497	$853,018	$126,026	$979,044	135	$7
133,204	11,100	41	Free-standing Ambulatory Surgery Center	22	22	$19,089	$2,316	$21,405	2	$0
133,204	11,100	44	Nursing Home	1	5	$946	$30	$976	0	$0
133,204	11,100	45	Home Based Care	139	482	$235,494	$10,662	$246,156	43	$2
133,204	11,100	46	Durable Medical Equipment	293	922	$333,014	$50,021	$383,034	83	$3
133,204	11,100	47	Mental Health Clinics	20	66	$7,559	$2,322	$9,881	6	$0
133,204	11,100	48	Other	585	1,033	$261,465	$60,874	$322,339	93	$2

Vermont HealthCare Utilization and Expenditure 2008
Total By St. Albans Hospital Service Area- Major Medical Members Under 65

Member Months	Average Members (member months / 12)	Expenditure Category	Expenditure Category Description	Count of Unique Members Using Service	Count of Visits	Plan Paid	Member Paid	Plan + Member Paid	Visits per 1,000 Members	Plan + Member Paid Per Member Per Month
203,689	16,974	0	Total	22,252	275,578	$59,308,274	$8,898,382	$68,206,656	16,235	$335
203,689	16,974	1	Hospital Inpatient	694	842	$8,597,768	$267,850	$8,865,618	50	$44
203,689	16,974	2	Mental/Susbstance Inpatient	32	44	$225,649	$27,247	$252,896	3	$1
203,689	16,974	3	Private Psych Hospital	6	14	$69,267	$7,616	$76,882	1	$0
203,689	16,974	4	Other Hospitals	27	30	$156,382	$19,632	$176,013	2	$1
203,689	16,974	5	Maternity-related and newborns	325	327	$1,242,970	$76,074	$1,319,045	19	$6
203,689	16,974	6	Surgical	205	231	$4,826,913	$84,867	$4,911,780	14	$24
203,689	16,974	7	Medical	188	240	$2,303,069	$79,662	$2,382,731	14	$12
203,689	16,974	8	Hospital Outpatient	11,158	39,143	$22,185,086	$2,684,777	$24,869,864	2,306	$122
203,689	16,974	9	Mental/Substance Hospital Outpatient	244	409	$142,284	$26,385	$168,669	24	$1
203,689	16,974	10	Observation Bed	219	240	$1,312,439	$80,053	$1,392,492	14	$7
203,689	16,974	11	Emergency Room	3,126	4,442	$3,056,219	$572,508	$3,628,727	262	$18
203,689	16,974	12	Outpatient Surgery	887	1,029	$4,117,709	$278,661	$4,396,370	61	$22
203,689	16,974	13	Outpatient Radiology	3,478	6,128	$5,702,881	$556,259	$6,259,140	361	$31
203,689	16,974	14	Outpatient Lab	7,598	16,849	$3,595,990	$666,033	$4,262,023	993	$21
203,689	16,974	15	Hospital-Dispensed Pharmacy	604	753	$1,162,417	$102,650	$1,265,067	44	$6
203,689	16,974	16	Outpatient Physical Therapy	682	1,375	$465,699	$82,591	$548,290	81	$3
203,689	16,974	17	Outpatient Other Therapy	92	179	$55,914	$9,589	$65,503	11	$0
203,689	16,974	18	Other Outpatient Hospital	4,757	7,739	$2,571,118	$310,223	$2,881,341	456	$14
203,689	16,974	19	Non-Mental Health Professional Services	15,530	109,206	$17,579,249	$2,948,558	$20,527,807	6,434	$101
203,689	16,974	20	Physician Services	14,794	87,147	$15,359,016	$2,324,436	$17,683,452	5,134	$87
203,689	16,974	21	Physician Inpatient Setting	805	4,236	$2,643,974	$166,844	$2,810,818	250	$14
203,689	16,974	22	Physician Outpatient Setting	6,921	18,993	$5,166,766	$593,970	$5,760,736	1,119	$28
203,689	16,974	23	Physician Office Setting	14,204	60,845	$7,120,829	$1,514,790	$8,635,619	3,585	$42
203,689	16,974	24	Physician Other Setting	2,113	3,073	$427,431	$48,834	$476,265	181	$2
203,689	16,974	25	Other Professional Services	6,226	22,059	$2,223,666	$624,802	$2,848,468	1,300	$14
203,689	16,974	26	Nurse Practitioners or Physician Assistants	2,761	5,304	$664,487	$144,213	$808,700	312	$4
203,689	16,974	27	Physical Therapists	548	4,524	$369,134	$115,669	$484,803	267	$2
203,689	16,974	28	Chiropractors	1,402	8,035	$579,567	$200,822	$780,390	473	$4
203,689	16,974	29	Podiatrists	402	695	$115,834	$24,388	$140,222	41	$1
203,689	16,974	30	Other Professional Services	2,527	3,501	$494,643	$139,710	$634,353	206	$3
203,689	16,974	31	Non-Hospital Mental Health Professional Services	1,820	9,224	$880,692	$282,556	$1,163,248	543	$6
203,689	16,974	32	Psychiatrists	131	556	$63,579	$19,876	$83,455	33	$0
203,689	16,974	33	Psychologists	146	771	$74,491	$27,804	$102,294	45	$1
203,689	16,974	34	Social Workers (including MSWs, LICSW, LCSW)	499	3,114	$221,825	$101,494	$323,319	183	$2
203,689	16,974	36	Other non-hospital Mental	1,389	4,783	$518,806	$133,010	$651,816	282	$3
203,689	16,974	37	Pharmacy	15,652	104,319	$8,885,276	$2,538,035	$11,423,311	6,146	$56
203,689	16,974	38	Pharmacy in pharmacy claims	15,566	100,110	$8,779,814	$2,316,093	$11,095,906	5,898	$54
203,689	16,974	39	Pharmacy in medical claims	740	4,209	$105,501	$221,977	$327,478	248	$2
203,689	16,974	40	All Other Services	1,276	1,785	$1,180,202	$176,606	$1,356,809	105	$7
203,689	16,974	41	Free-standing Ambulatory Surgery Center	2	2	$11,481	$1,022	$12,503	0	$0
203,689	16,974	45	Home Based Care	309	793	$346,932	$36,302	$383,234	47	$2
203,689	16,974	46	Durable Medical Equipment	324	989	$276,599	$48,374	$324,973	58	$2
203,689	16,974	47	Mental Health Clinics	1	1	$0	$88	$88	0	$0
203,689	16,974	48	Other	759	1,518	$545,137	$90,819	$635,956	89	$3

Vermont HealthCare Utilization and Expenditure 2008
Total By St. Johnsbury Hospital Service Area- Major Medical Members Under 65

Member Months	Average Members (member months / 12)	Expenditure Category	Expenditure Category Description	Count of Unique Members Using Service	Count of Visits	Plan Paid	Member Paid	Plan + Member Paid	Visits per 1,000 Members	Plan + Member Paid Per Member Per Month
108,967	9,081	0	Total	12,471	152,789	$34,280,225	$5,449,134	$39,729,359	16,826	$365
108,967	9,081	1	Hospital Inpatient	409	513	$6,172,437	$200,782	$6,373,219	56	$58
108,967	9,081	2	Mental/Susbstance Inpatient	20	24	$140,562	$10,013	$150,575	3	$1
108,967	9,081	3	Private Psych Hospital	3	3	$14,799	$4,754	$19,553	0	$0
108,967	9,081	4	Other Hospitals	17	21	$125,764	$5,259	$131,022	2	$1
108,967	9,081	5	Maternity-related and newborns	156	157	$643,372	$53,185	$696,557	17	$6
108,967	9,081	6	Surgical	118	134	$3,383,130	$39,390	$3,422,521	15	$31
108,967	9,081	7	Medical	159	198	$2,003,129	$97,969	$2,101,098	22	$19
108,967	9,081	8	Hospital Outpatient	6,049	21,181	$14,229,083	$1,897,301	$16,126,384	2,333	$148
108,967	9,081	9	Mental/Substance Hospital Outpatient	152	264	$67,119	$19,097	$86,216	29	$1
108,967	9,081	10	Observation Bed	146	168	$1,425,546	$52,128	$1,477,674	19	$14
108,967	9,081	11	Emergency Room	1,417	1,820	$939,902	$258,464	$1,198,366	200	$11
108,967	9,081	12	Outpatient Surgery	791	986	$3,448,931	$334,504	$3,783,435	109	$35
108,967	9,081	13	Outpatient Radiology	1,798	2,880	$3,851,895	$353,498	$4,205,393	317	$39
108,967	9,081	14	Outpatient Lab	4,526	10,224	$1,981,902	$531,060	$2,512,962	1,126	$23
108,967	9,081	15	Hospital-Dispensed Pharmacy	243	299	$309,292	$56,439	$365,731	33	$3
108,967	9,081	16	Outpatient Physical Therapy	538	1,184	$743,056	$96,985	$840,041	130	$8
108,967	9,081	17	Outpatient Other Therapy	22	47	$13,451	$2,817	$16,269	5	$0
108,967	9,081	18	Other Outpatient Hospital	2,140	3,309	$1,447,555	$192,096	$1,639,651	364	$15
108,967	9,081	19	Non-Mental Health Professional Services	8,307	57,083	$8,045,063	$1,562,623	$9,607,685	6,286	$88
108,967	9,081	20	Physician Services	7,571	40,096	$6,564,671	$1,102,410	$7,667,081	4,416	$70
108,967	9,081	21	Physician Inpatient Setting	462	2,247	$1,295,238	$82,103	$1,377,341	247	$13
108,967	9,081	22	Physician Outpatient Setting	4,039	9,981	$2,428,308	$347,710	$2,776,018	1,099	$25
108,967	9,081	23	Physician Office Setting	6,425	23,337	$2,385,545	$584,579	$2,970,123	2,570	$27
108,967	9,081	24	Physician Other Setting	2,174	4,531	$455,696	$88,034	$543,730	499	$5
108,967	9,081	25	Other Professional Services	4,799	16,987	$1,482,945	$460,825	$1,943,770	1,871	$18
108,967	9,081	26	Nurse Practitioners or Physician Assistants	2,864	5,144	$650,603	$139,176	$789,779	566	$7
108,967	9,081	27	Physical Therapists	342	1,660	$178,383	$58,297	$236,680	183	$2
108,967	9,081	28	Chiropractors	1,105	6,631	$285,050	$156,978	$442,029	730	$4
108,967	9,081	29	Podiatrists	307	790	$97,356	$27,129	$124,484	87	$1
108,967	9,081	30	Other Professional Services	1,820	2,762	$271,554	$79,245	$350,799	304	$3
108,967	9,081	31	Non-Hospital Mental Health Professional Services	1,063	5,356	$469,342	$145,474	$614,816	590	$6
108,967	9,081	32	Psychiatrists	66	404	$65,746	$10,384	$76,130	44	$1
108,967	9,081	33	Psychologists	105	540	$46,548	$14,563	$61,111	59	$1
108,967	9,081	34	Social Workers (including MSWs, LICSW, LCSW)	214	1,289	$83,084	$41,245	$124,329	142	$1
108,967	9,081	36	Other non-hospital Mental	842	3,123	$270,461	$78,478	$348,938	344	$3
108,967	9,081	37	Pharmacy	8,655	59,381	$4,834,202	$1,528,503	$6,362,705	6,539	$58
108,967	9,081	38	Pharmacy in pharmacy claims	8,589	56,218	$4,757,334	$1,365,507	$6,122,841	6,191	$56
108,967	9,081	39	Pharmacy in medical claims	546	3,163	$76,868	$162,996	$239,864	348	$2
108,967	9,081	40	All Other Services	660	810	$530,098	$114,452	$644,550	89	$6
108,967	9,081	41	Free-standing Ambulatory Surgery Center	1	1	$311	$78	$389	0	$0
108,967	9,081	45	Home Based Care	94	284	$109,547	$18,203	$127,750	31	$1
108,967	9,081	46	Durable Medical Equipment	186	524	$139,642	$25,319	$164,961	58	$2
108,967	9,081	47	Mental Health Clinics	1	1	$117	$13	$130	0	$0
108,967	9,081	48	Other	446	828	$280,481	$70,839	$351,320	91	$3

Vermont HealthCare Utilization and Expenditure 2008
Total By White River Hospital Service Area- Major Medical Members Under 65

Member Months	Average Members (member months / 12)	Expenditure Category	Expenditure Category Description	Count of Unique Members Using Service	Count of Visits	Plan Paid	Member Paid	Plan + Member Paid	Visits per 1,000 Members	Plan + Member Paid Per Member Per Month
188,557	15,713	0	Total	26,962	306,093	$62,626,357	$12,028,488	$74,654,846	19,480	$398
188,557	15,713	1	Hospital Inpatient	605	773	$9,497,522	$271,255	$9,768,777	49	$52
188,557	15,713	2	Mental/Susbstance Inpatient	38	74	$649,414	$34,929	$684,343	5	$4
188,557	15,713	3	Private Psych Hospital	9	10	$48,725	$9,013	$57,738	1	$0
188,557	15,713	4	Other Hospitals	30	64	$600,689	$25,916	$626,605	4	$3
188,557	15,713	5	Maternity-related and newborns	246	255	$1,410,008	$74,556	$1,484,564	16	$8
188,557	15,713	6	Surgical	184	205	$4,589,326	$76,978	$4,666,305	13	$25
188,557	15,713	7	Medical	195	239	$2,848,773	$84,792	$2,933,565	15	$16
188,557	15,713	8	Hospital Outpatient	10,100	35,887	$24,780,978	$3,416,725	$28,197,703	2,284	$150
188,557	15,713	9	Mental/Substance Hospital Outpatient	260	427	$177,039	$26,080	$203,119	27	$1
188,557	15,713	10	Observation Bed	148	158	$1,321,848	$71,072	$1,392,919	10	$7
188,557	15,713	11	Emergency Room	2,324	3,043	$1,969,741	$545,356	$2,515,097	194	$13
188,557	15,713	12	Outpatient Surgery	1,305	1,616	$5,251,464	$530,757	$5,782,221	103	$31
188,557	15,713	13	Outpatient Radiology	3,350	6,185	$8,411,666	$783,432	$9,195,098	394	$49
188,557	15,713	14	Outpatient Lab	6,845	15,450	$3,146,103	$835,828	$3,981,930	983	$21
188,557	15,713	15	Hospital-Dispensed Pharmacy	268	321	$469,649	$58,450	$528,099	20	$3
188,557	15,713	16	Outpatient Physical Therapy	809	1,787	$867,556	$126,226	$993,782	114	$5
188,557	15,713	17	Outpatient Other Therapy	221	477	$185,136	$28,436	$213,572	30	$1
188,557	15,713	18	Other Outpatient Hospital	3,993	6,423	$2,983,104	$411,345	$3,394,449	409	$18
188,557	15,713	19	Non-Mental Health Professional Services	14,446	99,533	$13,756,831	$3,000,173	$16,757,004	6,334	$89
188,557	15,713	20	Physician Services	13,470	71,373	$11,445,473	$2,148,253	$13,593,725	4,542	$72
188,557	15,713	21	Physician Inpatient Setting	678	3,692	$1,939,379	$155,080	$2,094,459	235	$11
188,557	15,713	22	Physician Outpatient Setting	6,838	17,923	$3,782,557	$624,979	$4,407,536	1,141	$23
188,557	15,713	23	Physician Office Setting	12,589	46,380	$5,231,734	$1,282,271	$6,514,005	2,952	$35
188,557	15,713	24	Physician Other Setting	2,132	3,378	$491,803	$85,923	$577,726	215	$3
188,557	15,713	25	Other Professional Services	7,877	28,160	$2,314,378	$852,846	$3,167,224	1,792	$17
188,557	15,713	26	Nurse Practitioners or Physician Assistants	3,837	7,440	$995,117	$219,399	$1,214,516	473	$6
188,557	15,713	27	Physical Therapists	966	5,194	$389,869	$189,013	$578,882	331	$3
188,557	15,713	28	Chiropractors	1,697	8,578	$328,104	$234,207	$562,312	546	$3
188,557	15,713	29	Podiatrists	498	1,086	$134,195	$34,199	$168,393	69	$1
188,557	15,713	30	Other Professional Services	3,702	5,862	$467,092	$176,028	$643,121	373	$3
188,557	15,713	31	Non-Hospital Mental Health Professional Services	1,900	8,805	$873,280	$303,270	$1,176,550	560	$6
188,557	15,713	32	Psychiatrists	282	1,257	$180,974	$32,844	$213,818	80	$1
188,557	15,713	33	Psychologists	308	1,539	$174,943	$79,397	$254,340	98	$1
188,557	15,713	34	Social Workers (including MSWs, LICSW, LCSW)	371	2,144	$156,763	$80,588	$237,351	136	$1
188,557	15,713	36	Other non-hospital Mental	1,309	3,865	$355,453	$109,501	$464,954	246	$2
188,557	15,713	37	Pharmacy	21,029	146,948	$12,540,834	$4,844,454	$17,385,288	9,352	$92
188,557	15,713	38	Pharmacy in pharmacy claims	20,915	141,010	$12,344,146	$4,516,018	$16,860,164	8,974	$89
188,557	15,713	39	Pharmacy in medical claims	984	5,938	$196,527	$328,304	$524,830	378	$3
188,557	15,713	40	All Other Services	1,134	1,815	$1,176,912	$192,612	$1,369,524	116	$7
188,557	15,713	41	Free-standing Ambulatory Surgery Center	45	46	$27,912	$5,920	$33,832	3	$0
188,557	15,713	44	Nursing Home	2	3	$671	$0	$671	0	$0
188,557	15,713	45	Home Based Care	216	540	$184,072	$23,855	$207,927	34	$1
188,557	15,713	46	Durable Medical Equipment	390	1,069	$327,326	$67,617	$394,943	68	$2
188,557	15,713	47	Mental Health Clinics	29	157	$14,783	$6,211	$20,994	10	$0
188,557	15,713	48	Other	580	1,079	$622,149	$89,008	$711,158	69	$4

Vermont HealthCare Utilization and Expenditure 2008
Total by Blue Cross Blue Shield of Vermont (VTC0802) - Major Medical Members Under 65

Member Months	Average Members (member months / 12)	Expenditure Category	Expenditure Category Description	Count of Unique Members Using Service	Count of Visits	Plan Paid	Member Paid	Plan + Member Paid	Visits per 1,000 Members	Plan + Member Paid Per Member Per Month
1,051,174	87,598	0	Total	89,090	1,305,325	$318,725,810	$43,360,430	$362,086,240	14,901.3	$344
1,051,174	87,598	1	Hospital Inpatient	3,835	4,972	$56,127,913	$1,274,563	$57,402,476	56.8	$55
1,051,174	87,598	2	Mental/Susbstance Inpatient	247	424	$2,682,408	$131,017	$2,813,426	4.8	$3
1,051,174	87,598	3	Private Psych Hospital	64	129	$700,944	$29,013	$729,958	1.5	$1
1,051,174	87,598	4	Other Hospitals	194	295	$1,981,464	$102,004	$2,083,468	3.4	$2
1,051,174	87,598	5	Maternity-related and newborns	1,582	1,615	$6,828,603	$244,910	$7,073,513	18.4	$7
1,051,174	87,598	6	Surgical	1,226	1,395	$31,682,739	$465,144	$32,147,883	15.9	$31
1,051,174	87,598	7	Medical	1,160	1,538	$14,934,162	$433,492	$15,367,654	17.6	$15
1,051,174	87,598	8	Hospital Outpatient	57,368	184,477	$119,021,592	$14,351,085	$133,372,677	2,106.0	$127
1,051,174	87,598	9	Mental/Substance Hospital Outpatient	1,306	2,112	$773,946	$160,442	$934,388	24.1	$1
1,051,174	87,598	10	Observation Bed	868	946	$6,256,983	$270,858	$6,527,841	10.8	$6
1,051,174	87,598	11	Emergency Room	12,278	15,987	$10,104,302	$2,290,983	$12,395,285	182.5	$12
1,051,174	87,598	12	Outpatient Surgery	6,776	8,034	$27,886,713	$2,029,916	$29,916,629	91.7	$28
1,051,174	87,598	13	Outpatient Radiology	16,775	28,578	$37,473,419	$3,110,485	$40,583,904	326.2	$39
1,051,174	87,598	14	Outpatient Lab	40,681	88,117	$17,738,236	$4,179,805	$21,918,041	1,005.9	$21
1,051,174	87,598	15	Hospital-Dispensed Pharmacy	2,277	2,751	$5,079,627	$362,722	$5,442,350	31.4	$5
1,051,174	87,598	16	Outpatient Physical Therapy	2,564	5,805	$2,460,731	$286,031	$2,746,763	66.3	$3
1,051,174	87,598	17	Outpatient Other Therapy	665	1,350	$477,676	$57,663	$535,339	15.4	$1
1,051,174	87,598	18	Other Outpatient Hospital	21,228	30,797	$10,769,958	$1,602,181	$12,372,139	351.6	$12
1,051,174	87,598	19	Non-Mental Health Professional Services	84,040	629,617	$92,510,872	$16,560,559	$109,071,431	7,187.6	$104
1,051,174	87,598	20	Physician Services	78,923	441,440	$75,242,282	$11,915,601	$87,157,882	5,039.4	$83
1,051,174	87,598	21	Physician Inpatient Setting	4,208	22,720	$12,562,608	$855,426	$13,418,034	259.4	$13
1,051,174	87,598	22	Physician Outpatient Setting	39,180	102,362	$24,612,442	$3,053,304	$27,665,746	1,168.5	$26
1,051,174	87,598	23	Physician Office Setting	75,215	300,732	$35,227,348	$7,691,240	$42,918,588	3,433.1	$41
1,051,174	87,598	24	Physician Other Setting	11,291	15,626	$2,839,883	$315,631	$3,155,514	178.4	$3
1,051,174	87,598	25	Other Professional Services	45,608	188,177	$17,320,530	$4,656,540	$21,977,070	2,148.2	$21
1,051,174	87,598	26	Nurse Practitioners or Physician Assistants	27,831	53,432	$6,221,416	$1,320,139	$7,541,556	610.0	$7
1,051,174	87,598	27	Physical Therapists	6,516	48,709	$4,365,618	$1,205,179	$5,570,798	556.1	$5
1,051,174	87,598	28	Chiropractors	10,646	56,880	$3,545,115	$1,250,444	$4,795,558	649.3	$5
1,051,174	87,598	29	Podiatrists	2,667	5,849	$581,245	$165,234	$746,479	66.8	$1
1,051,174	87,598	30	Other Professional Services	14,940	23,307	$2,607,135	$715,543	$3,322,679	266.1	$3
1,051,174	87,598	31	Non-Hospital Mental Health Professional Services	12,678	76,917	$6,390,505	$2,025,592	$8,416,098	878.1	$8
1,051,174	87,598	32	Psychiatrists	978	4,283	$417,304	$92,941	$510,245	48.9	$0
1,051,174	87,598	33	Psychologists	3,144	21,518	$1,912,157	$632,252	$2,544,408	245.6	$2
1,051,174	87,598	34	Social Workers (including MSWs, LICSW, LCSW)	3,975	27,094	$1,833,758	$739,010	$2,572,768	309.3	$2
1,051,174	87,598	36	Other non-hospital Mental	7,466	24,022	$2,175,346	$549,808	$2,725,155	274.2	$3
1,051,174	87,598	37	Pharmacy	60,747	316,075	$39,237,275	$8,371,856	$47,609,131	3,608.3	$45
1,051,174	87,598	38	Pharmacy in pharmacy claims	59,932	271,675	$37,996,432	$5,833,330	$43,829,763	3,101.4	$42
1,051,174	87,598	39	Pharmacy in medical claims	7,786	44,400	$1,240,842	$2,538,525	$3,779,368	506.9	$4
1,051,174	87,598	40	All Other Services	6,658	10,302	$5,437,654	$776,774	$6,214,427	117.6	$6
1,051,174	87,598	41	Free-standing Ambulatory Surgery Center	36	36	$22,154	$4,158	$26,312	0.4	$0
1,051,174	87,598	45	Home Based Care	884	2,431	$1,199,207	$54,954	$1,254,161	27.8	$1
1,051,174	87,598	46	Durable Medical Equipment	2,912	7,821	$2,298,127	$398,909	$2,697,036	89.3	$3
1,051,174	87,598	47	Mental Health Clinics	7	14	$8,912	$208	$9,120	0.2	$0
1,051,174	87,598	48	Other	3,660	5,565	$1,909,253	$318,545	$2,227,799	63.5	$2

Vermont HealthCare Utilization and Expenditure 2008
Total by Comprehensive Benefits Administrator, Inc dba CBA Blue (VTT0037) - Major Medical Members Under 65

Member Months	Average Members (member months / 12)	Expenditure Category	Expenditure Category Description	Count of Unique Members Using Service	Count of Visits	Plan Paid	Member Paid	Plan + Member Paid	Visits per 1,000 Members	Plan + Member Paid Per Member Per Month
134,129	11,177	0	Total	11,438	185,613	$41,649,813	$5,408,771	$47,058,584	16,606.1	$351
134,129	11,177	1	Hospital Inpatient	505	660	$7,038,283	$118,089	$7,156,371	59.0	$53
134,129	11,177	2	Mental/Susbstance Inpatient	27	62	$427,367	$12,321	$439,687	5.5	$3
134,129	11,177	3	Private Psych Hospital	2	2	$31,011	$1,560	$32,572	0.2	$0
134,129	11,177	4	Other Hospitals	25	60	$396,356	$10,760	$407,116	5.4	$3
134,129	11,177	5	Maternity-related and newborns	205	208	$776,765	$47,608	$824,373	18.6	$6
134,129	11,177	6	Surgical	68	74	$1,586,032	$13,286	$1,599,318	6.6	$12
134,129	11,177	7	Medical	243	316	$4,248,118	$44,874	$4,292,992	28.3	$32
134,129	11,177	8	Hospital Outpatient	7,170	23,446	$15,145,655	$1,542,971	$16,688,626	2,097.6	$124
134,129	11,177	9	Mental/Substance Hospital Outpatient	164	305	$131,169	$21,307	$152,475	27.3	$1
134,129	11,177	10	Observation Bed	96	108	$850,302	$15,389	$865,692	9.7	$6
134,129	11,177	11	Emergency Room	1,831	2,382	$1,870,714	$282,875	$2,153,590	213.1	$16
134,129	11,177	12	Outpatient Surgery	829	967	$3,901,958	$196,612	$4,098,570	86.5	$31
134,129	11,177	13	Outpatient Radiology	2,014	3,258	$3,914,800	$316,372	$4,231,172	291.5	$32
134,129	11,177	14	Outpatient Lab	5,267	11,805	$2,400,871	$475,661	$2,876,531	1,056.1	$21
134,129	11,177	15	Hospital-Dispensed Pharmacy	270	316	$469,113	$39,696	$508,808	28.3	$4
134,129	11,177	16	Outpatient Physical Therapy	396	886	$426,605	$41,859	$468,464	79.3	$3
134,129	11,177	17	Outpatient Other Therapy	58	125	$47,060	$6,737	$53,797	11.2	$0
134,129	11,177	18	Other Outpatient Hospital	2,297	3,294	$1,133,064	$146,463	$1,279,528	294.7	$10
134,129	11,177	19	Non-Mental Health Professional Services	10,564	73,773	$11,603,341	$1,995,121	$13,598,461	6,600.2	$101
134,129	11,177	20	Physician Services	9,836	52,051	$9,510,753	$1,456,701	$10,967,453	4,656.8	$82
134,129	11,177	21	Physician Inpatient Setting	506	2,172	$1,600,022	$97,059	$1,697,082	194.3	$13
134,129	11,177	22	Physician Outpatient Setting	4,340	10,613	$3,077,844	$371,263	$3,449,106	949.5	$26
134,129	11,177	23	Physician Office Setting	9,231	36,448	$4,509,242	$933,620	$5,442,862	3,260.9	$41
134,129	11,177	24	Physician Other Setting	1,604	2,818	$323,645	$54,759	$378,404	252.1	$3
134,129	11,177	25	Other Professional Services	5,231	21,722	$2,100,466	$540,139	$2,640,605	1,943.4	$20
134,129	11,177	26	Nurse Practitioners or Physician Assistants	2,429	4,407	$556,272	$111,545	$667,817	394.3	$5
134,129	11,177	27	Physical Therapists	630	5,497	$483,043	$117,430	$600,473	491.8	$4
134,129	11,177	28	Chiropractors	1,132	6,911	$417,015	$144,769	$561,784	618.3	$4
134,129	11,177	29	Podiatrists	327	820	$102,523	$23,759	$126,281	73.4	$1
134,129	11,177	30	Other Professional Services	2,448	4,087	$541,614	$142,637	$684,251	365.6	$5
134,129	11,177	31	Non-Hospital Mental Health Professional Services	1,730	9,759	$1,089,210	$353,293	$1,442,503	873.1	$11
134,129	11,177	32	Psychiatrists	317	1,489	$180,837	$55,202	$236,039	133.2	$2
134,129	11,177	33	Psychologists	407	2,737	$301,550	$99,375	$400,925	244.9	$3
134,129	11,177	34	Social Workers (including MSWs, LICSW, LCSW)	378	2,224	$248,358	$84,719	$333,077	199.0	$2
134,129	11,177	36	Other non-hospital Mental	1,018	3,309	$350,587	$112,277	$462,864	296.0	$3
134,129	11,177	37	Pharmacy	7,612	60,962	$5,925,891	$1,260,020	$7,185,911	5,454.0	$54
134,129	11,177	38	Pharmacy in pharmacy claims	7,601	60,901	$5,799,654	$1,257,946	$7,057,599	5,448.6	$53
134,129	11,177	39	Pharmacy in medical claims	47	61	$126,238	$2,074	$128,312	5.5	$1
134,129	11,177	40	All Other Services	1,250	1,319	$847,433	$139,278	$986,711	118.0	$7
134,129	11,177	41	Free-standing Ambulatory Surgery Center	9	9	$15,003	$1,551	$16,553	0.8	$0
134,129	11,177	45	Home Based Care	79	228	$79,797	$7,614	$87,411	20.4	$1
134,129	11,177	46	Durable Medical Equipment	427	1,082	$319,087	$41,784	$360,871	96.8	$3
134,129	11,177	48	Other	836	2,078	$433,546	$88,329	$521,875	185.9	$4

Vermont HealthCare Utilization and Expenditure 2008
Total by Connecticut General Life Insurance Company (VTC0125) - Major Medical Members Under 65

Member Months	Average Members (member months / 12)	Expenditure Category	Expenditure Category Description	Count of Unique Members Using Service	Count of Visits	Plan Paid	Member Paid	Plan + Member Paid	Visits per 1,000 Members	Plan + Member Paid Per Member Per Month
1,099,514	91,626	0	Total	106,005	1,287,235	$264,278,507	$45,506,379	$309,784,886	14,048.8	$282
1,099,514	91,626	1	Hospital Inpatient	3,300	4,082	$42,279,160	$1,604,740	$43,883,900	44.6	$40
1,099,514	91,626	2	Mental/Susbstance Inpatient	154	274	$1,309,734	$73,029	$1,382,763	3.0	$1
1,099,514	91,626	3	Private Psych Hospital	37	83	$517,126	$7,055	$524,181	0.9	$0
1,099,514	91,626	4	Other Hospitals	122	191	$792,608	$65,974	$858,582	2.1	$1
1,099,514	91,626	5	Maternity-related and newborns	1,288	1,310	$5,147,266	$504,378	$5,651,644	14.3	$5
1,099,514	91,626	6	Surgical	1,079	1,195	$24,206,302	$404,578	$24,610,880	13.0	$22
1,099,514	91,626	7	Medical	1,032	1,303	$11,615,858	$622,754	$12,238,612	14.2	$11
1,099,514	91,626	8	Hospital Outpatient	54,961	173,276	$98,578,547	$13,284,783	$111,863,330	1,891.1	$102
1,099,514	91,626	9	Mental/Substance Hospital Outpatient	1,305	2,168	$618,556	$198,855	$817,412	23.7	$1
1,099,514	91,626	10	Observation Bed	721	783	$4,884,064	$191,571	$5,075,635	8.5	$5
1,099,514	91,626	11	Emergency Room	12,258	16,069	$12,210,921	$2,607,346	$14,818,267	175.4	$13
1,099,514	91,626	12	Outpatient Surgery	5,770	6,790	$22,348,383	$1,838,280	$24,186,663	74.1	$22
1,099,514	91,626	13	Outpatient Radiology	14,936	24,533	$27,472,138	$2,803,750	$30,275,888	267.8	$28
1,099,514	91,626	14	Outpatient Lab	38,831	82,154	$15,064,927	$3,170,928	$18,235,855	896.6	$17
1,099,514	91,626	15	Hospital-Dispensed Pharmacy	1,971	2,448	$3,655,540	$383,525	$4,039,064	26.7	$4
1,099,514	91,626	16	Outpatient Physical Therapy	2,486	5,248	$2,169,274	$359,195	$2,528,470	57.3	$2
1,099,514	91,626	17	Outpatient Other Therapy	601	1,160	$404,558	$61,760	$466,318	12.7	$0
1,099,514	91,626	18	Other Outpatient Hospital	20,544	31,923	$9,750,187	$1,669,571	$11,419,757	348.4	$10
1,099,514	91,626	19	Non-Mental Health Professional Services	83,266	597,393	$82,893,216	$18,122,245	$101,015,461	6,519.9	$92
1,099,514	91,626	20	Physician Services	78,529	430,684	$69,511,634	$13,385,285	$82,896,920	4,700.4	$75
1,099,514	91,626	21	Physician Inpatient Setting	4,040	19,730	$10,178,182	$941,376	$11,119,558	215.3	$10
1,099,514	91,626	22	Physician Outpatient Setting	36,839	96,609	$24,500,698	$4,138,111	$28,638,810	1,054.4	$26
1,099,514	91,626	23	Physician Office Setting	74,885	298,160	$32,202,561	$7,808,527	$40,011,088	3,254.1	$36
1,099,514	91,626	24	Physician Other Setting	10,025	16,185	$2,630,193	$497,271	$3,127,464	176.6	$3
1,099,514	91,626	25	Other Professional Services	39,973	166,709	$13,381,713	$4,736,984	$18,118,697	1,819.4	$16
1,099,514	91,626	26	Nurse Practitioners or Physician Assistants	17,586	29,504	$3,491,117	$898,448	$4,389,565	322.0	$4
1,099,514	91,626	27	Physical Therapists	5,724	41,805	$3,553,151	$1,168,014	$4,721,166	456.3	$4
1,099,514	91,626	28	Chiropractors	9,942	65,152	$3,478,239	$1,830,501	$5,308,739	711.1	$5
1,099,514	91,626	29	Podiatrists	2,181	4,658	$508,459	$159,339	$667,798	50.8	$1
1,099,514	91,626	30	Other Professional Services	17,725	25,590	$2,350,747	$680,682	$3,031,428	279.3	$3
1,099,514	91,626	31	Non-Hospital Mental Health Professional Services	10,140	50,565	$4,302,736	$1,402,766	$5,705,502	551.9	$5
1,099,514	91,626	32	Psychiatrists	1,011	4,395	$427,478	$120,080	$547,557	48.0	$0
1,099,514	91,626	33	Psychologists	1,259	7,673	$718,188	$231,255	$949,444	83.7	$1
1,099,514	91,626	34	Social Workers (including MSWs, LICSW, LCSW)	1,298	7,411	$532,204	$284,381	$816,584	80.9	$1
1,099,514	91,626	36	Other non-hospital Mental	7,957	31,086	$2,624,736	$767,026	$3,391,762	339.3	$3
1,099,514	91,626	37	Pharmacy	47,588	375,718	$29,429,585	$10,345,604	$39,775,189	4,100.6	$36
1,099,514	91,626	38	Pharmacy in pharmacy claims	47,481	375,388	$28,983,693	$10,330,951	$39,314,645	4,097.0	$36
1,099,514	91,626	39	Pharmacy in medical claims	181	330	$445,891	$14,653	$460,544	3.6	$0
1,099,514	91,626	40	All Other Services	7,328	8,874	$6,795,263	$746,241	$7,541,504	96.9	$7
1,099,514	91,626	41	Free-standing Ambulatory Surgery Center	34	37	$60,741	$2,437	$63,178	0.4	$0
1,099,514	91,626	44	Nursing Home	5	10	$8,186	$24	$8,210	0.1	$0
1,099,514	91,626	45	Home Based Care	2,041	6,456	$3,416,581	$195,324	$3,611,905	70.5	$3
1,099,514	91,626	46	Durable Medical Equipment	1,272	2,334	$851,471	$110,276	$961,747	25.5	$1
1,099,514	91,626	47	Mental Health Clinics	18	37	$16,623	$1,846	$18,469	0.4	$0
1,099,514	91,626	48	Other	4,613	8,198	$2,441,661	$436,334	$2,877,995	89.5	$3

Vermont HealthCare Utilization and Expenditure 2008
Total by MVP Health Insurance Company (VTC0818) - Major Medical Members Under 65

Member Months	Average Members (member months / 12)	Expenditure Category	Expenditure Category Description	Count of Unique Members Using Service	Count of Visits	Plan Paid	Member Paid	Plan + Member Paid	Visits per 1,000 Members	Plan + Member Paid Per Member Per Month
67,602	5,634	0	Total	5,847	78,433	$15,747,667	$2,777,714	$18,525,382	13,922.6	$274
67,602	5,634	1	Hospital Inpatient	224	287	$3,356,931	$131,249	$3,488,180	50.9	$52
67,602	5,634	2	Mental/Susbstance Inpatient	24	31	$203,474	$23,720	$227,194	5.5	$3
67,602	5,634	3	Private Psych Hospital	10	12	$48,124	$7,685	$55,809	2.1	$1
67,602	5,634	4	Other Hospitals	16	19	$155,349	$16,035	$171,385	3.4	$3
67,602	5,634	5	Maternity-related and newborns	72	75	$373,711	$27,549	$401,260	13.3	$6
67,602	5,634	6	Surgical	71	77	$1,979,619	$14,051	$1,993,670	13.7	$29
67,602	5,634	7	Medical	82	104	$800,128	$65,928	$866,056	18.5	$13
67,602	5,634	8	Hospital Outpatient	2,285	7,105	$5,839,825	$1,029,981	$6,869,806	1,261.2	$102
67,602	5,634	9	Mental/Substance Hospital Outpatient	89	184	$51,167	$12,021	$63,188	32.7	$1
67,602	5,634	10	Observation Bed	37	40	$197,481	$25,897	$223,377	7.1	$3
67,602	5,634	11	Emergency Room	520	675	$513,705	$191,255	$704,961	119.8	$10
67,602	5,634	12	Outpatient Surgery	342	404	$1,300,385	$230,735	$1,531,120	71.7	$23
67,602	5,634	13	Outpatient Radiology	638	1,277	$2,494,791	$267,281	$2,762,072	226.7	$41
67,602	5,634	14	Outpatient Lab	1,420	2,846	$652,124	$166,664	$818,789	505.2	$12
67,602	5,634	15	Hospital-Dispensed Pharmacy	94	128	$134,370	$26,421	$160,791	22.7	$2
67,602	5,634	16	Outpatient Physical Therapy	121	235	$88,857	$10,093	$98,950	41.7	$1
67,602	5,634	17	Outpatient Other Therapy	30	51	$16,573	$1,158	$17,731	9.1	$0
67,602	5,634	18	Other Outpatient Hospital	861	1,265	$390,372	$98,456	$488,828	224.5	$7
67,602	5,634	19	Non-Mental Health Professional Services	4,183	22,328	$3,306,532	$452,425	$3,758,957	3,963.4	$56
67,602	5,634	20	Physician Services	3,921	18,065	$2,924,028	$381,309	$3,305,338	3,206.7	$49
67,602	5,634	21	Physician Inpatient Setting	214	1,264	$579,009	$42,886	$621,896	224.4	$9
67,602	5,634	22	Physician Outpatient Setting	1,349	3,490	$825,291	$102,345	$927,636	619.5	$14
67,602	5,634	23	Physician Office Setting	3,638	12,360	$1,409,248	$217,083	$1,626,332	2,194.0	$24
67,602	5,634	24	Physician Other Setting	542	951	$110,480	$18,994	$129,474	168.8	$2
67,602	5,634	25	Other Professional Services	1,476	4,263	$382,504	$71,116	$453,620	756.7	$7
67,602	5,634	26	Nurse Practitioners or Physician Assistants	821	1,409	$157,524	$25,218	$182,743	250.1	$3
67,602	5,634	27	Physical Therapists	186	1,232	$105,841	$18,730	$124,571	218.7	$2
67,602	5,634	28	Chiropractors	204	773	$34,327	$11,898	$46,225	137.2	$1
67,602	5,634	29	Podiatrists	97	204	$20,356	$3,767	$24,123	36.2	$0
67,602	5,634	30	Other Professional Services	468	645	$64,455	$11,503	$75,959	114.5	$1
67,602	5,634	31	Non-Hospital Mental Health Professional Services	715	3,893	$434,833	$81,150	$515,983	691.0	$8
67,602	5,634	32	Psychiatrists	123	554	$64,938	$8,135	$73,073	98.3	$1
67,602	5,634	33	Psychologists	107	601	$57,276	$10,670	$67,945	106.7	$1
67,602	5,634	34	Social Workers (including MSWs, LICSW, LCSW)	208	1,261	$98,530	$23,377	$121,907	223.8	$2
67,602	5,634	36	Other non-hospital Mental	436	1,477	$214,089	$38,968	$253,057	262.2	$4
67,602	5,634	37	Pharmacy	4,749	40,301	$2,555,572	$1,042,324	$3,597,897	7,153.8	$53
67,602	5,634	38	Pharmacy in pharmacy claims	4,749	40,293	$2,551,044	$1,042,174	$3,593,218	7,152.4	$53
67,602	5,634	39	Pharmacy in medical claims	3	8	$4,528	$150	$4,678	1.4	$0
67,602	5,634	40	All Other Services	303	483	$253,974	$40,585	$294,559	85.7	$4
67,602	5,634	41	Free-standing Ambulatory Surgery Center	7	9	$10,935	$1,383	$12,318	1.6	$0
67,602	5,634	45	Home Based Care	35	75	$65,300	$2,283	$67,583	13.3	$1
67,602	5,634	46	Durable Medical Equipment	120	292	$67,470	$11,983	$79,453	51.8	$1
67,602	5,634	47	Mental Health Clinics	20	107	$12,598	$2,258	$14,857	19.0	$0
67,602	5,634	48	Other	163	305	$97,671	$22,677	$120,348	54.1	$2

Vermont HealthCare Utilization and Expenditure 2008
Total by MVP Health Plan, Inc. (VTC0831) - Major Medical Members Under 65

Member Months	Average Members (member months / 12)	Expenditure Category	Expenditure Category Description	Count of Unique Members Using Service	Count of Visits	Plan Paid	Member Paid	Plan + Member Paid	Visits per 1,000 Members	Plan + Member Paid Per Member Per Month
239,464	19,955	0	Total	20,722	355,912	$143,823,542	$11,246,028	$155,069,569	17,835.4	$648
239,464	19,955	1	Hospital Inpatient	979	1,246	$27,267,365	$795,234	$28,062,599	62.4	$117
239,464	19,955	2	Mental/Susbstance Inpatient	67	101	$955,617	$62,422	$1,018,039	5.1	$4
239,464	19,955	3	Private Psych Hospital	16	31	$325,587	$17,314	$342,900	1.6	$1
239,464	19,955	4	Other Hospitals	56	70	$630,031	$45,109	$675,139	3.5	$3
239,464	19,955	5	Maternity-related and newborns	414	424	$4,423,479	$230,585	$4,654,064	21.2	$19
239,464	19,955	6	Surgical	311	362	$15,546,783	$282,692	$15,829,476	18.1	$66
239,464	19,955	7	Medical	279	359	$6,341,485	$219,535	$6,561,020	18.0	$27
239,464	19,955	8	Hospital Outpatient	12,868	41,648	$60,894,342	$2,227,134	$63,121,476	2,087.1	$264
239,464	19,955	9	Mental/Substance Hospital Outpatient	381	795	$521,704	$39,743	$561,447	39.8	$2
239,464	19,955	10	Observation Bed	147	155	$1,709,064	$43,917	$1,752,981	7.8	$7
239,464	19,955	11	Emergency Room	2,813	3,684	$6,282,370	$471,056	$6,753,426	184.6	$28
239,464	19,955	12	Outpatient Surgery	1,407	1,624	$11,804,059	$746,477	$12,550,536	81.4	$52
239,464	19,955	13	Outpatient Radiology	3,835	6,705	$20,545,492	$252,986	$20,798,477	336.0	$87
239,464	19,955	14	Outpatient Lab	9,094	19,968	$9,735,500	$250,469	$9,985,968	1,000.6	$42
239,464	19,955	15	Hospital-Dispensed Pharmacy	562	679	$3,133,668	$178,798	$3,312,467	34.0	$14
239,464	19,955	16	Outpatient Physical Therapy	592	1,228	$893,274	$139,700	$1,032,974	61.5	$4
239,464	19,955	17	Outpatient Other Therapy	138	252	$162,848	$21,539	$184,387	12.6	$1
239,464	19,955	18	Other Outpatient Hospital	4,705	6,558	$6,106,363	$82,450	$6,188,813	328.6	$26
239,464	19,955	19	Non-Mental Health Professional Services	18,535	119,371	$39,121,746	$3,394,113	$42,515,860	5,981.9	$178
239,464	19,955	20	Physician Services	17,672	96,596	$34,349,786	$2,574,333	$36,924,120	4,840.6	$154
239,464	19,955	21	Physician Inpatient Setting	1,105	6,087	$6,338,403	$50,250	$6,388,653	305.0	$27
239,464	19,955	22	Physician Outpatient Setting	7,758	19,554	$9,741,217	$112,057	$9,853,275	979.9	$41
239,464	19,955	23	Physician Office Setting	16,808	65,725	$16,880,119	$2,392,688	$19,272,807	3,293.6	$80
239,464	19,955	24	Physician Other Setting	2,940	5,230	$1,390,046	$19,338	$1,409,384	262.1	$6
239,464	19,955	25	Other Professional Services	8,009	22,775	$4,773,875	$820,455	$5,594,330	1,141.3	$23
239,464	19,955	26	Nurse Practitioners or Physician Assistants	3,825	6,468	$1,611,727	$226,707	$1,838,435	324.1	$8
239,464	19,955	27	Physical Therapists	1,188	8,452	$1,251,795	$359,316	$1,611,111	423.5	$7
239,464	19,955	28	Chiropractors	145	773	$63,606	$21,016	$84,622	38.7	$0
239,464	19,955	29	Podiatrists	438	944	$217,615	$38,412	$256,027	47.3	$1
239,464	19,955	30	Other Professional Services	4,323	6,138	$1,629,132	$175,003	$1,804,135	307.6	$8
239,464	19,955	31	Non-Hospital Mental Health Professional Services	2,692	15,950	$2,620,341	$808,737	$3,429,077	799.3	$14
239,464	19,955	32	Psychiatrists	406	2,147	$451,008	$88,265	$539,272	107.6	$2
239,464	19,955	33	Psychologists	435	2,715	$424,479	$143,007	$567,486	136.1	$2
239,464	19,955	34	Social Workers (including MSWs, LICSW, LCSW)	872	6,554	$808,441	$374,874	$1,183,315	328.4	$5
239,464	19,955	36	Other non-hospital Mental	1,595	4,534	$934,498	$201,916	$1,136,414	227.2	$5
239,464	19,955	37	Pharmacy	15,176	160,351	$11,125,827	$3,729,409	$14,855,236	8,035.5	$62
239,464	19,955	38	Pharmacy in pharmacy claims	15,175	160,325	$11,084,756	$3,729,204	$14,813,960	8,034.2	$62
239,464	19,955	39	Pharmacy in medical claims	19	26	$41,071	$205	$41,276	1.3	$0
239,464	19,955	40	All Other Services	1,326	2,472	$2,793,921	$291,402	$3,085,323	123.9	$13
239,464	19,955	41	Free-standing Ambulatory Surgery Center	12	14	$27,570	$2,450	$30,020	0.7	$0
239,464	19,955	44	Nursing Home	2	6	$1,224	$30	$1,254	0.3	$0
239,464	19,955	45	Home Based Care	177	433	$520,393	$56,030	$576,423	21.7	$2
239,464	19,955	46	Durable Medical Equipment	642	1,785	$1,056,998	$156,130	$1,213,128	89.4	$5
239,464	19,955	47	Mental Health Clinics	52	234	$32,660	$14,470	$47,130	11.7	$0
239,464	19,955	48	Other	646	1,242	$1,155,076	$62,292	$1,217,367	62.2	$5

Vermont HealthCare Utilization and Expenditure 2008
Total by MVP Select Care, Inc. (VTT0445) - Major Medical Members Under 65

Member Months	Average Members (member months / 12)	Expenditure Category	Expenditure Category Description	Count of Unique Members Using Service	Count of Visits	Plan Paid	Member Paid	Plan + Member Paid	Visits per 1,000 Members	Plan + Member Paid Per Member Per Month
62,586	5,216	0	Total	5,040	82,664	$18,535,164	$1,621,082	$20,156,246	15,849.7	$322
62,586	5,216	1	Hospital Inpatient	218	287	$3,316,786	$49,672	$3,366,458	55.0	$54
62,586	5,216	2	Mental/Susbstance Inpatient	18	22	$96,108	$8,022	$104,130	4.2	$2
62,586	5,216	3	Private Psych Hospital	3	3	$14,830	$1,250	$16,080	0.6	$0
62,586	5,216	4	Other Hospitals	15	19	$81,278	$6,772	$88,050	3.6	$1
62,586	5,216	5	Maternity-related and newborns	92	92	$363,621	$7,927	$371,548	17.6	$6
62,586	5,216	6	Surgical	65	75	$1,803,313	$14,543	$1,817,856	14.4	$29
62,586	5,216	7	Medical	70	98	$1,053,744	$19,181	$1,072,925	18.8	$17
62,586	5,216	8	Hospital Outpatient	3,258	10,879	$7,305,510	$395,018	$7,700,529	2,085.9	$123
62,586	5,216	9	Mental/Substance Hospital Outpatient	104	193	$57,823	$6,240	$64,063	37.0	$1
62,586	5,216	10	Observation Bed	47	50	$270,309	$2,733	$273,042	9.6	$4
62,586	5,216	11	Emergency Room	931	1,262	$1,044,229	$114,237	$1,158,466	242.0	$19
62,586	5,216	12	Outpatient Surgery	369	432	$1,749,669	$57,934	$1,807,603	82.8	$29
62,586	5,216	13	Outpatient Radiology	990	1,665	$2,049,014	$80,171	$2,129,185	319.2	$34
62,586	5,216	14	Outpatient Lab	2,293	5,108	$1,167,205	$69,746	$1,236,951	979.4	$20
62,586	5,216	15	Hospital-Dispensed Pharmacy	119	130	$222,573	$8,138	$230,711	24.9	$4
62,586	5,216	16	Outpatient Physical Therapy	169	350	$149,515	$19,870	$169,385	67.1	$3
62,586	5,216	17	Outpatient Other Therapy	35	68	$23,277	$2,704	$25,981	13.0	$0
62,586	5,216	18	Other Outpatient Hospital	1,134	1,621	$571,895	$33,245	$605,141	310.8	$10
62,586	5,216	19	Non-Mental Health Professional Services	4,564	30,515	$4,826,635	$479,790	$5,306,425	5,850.8	$85
62,586	5,216	20	Physician Services	4,373	25,150	$4,229,047	$382,016	$4,611,063	4,822.2	$74
62,586	5,216	21	Physician Inpatient Setting	244	1,318	$601,983	$16,334	$618,317	252.7	$10
62,586	5,216	22	Physician Outpatient Setting	1,808	4,699	$1,165,043	$64,361	$1,229,405	901.0	$20
62,586	5,216	23	Physician Office Setting	4,144	17,477	$2,243,223	$285,666	$2,528,888	3,351.0	$40
62,586	5,216	24	Physician Other Setting	878	1,656	$218,798	$15,656	$234,453	317.5	$4
62,586	5,216	25	Other Professional Services	1,692	5,365	$597,589	$97,773	$695,362	1,028.7	$11
62,586	5,216	26	Nurse Practitioners or Physician Assistants	887	1,634	$217,838	$25,349	$243,187	313.3	$4
62,586	5,216	27	Physical Therapists	219	1,837	$143,465	$34,803	$178,268	352.2	$3
62,586	5,216	28	Chiropractors	122	520	$24,113	$13,012	$37,126	99.7	$1
62,586	5,216	29	Podiatrists	125	283	$36,978	$4,971	$41,948	54.3	$1
62,586	5,216	30	Other Professional Services	710	1,091	$175,195	$19,639	$194,833	209.2	$3
62,586	5,216	31	Non-Hospital Mental Health Professional Services	608	2,744	$229,304	$60,213	$289,517	526.1	$5
62,586	5,216	32	Psychiatrists	53	239	$29,977	$4,371	$34,348	45.8	$1
62,586	5,216	33	Psychologists	63	373	$27,660	$8,812	$36,471	71.5	$1
62,586	5,216	34	Social Workers (including MSWs, LICSW, LCSW)	133	772	$55,747	$19,648	$75,395	148.0	$1
62,586	5,216	36	Other non-hospital Mental	457	1,360	$115,921	$27,382	$143,303	260.8	$2
62,586	5,216	37	Pharmacy	3,393	34,006	$2,464,463	$592,005	$3,056,468	6,520.2	$49
62,586	5,216	38	Pharmacy in pharmacy claims	3,393	34,005	$2,464,439	$591,999	$3,056,438	6,520.0	$49
62,586	5,216	39	Pharmacy in medical claims	1	1	$24	$6	$30	0.2	$0
62,586	5,216	40	All Other Services	355	771	$392,465	$44,384	$436,849	147.8	$7
62,586	5,216	41	Free-standing Ambulatory Surgery Center	3	5	$4,527	$540	$5,067	1.0	$0
62,586	5,216	45	Home Based Care	35	111	$68,952	$3,918	$72,870	21.3	$1
62,586	5,216	46	Durable Medical Equipment	171	613	$160,312	$24,917	$185,229	117.5	$3
62,586	5,216	47	Mental Health Clinics	8	42	$2,538	$766	$3,304	8.1	$0
62,586	5,216	48	Other	189	312	$156,137	$14,243	$170,380	59.8	$3

Vermont HealthCare Utilization and Expenditure 2008
Total by The Vermont Health Plan (VTC0830) - Major Medical Members Under 65

Member Months	Average Members (member months / 12)	Expenditure Category	Expenditure Category Description	Count of Unique Members Using Service	Count of Visits	Plan Paid	Member Paid	Plan + Member Paid	Visits per 1,000 Members	Plan + Member Paid Per Member Per Month
323,975	26,998	0	Total	35,905	428,949	$78,897,581	$20,669,972	$99,567,553	15,888.2	$307
323,975	26,998	1	Hospital Inpatient	1,222	1,499	$13,163,000	$515,799	$13,678,798	55.5	$42
323,975	26,998	2	Mental/Susbstance Inpatient	84	120	$612,582	$56,058	$668,640	4.4	$2
323,975	26,998	3	Private Psych Hospital	22	33	$136,920	$19,645	$156,565	1.2	$0
323,975	26,998	4	Other Hospitals	65	87	$475,662	$36,413	$512,075	3.2	$2
323,975	26,998	5	Maternity-related and newborns	562	582	$1,764,212	$184,172	$1,948,384	21.6	$6
323,975	26,998	6	Surgical	322	355	$7,049,815	$104,882	$7,154,696	13.1	$22
323,975	26,998	7	Medical	359	442	$3,736,390	$170,688	$3,907,078	16.4	$12
323,975	26,998	8	Hospital Outpatient	17,385	55,081	$28,655,799	$5,535,012	$34,190,811	2,040.2	$106
323,975	26,998	9	Mental/Substance Hospital Outpatient	428	654	$219,898	$52,560	$272,458	24.2	$1
323,975	26,998	10	Observation Bed	253	265	$1,428,342	$97,087	$1,525,429	9.8	$5
323,975	26,998	11	Emergency Room	3,739	4,854	$2,574,146	$1,040,165	$3,614,311	179.8	$11
323,975	26,998	12	Outpatient Surgery	2,017	2,422	$7,219,524	$1,043,418	$8,262,942	89.7	$26
323,975	26,998	13	Outpatient Radiology	4,893	8,283	$8,524,326	$1,140,110	$9,664,436	306.8	$30
323,975	26,998	14	Outpatient Lab	12,880	28,090	$4,433,926	$1,358,096	$5,792,022	1,040.5	$18
323,975	26,998	15	Hospital-Dispensed Pharmacy	639	798	$1,187,625	$165,092	$1,352,717	29.6	$4
323,975	26,998	16	Outpatient Physical Therapy	641	1,378	$403,949	$151,007	$554,956	51.0	$2
323,975	26,998	17	Outpatient Other Therapy	181	351	$96,548	$30,245	$126,793	13.0	$0
323,975	26,998	18	Other Outpatient Hospital	5,820	7,986	$2,567,516	$457,232	$3,024,748	295.8	$9
323,975	26,998	19	Non-Mental Health Professional Services	25,408	175,707	$20,238,643	$6,403,246	$26,641,889	6,508.2	$82
323,975	26,998	20	Physician Services	23,699	124,662	$16,404,671	$4,414,459	$20,819,130	4,617.5	$64
323,975	26,998	21	Physician Inpatient Setting	1,255	6,395	$2,589,547	$228,537	$2,818,084	236.9	$9
323,975	26,998	22	Physician Outpatient Setting	11,023	28,091	$5,017,603	$843,760	$5,861,363	1,040.5	$18
323,975	26,998	23	Physician Office Setting	22,584	85,655	$8,310,452	$3,202,695	$11,513,146	3,172.7	$36
323,975	26,998	24	Physician Other Setting	3,376	4,521	$487,068	$139,467	$626,536	167.5	$2
323,975	26,998	25	Other Professional Services	13,396	51,045	$3,847,119	$1,995,759	$5,842,878	1,890.7	$18
323,975	26,998	26	Nurse Practitioners or Physician Assistants	8,212	15,669	$1,564,980	$605,952	$2,170,932	580.4	$7
323,975	26,998	27	Physical Therapists	2,779	13,940	$893,107	$497,033	$1,390,140	516.3	$4
323,975	26,998	28	Chiropractors	2,885	14,433	$665,119	$547,907	$1,213,026	534.6	$4
323,975	26,998	29	Podiatrists	681	1,576	$157,490	$68,574	$226,064	58.4	$1
323,975	26,998	30	Other Professional Services	3,640	5,427	$566,425	$276,291	$842,716	201.0	$3
323,975	26,998	31	Non-Hospital Mental Health Professional Services	3,662	21,072	$1,396,187	$885,243	$2,281,431	780.5	$7
323,975	26,998	32	Psychiatrists	225	835	$67,940	$24,592	$92,533	30.9	$0
323,975	26,998	33	Psychologists	863	5,663	$361,609	$277,730	$639,339	209.8	$2
323,975	26,998	34	Social Workers (including MSWs, LICSW, LCSW)	1,110	7,638	$372,487	$325,440	$697,926	282.9	$2
323,975	26,998	36	Other non-hospital Mental	2,199	6,936	$581,004	$250,510	$831,514	256.9	$3
323,975	26,998	37	Pharmacy	28,475	152,255	$14,027,502	$7,079,555	$21,107,056	5,639.5	$65
323,975	26,998	38	Pharmacy in pharmacy claims	27,684	100,697	$13,205,046	$4,294,599	$17,499,646	3,729.8	$54
323,975	26,998	39	Pharmacy in medical claims	8,902	51,558	$822,455	$2,784,955	$3,607,411	1,909.7	$11
323,975	26,998	40	All Other Services	1,837	2,829	$1,416,451	$251,118	$1,667,569	104.8	$5
323,975	26,998	41	Free-standing Ambulatory Surgery Center	4	4	$1,440	$1,280	$2,720	0.1	$0
323,975	26,998	44	Nursing Home	3	5	$910	$600	$1,510	0.2	$0
323,975	26,998	45	Home Based Care	247	594	$264,105	$27,730	$291,835	22.0	$1
323,975	26,998	46	Durable Medical Equipment	882	2,222	$642,511	$133,905	$776,417	82.3	$2
323,975	26,998	47	Mental Health Clinics	3	4	$2,720	$0	$2,720	0.1	$0
323,975	26,998	48	Other	929	1,400	$504,764	$87,603	$592,367	51.9	$2

Vermont HealthCare Utilization and Expenditure 2008
Total by Other Payers (99) - Major Medical Members Under 65

Member Months	Average Members (member months / 12)	Expenditure Category	Expenditure Category Description	Count of Unique Members Using Service	Count of Visits	Plan Paid	Member Paid	Plan + Member Paid	Visits per 1,000 Members	Plan + Member Paid Per Member Per Month
229,761	19,147	0	Total	85,418	780,446	$98,094,210	$24,082,008	$122,176,218	40,761.3	$532
229,761	19,147	1	Hospital Inpatient	617	754	$7,026,294	$377,897	$7,404,190	39.4	$32
229,761	19,147	2	Mental/Susbstance Inpatient	44	61	$252,562	$40,758	$293,320	3.2	$1
229,761	19,147	3	Private Psych Hospital	10	17	$95,562	$7,711	$103,273	0.9	$0
229,761	19,147	4	Other Hospitals	35	44	$157,001	$33,047	$190,047	2.3	$1
229,761	19,147	5	Maternity-related and newborns	277	286	$1,258,886	$129,588	$1,388,473	14.9	$6
229,761	19,147	6	Surgical	68	76	$1,473,220	$33,452	$1,506,672	4.0	$7
229,761	19,147	7	Medical	266	331	$4,041,625	$174,099	$4,215,724	17.3	$18
229,761	19,147	8	Hospital Outpatient	10,721	31,478	$21,599,580	$3,528,967	$25,128,547	1,644.0	$109
229,761	19,147	9	Mental/Substance Hospital Outpatient	286	429	$144,388	$46,455	$190,843	22.4	$1
229,761	19,147	10	Observation Bed	49	52	$267,261	$21,069	$288,329	2.7	$1
229,761	19,147	11	Emergency Room	1,764	2,176	$1,622,721	$440,369	$2,063,090	113.6	$9
229,761	19,147	12	Outpatient Surgery	490	560	$1,979,017	$224,718	$2,203,735	29.2	$10
229,761	19,147	13	Outpatient Radiology	2,965	4,638	$4,941,928	$714,560	$5,656,488	242.2	$25
229,761	19,147	14	Outpatient Lab	7,311	14,704	$2,958,676	$868,084	$3,826,760	768.0	$17
229,761	19,147	15	Hospital-Dispensed Pharmacy	929	1,244	$2,579,870	$384,342	$2,964,212	65.0	$13
229,761	19,147	16	Outpatient Physical Therapy	426	865	$396,531	$76,659	$473,190	45.2	$2
229,761	19,147	17	Outpatient Other Therapy	83	143	$54,647	$10,229	$64,876	7.5	$0
229,761	19,147	18	Other Outpatient Hospital	4,169	6,667	$6,654,542	$742,483	$7,397,025	348.2	$32
229,761	19,147	19	Non-Mental Health Professional Services	17,064	93,267	$15,783,973	$4,114,721	$19,898,694	4,871.2	$87
229,761	19,147	20	Physician Services	15,981	70,204	$13,519,231	$3,170,574	$16,689,805	3,666.6	$73
229,761	19,147	21	Physician Inpatient Setting	786	2,778	$2,117,985	$223,401	$2,341,386	145.1	$10
229,761	19,147	22	Physician Outpatient Setting	6,525	14,616	$4,597,957	$817,604	$5,415,561	763.4	$24
229,761	19,147	23	Physician Office Setting	14,748	50,562	$6,091,974	$1,931,691	$8,023,665	2,640.8	$35
229,761	19,147	24	Physician Other Setting	1,587	2,248	$711,315	$197,878	$909,192	117.4	$4
229,761	19,147	25	Other Professional Services	6,289	23,063	$2,274,333	$945,157	$3,219,490	1,204.5	$14
229,761	19,147	26	Nurse Practitioners or Physician Assistants	2,657	4,405	$687,138	$192,186	$879,324	230.1	$4
229,761	19,147	27	Physical Therapists	881	6,447	$620,656	$225,922	$846,578	336.7	$4
229,761	19,147	28	Chiropractors	1,513	8,026	$435,285	$270,588	$705,873	419.2	$3
229,761	19,147	29	Podiatrists	345	731	$66,681	$40,078	$106,759	38.2	$0
229,761	19,147	30	Other Professional Services	2,318	3,454	$464,573	$216,383	$680,957	180.4	$3
229,761	19,147	31	Non-Hospital Mental Health Professional Services	2,051	8,867	$924,428	$460,795	$1,385,223	463.1	$6
229,761	19,147	32	Psychiatrists	181	610	$65,421	$32,377	$97,798	31.9	$0
229,761	19,147	33	Psychologists	282	1,550	$177,311	$86,544	$263,854	81.0	$1
229,761	19,147	34	Social Workers (including MSWs, LICSW, LCSW)	326	1,755	$148,068	$87,714	$235,783	91.7	$1
229,761	19,147	36	Other non-hospital Mental	1,560	4,952	$524,037	$253,150	$777,187	258.6	$3
229,761	19,147	37	Pharmacy	77,344	628,322	$51,017,845	$15,022,467	$66,040,312	32,816.1	$287
229,761	19,147	38	Pharmacy in pharmacy claims	77,323	625,982	$50,897,567	$14,864,890	$65,762,457	32,693.9	$286
229,761	19,147	39	Pharmacy in medical claims	428	2,340	$120,279	$157,577	$277,855	122.2	$1
229,761	19,147	40	All Other Services	2,764	1,706	$1,742,089	$577,162	$2,319,251	89.1	$10
229,761	19,147	41	Free-standing Ambulatory Surgery Center	17	17	$23,213	$4,783	$27,996	0.9	$0
229,761	19,147	45	Home Based Care	180	645	$214,732	$37,821	$252,553	33.7	$1
229,761	19,147	46	Durable Medical Equipment	333	1,001	$220,493	$62,072	$282,565	52.3	$1
229,761	19,147	47	Mental Health Clinics	15	43	$1,239	$3,037	$4,277	2.2	$0
229,761	19,147	48	Other	2,362	5,850	$1,282,412	$469,449	$1,751,861	305.5	$8

Appendix 3

I. Consumer's Tips: Shopping for Individual and Small Group Health Insurance

CONSUMER TIPS

PUBLISHED BY THE VERMONT DIVISION OF HEALTH CARE ADMINISTRATION

Shopping for Individual and Small Group Health Insurance

FEBRUARY 2010

The rates published in this booklet are current as of the date of the publication. However, rates are submitted on a continuous basis. You should check with the insurer for the most current terms and rates before deciding on a particular policy.

VERMONT

DEPARTMENT OF BANKING, INSURANCE,
SECURITIES & HEALTH CARE ADMINISTRATION
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CONSUMER WEBSITE: www.bishca.state.vt.us

VERMONT

ALTERNATIVE FORMATS

This publication is also available on the Department's website at www.bishca.state.vt.us , using the Division of Health Care Administration's "Consumer Publications" link. To speak with a health insurance consumer specialist, call 1-800-631-7788.

Persons with hearing impairments may contact the Vermont Relay Service at 1-800-253-0191 (TTY) or 1-800-253-0195 (voice).

Persons with reading or visual impairments may contact the Vermont Association for the Blind and Visually Impaired (VABVI) at 1-800-639-5861.

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Section One: Introduction

Health insurance is usually offered in two ways. The first way is through your employer; your employer may offer group insurance, or if you are self-employed, you can purchase small group insurance. If you are not offered insurance through your employment, you can buy individual health insurance for yourself and your family. This guide provides basic information about purchasing individual and small group health insurance.

INDIVIDUAL HEALTH INSURANCE (ALSO KNOWN AS NON-GROUP INSURANCE)

Individual health insurance is bought directly by a person who does not have access to group coverage through an employer. For that reason, it is also known as non-group insurance. If you buy a health insurance policy, the insurance company agrees to pay certain expenses listed in the policy in exchange for a payment known as a "premium." Premiums are paid on a monthly, quarterly or annual basis and remain at a set dollar amount for a period of time, usually a year. If you buy your own insurance, you are responsible for paying the premium to the insurance company.

In 2006 Vermont passed health care reform legislation that created access to affordable individual health insurance for qualified uninsured Vermonters who do not have access to employer insurance and do not qualify for other state sponsored health programs such as the Vermont Health Access Program (VHAP) or Dr. Dynasaur. Called Catamount Health, this new health insurance is available through private health insurers and includes Premium Assistance and Employer-Sponsored Insurance (ESI) Premium Assistance for eligible individuals. More information about this is available in the publication, "Shopping for Vermont's Catamount Health Insurance." To obtain a copy, call us at 1-800-631-7788 (toll free) or 802-828-2900 or visit our website at www.bishca.state.vt.us. Information is also available at www.GreenMountainHealth.org.

SMALL GROUP HEALTH INSURANCE

Small group health insurance is available to employers with 1 to 50 employees. Participation requirements that insurers are allowed to impose have recently changed. Small groups having between 11 and 50 employees need at least 75% of the employer's employees to participate in the employer's health plan. For employer groups with at least 10 employees, only 50% of the employees are required to participate in the employer's health plan. Employees who are covered by another group plan or a government program (such as VHAP) are not included in the total number of employees for purposes of the participation requirements. Insurers must not audit compliance with these requirements more than once per year and such monitoring must be done uniformly across all employers.

If an employer group drops below the required participation rate (50% or 75%, depending upon the size of the company), the employer has 120 days to try to come into compliance before the insurer can terminate coverage.

Small group employers pay the premium to the insurance company while each employee usually has a set amount of money withheld from their paycheck by the employer to pay their share of the premium. A self-employed individual may also qualify as a small group (sometimes referred to as a "group of one"). The insurance company may request a copy of your federal income tax return as proof of your self-employed status. Self-employed individuals can buy insurance from an agent or insurance company and will be responsible for paying the premium directly to the insurance company.

EXEMPT ASSOCIATIONS

Insurance offered through an association is defined as "small group" insurance, regardless of the number of members in the association. An association must meet certain requirements in order to be able to offer insurance to its members. For example, the association must have been organized for purposes other than obtaining insurance. The insurance offered by the association must be provided by a Vermont-licensed health insurer that is registered with the State as a small group insurer.

In order to offer this insurance, the association must have been granted an "exemption" by the Vermont Department of Banking, Insurance, Securities and Health Care Administration. An "exempt association" must offer insurance to all members, and acceptance of members cannot be based on health status. Employees of small employers who get their health insurance through an exempt association may only select the insurance plans and riders offered by the association.

Rates for each exempt association are based on the claims experience of all small employers in the association's health insurance plan, which can change over time. Exempt association rates may be lower than in the statewide community rated insurance market. However, association rates could be higher if the association's insured members have higher-than-average health care claims.

Small businesses may be eligible for membership in one or more exempt associations in Vermont. Your business or employer may already be a member of an exempt association. Some exempt associations restrict membership to small employer groups that work in a specific industry. For a list of exempt associations in Vermont, see pages 25 and 26.

Section Two: Before You Choose a Health Insurance Policy

☑ **Make sure** the agent and/or the company you are dealing with is licensed in the state and the insurance policy is approved for sale in Vermont. If you are not sure, call our Department at 1-800-631-7788 or 802-828-2900.

☑ **Learn** what kinds of policies will provide what you need, compare the policies and pick the one that is best for you. Don't hesitate to shop around and ask a lot of questions.

☑ **Do not sign** an application until you review it carefully to be sure your answers are complete and accurate.

☑ **Make sure** that the word "insurance" is actually used and that there is no disclaimer stating that, "This product is not insurance, nor is it intended to replace insurance."

☑ **When you buy a policy**, make the check payable to the company, not the agent. Always pay by check or money order, and write your policy number on the payment.

☑ **Ask** for a receipt for all payments. The receipt should include your policy number, the date of payment and the name of the insurance company.

Section Three: Special Protections

VERMONT PROTECTIONS FOR INDIVIDUAL AND SMALL GROUP POLICYHOLDERS

Individual and small group health insurance policyholders in Vermont are guaranteed certain rights and protections regarding coverage. Understanding these protections can help you make a more informed choice. You have the following rights and protections:

Individual and small group health insurance are "***community rated.***" This means that insurance companies are required to charge the same premium to their customers for the same type of policies with the same coverage, regardless of health status. However, if you buy an individual health plan from a for-profit health insurance company, the company can adjust the community rate for each policyholder based on age.

Individuals and small groups in Vermont also have "***guaranteed issue rights.***": Guaranteed issue means that insurance companies are required by law to sell you a small group or individual health insurance policy if you are eligible under Vermont law to buy such policies. Health insurers must "guarantee acceptance" of every eligible group member, individual, and their eligible dependents. In Vermont, you cannot be denied individual or small group comprehensive health insurance because of your health.

Similarly, a health insurance company cannot terminate your individual policy or your employer group policy because of your health status or claims history. This is called "***guaranteed renewability.***" Plans can only be "non-renewed" for the following reasons:

- Non-payment of premiums when they are due.
- Failure to follow the participation or contribution rules.
- For plans with provider network requirements, if the enrollee no longer lives or works in the plan's service area.
- For small group insurance, if your membership or employment in the group ended.
- Fraud or intentional misrepresentation of a material fact in connection with the coverage.

Section Four: Types of Health Insurance Plans

Individual and small group health insurance plan offerings include:

- Indemnity Plans
- Health Maintenance Organizations
- Preferred Provider Organizations and Point of Service Plans
- Health Savings Accounts and High Deductible Health Plans
- Healthy Lifestyle Plans

INDEMNITY PLANS

Indemnity plans are also known as traditional fee-for-service insurance or plans. You are usually required to pay an annual deductible or a set amount of your annual health care costs. After the deductible is paid, the insurance company will pay for covered expenses at a fixed percentage. You are responsible for the remaining percentage (called "coinsurance"). Each health care service that you receive is separately billed and reimbursed by the insurance company at the amount covered by the policy. Pure indemnity plans generally do not restrict your choice of provider or use of services, as long as the services are covered by the policy. Most indemnity plans in today's market are not pure indemnity plans. They often have at least one or two managed care features (see Health Maintenance Organizations and Preferred Provider Organizations and Point of Service Plans, below).

Important points about Indemnity Plans:

- You have the freedom to choose your doctor, specialist, or hospital with few limitations.
- Your options are seldom if ever limited by geographic restrictions.
- You may be responsible for paying a deductible before covered medical benefits are reimbursable.
- You may be required to pay a co-payment (a set dollar amount) and/or coinsurance for covered medical services.

Health Maintenance Organizations (HMOs)

A Health Maintenance Organization (HMO) is a type of "managed care" plan. An HMO provides comprehensive health care to its members through a network of health care providers within a defined geographic area. The health care providers may be employees or contractors of the HMO. The HMO's primary care providers are usually responsible for a group of patients, and they sometimes receive a fixed amount of money per month to cover the care of each patient (this is called "capitation"). In some cases, there is no deductible or co-insurance. There is often a co-payment for office visits and other services.

HMOs manage care in a variety of ways. Some examples include requiring members to: receive care only from a designated network of providers and hospitals, have a designated primary care provider, obtain permission from a primary care provider to see a specialist, obtain prior approval for certain services, and obtain review of ongoing services.

Important points about HMOs:

- You must obtain health care services from HMO providers, except in certain emergency situations. You may not have any coverage for certain services if you do not use a provider in the insurer's network.
- Your choice of primary care physician is important because he/she directs your care and often coordinates referrals to specialists.
- Your options may be limited by the geographic restrictions of the HMO network.
- You may be charged a co-payment each time you receive HMO-covered services.
- You may be charged more or receive no coverage if you do not obtain approval of certain services before you receive care.

PREFERRED PROVIDER ORGANIZATION (PPO) AND POINT OF SERVICE (POS) PLANS

Preferred Provider Organization (PPO) and a Point of Service (POS) plans are other forms of managed care. The insurance company contracts with a network of health care providers who agree to provide care to the health plan's members at a certain cost. Health plan members usually have more generous coverage if they use the PPO or POS network providers. Members may be permitted to use providers who are not members of the PPO or POS network, but they will usually have higher out-of-pocket costs if they do.

Important points about PPO/POS plans:

- You receive the highest reimbursement of benefits when staying within the PPO/POS network.
- You may have the option to go outside the PPO/POS network at a higher cost to you.
- Check to see if your provider is part of the PPO/POS network before receiving covered services.

HEALTH SAVINGS ACCOUNTS AND HIGH DEDUCTIBLE HEALTH PLANS

Health Savings Accounts (HSAs) became available under federal law January 1, 2004. An HSA is a savings account that allows consumers to pay for some of their health care with tax-free dollars. HSAs allow you to pay for current medical expenses and save for future qualified medical and retiree health expenses on a tax-free basis. Examples of qualified medical expenses include certain medical services not paid by your insurance policy and certain health insurance premiums.

You must be covered by a qualified **High Deductible Health Plan (HDHP)** to be able to take advantage of HSAs. Not all health insurance polices with a high deductible are federally qualified HDHPs. Some banks, credit unions, insurance companies and other approved financial institutions offer HSAs. In addition, some health insurance companies offer HSAs along with their HDHPs. If you want to use an HSA, verify that an HDHP product allows you to participate in an HSA, prior to purchase.

For more information, call us at 1-800-631-7788 or 802-828-2900 to request a fact sheet or visit our website at www.bishca.state.vt.us. You can also visit the U.S. Treasury Department's website at: http://www.treas.gov/offices/public-affairs/hsa/.

HEALTHY LIFESTYLE PLANS

Health insurance companies in Vermont have begun to develop and market health benefit plans that promote wellness and disease prevention. These plans will provide rewards or incentives to policyholders (such as lower premiums, deductibles or cost sharing) if policyholders take specific steps intended to promote healthy living. It is important to note that the law prohibits healthy lifestyle plans from requiring that rewards or incentives be based on an individual reaching a specific health goal (such a certain body weight or cholesterol level). Rather, individuals must commit to specific steps such as seeing a primary care practitioner, engaging in smoking cessation classes or participating in a walking program. Healthy lifestyle plans, like other plans in Vermont, may not deny coverage to individuals based on their health status.

Section Five: Vermont Registered Insurers Offering *Individual* Health Insurance Plans

The following health insurers are registered in Vermont to offer individual health insurance plans:

Indemnity/PPO Plans

Blue Cross Blue Shield of Vermont	(800) 255-4550 or www.bcbsvt.com
MVP Health Plan	(800) 825-5687 or www.mvphealthplan.com

HMO Plans

MVP Health Plan	(800) 825-5687 or www.mvphealthplan.com

High Deductible Health Plans

Blue Cross Blue Shield of Vermont	(800) 255-4550 or www.bcbsvt.com
MVP Health Plan	(800) 825-5687 or www.mvphealthplan.com

Catamount Health Plans*

Blue Cross Blue Shield of Vermont	(888) 445-5805 or www.bcbsvt.com
MVP Health Plan	(888) 687-6277 or www.mvpvermont.com

* **For information about Catamount Health Plan premium rates or premium assistance, see "Shopping for Vermont's Catamount Health Insurance." To obtain a copy or for more information, call us at 1-800-631-7788 or 802-828-2900 or visit our website at www.bishca.state.vt.us.**

Section Six: Individual Health Insurance Rates

BLUE CROSS BLUE SHIELD OF VERMONT (BCBSVT)

The following is a selection of plans and benefits offered by BCBSVT. Please contact BCBSVT or visit their website for more plan options and updated rates.

PPO Plans - Vermont Freedom Plans

PLAN	VISIT CO-PAYS	DEDUCTIBLE (INDIVIDUAL/ FAMILY)	IN-NETWORK COINSURANCE TO INDIVIDUAL COINSURANCE MAXIMUM*	SINGLE MONTHLY RATE	2-PERSON MONTHLY RATE	FAMILY MONTHLY RATE
Vermont Freedom Plan	$30	$3,500/$7,000	20% to $6,000	$558.57	$1,117.14	$1,508.14
Vermont Freedom Plan	$30	$5,000/$10,000	20% to $6,000	$439.71	$879.42	$1,187.22
Vermont Freedom Plan	$30	$7,500/$15,000	20% to $6,000	$366.82	$733.64	$990.41
Vermont Freedom Plan	$30	$10,000/$20,000	20% to $7,000	$320.20	$640.40	$864.54

* Two person and family coinsurance maximums are higher. Prescription drug coverage is included in base plans, subject to a $100 deductible, and 40% generic/50% brand/60% non-formulary drug coinsurance with an out-of-pocket maximum of $5,000.

High Deductible Health Plans

DEDUCTIBLE (INDIVIDUAL /FAMILY)	COINSURANCE (AFTER DEDUCTIBLE)	OUT-OF-POCKET MAXIMUMS (INDIVIDUAL/FAMILY)	SINGLE MONTHLY RATE	2-PERSON MONTHLY RATE	FAMILY MONTHLY RATE
$5,000/$10,000	0% In-Network 30% Out-of-Network	(In-Network) $5,000/$10,000 (Out-of-Network) $7,000/$14,000	$416.11	$832.22	$1,123.50

*Amounts you pay towards the In-Network out-of-pocket maximum also apply to Out-of-Network out-of-pocket limit, and vice versa. Prescription drug coverage is included in base plans, subject to deductible and coinsurance.

Individual Health Insurance Rates (continued)

MVP HEALTH PLAN (MVP)

The following is a selection of plans and benefits offered by MVP. Please contact MVP or visit their website for more plan options and updated rates.

Indemnity Plans

Under these plans, premiums are initially determined by the age of each adult at the time of enrollment. Premiums may be higher or lower, depending upon an individual's age at the time of enrollment. Examples of age-rated adult premiums are provided below. Contact MVP for further plan details and additional rates, including children-only.

PLANS	DEDUCTIBLE (INDIVIDUAL)	COINSURANCE	PER ADULT (Examples of initial monthly rates are based on age and adjusted annually thereafter)				PER CHILD (Any Age)
			Age 29	Age 45	Age 56	Age 64+	
1	$3,500	30%	$211.72	$257.70	$295.00	$317.55	$99.25
2	$5,000	30%	$179.72	$218.80	$250.47	$269.64	$84.23
3	$10,000	30%	$143.61	$174.79	$200.08	$215.37	$67.32
4	$25,000	30%	$58.22	$70.87	$81.12	$87.31	$27.29
5	$100,000	30%	$15.75	$19.15	$21.91	$23.60	$7.38

There is no coinsurance maximum. Coinsurance of 30% is required on five types of outpatient services (surgery, lab/x-ray, pre-admission testing and emergency room) after the deductible. There is a per person, calendar year benefit maximum of $250,000. Prescription drug coverage is included in base plans, subject to a $250 deductible, 50% co-insurance and $5,000 annual cap per individual.

HMO Plan

VISIT CO-PAYS	DEDUCTIBLE (INPATIENT/OUTPATIENT)	SINGLE MONTHLY RATE	2-PERSON MONTHLY RATE	FAMILY MONTHLY RATE
$25	$2,000/$1,000	$1,057.50	$2,115.00	$2,749.50

Prescription drug coverage is included in base plans, subject to 50% coinsurance and $2,500 annual cap.

Section Seven: Vermont Registered Insurers Offering *Small Group* Health Insurance Plans

The following health insurers are registered in Vermont to offer small group health plans:

Health Maintenance Organization (HMO), Preferred Provider Organization (PPO) and Point of Service (POS) Plans

Blue Cross Blue Shield of Vermont	(800) 255-4550 or www.bcbsvt.com
CIGNA Healthcare (Connecticut General Life Insurance)	(800) 456-6575 or www.cigna.com
MVP Health Plan	(800) 825-5687 or www.mvphealthplan.com
The Vermont Health Plan	(800) 255-4550 or www.tvhp.com

High Deductible Health Plans

Blue Cross Blue Shield of Vermont	(800) 255-4550 or www.bcbsvt.com
MVP Health Plan	(800) 825-5687 or www.mvphealthplan.com
The Vermont Health Plan	(800) 255-4550 or www.tvhp.com

Healthy Lifestyle Plans

MVP Health Plan	(800) 825-5687 or www.mvphealthplan.com

Section Eight: Small Group Health Insurance Rates

BLUE CROSS BLUE SHIELD OF VERMONT (BCBSVT)

The following is a selection of plans and benefits offered by BCBSVT. While rates in the table are effective January 1, 2010 to March 31, 2010, check with the insurer to ensure product availability, and for more plan options and updated rates.

PPO Plans - Vermont Freedom Plans

PLAN	IN-NETWORK DEDUCTIBLE (INDIVIDUAL/ FAMILY)	IN-NETWORK COINSURANCE UP TO INDIVIDUAL COINSURANCE MAXIMUM*	VISIT CO-PAYS	PRESCRIPTION DRUG DEDUCTIBLE AND CO-PAYS (GENERIC/ BRAND/NON-FORMULARY)	SINGLE MONTHLY RATE	2-PERSON MONTHLY RATE	FAMILY MONTHLY RATE
A2	$200/$600	20% to $600	$10	$50 Deductible $5/$10/$25	$1,209.43	$2,418.86	$3,265.46
A1	$200/$600	20% to $600	$10	$0 Deductible $5/$10/$25	$1,222.83	$2,445.66	$3301.64
E2	$500/$1,500	20% to $1,500	$10	$50 Deductible $5/$10/$25	$1,123.32	$2,246.64	$3,032.96
I	$1,000/$3,000	20% to $3,000	$15	$50 Deductible $10/$15/$30	$999.36	$1,998.72	$2,698.27
L	$2,500/$5,000	20% to $2,500	$20	$50 Deductible $10/$20/$35	$854.28	$1,708.56	$2,306.56
M	$5,000/$5,000	0% after deductible	$25	$50 Deductible $15/$25/$40	$758.78	$1,517.56	$2,048.71

*Two person and family co-insurance maximums are higher. Prescription drug coverage is included in base plans, subject to deductible and co-pays.

POS Plans -Vermont Health Partnership

PLANS	VISIT CO-PAYS	INPATIENT CO-PAYS	OUTPATIENT CO-PAYS	SINGLE MONTHLY RATE	2-PERSON MONTHLY RATE	FAMILY MONTHLY RATE
Vermont Health Partnership #8	$10	$250	$100	$851.14	$1,702.28	$2,298.08

Prescription drug coverage is included in base plans, subject to a $100 deductible with $10 generic/$15 brand/$30 non-formulary co-pays.

Small Group Health Insurance Rates (continued)

BLUE CROSS BLUE SHIELD OF VERMONT

The following is a selection of plans and benefits offered by BCBSVT. While rates in the table are effective January 1, 2010 to March 31, 2010, check with the insurer to ensure product availability, and for more plan options and updated rates.

High Deductible Health Plans

PLAN	DEDUCTIBLE (INDIVIDUAL/ FAMILY)	COINSURANCE (AFTER DEDUCTIBLE)	OUT-OF-POCKET MAXIMUMS (INDIVIDUAL/ FAMILY)	SINGLE MONTHLY RATE	2-PERSON MONTHLY RATE	FAMILY MONTHLY RATE
Comp $1,500	$1,500/$3,000	0%	$1,500/$3,000	$740.38	$1,292.02	$1,871.55
Comp $1,500	$1,500/$3,000	20%	$2,500/$5,000	$724.37	$1,227.69	$1,772.86
Comp $2,250	$2,250/$4,500	0%	$2,250/$4,500	$641.21	$1,080.18	$1,562.72
Comp $2,500	$2,500/$5,000	20%	$3,500/$7,000	$565.48	$907.01	$1,309.85
Comp $3,000	$3,000/$6,000	0%	$3,000/$6,000	$582.55	$946.15	$1,367.07
Comp $3,000	$3,000/$6,000	20%	$4,000/$8,000	$526.50	$818.06	$1,182.55

Prescription drug coverage is included in base plans, subject to deductible and co-pays.

Small Group Health Insurance Rates (continued)

CIGNA HEALTHCARE

The following is a selection of plans and benefits offered by CIGNA HealthCare. While rates in the table are effective January 1, 2010 to March 31, 2010, check with the insurer to ensure product availability, and for more plan options and updated rates.

POS Plans: Open Access Plus (OAP)

PLANS	IN-NETWORK/ OUT-OF-NETWORK DEDUCTIBLE (INDIVIDUAL)	IN-NETWORK COINSURANCE TO COINSURANCE MAXIMUM* (INDIVIDUAL)	OUT-OF-NETWORK CONSURANCE TO COINSURANCE MAXIMUM* (INDIVIDUAL)	IN-NETWORK VISIT CO-PAYS	SINGLE MONTHLY RATE	2-PERSON MONTHLY RATE	FAMILY MONTHLY RATE
21	$1,000/$3,000	80% to $4,000	60% to $8,000	$20	$579.85	$1,152.65	$1,543.28
22	$2,500/$4,000	80% to $4,000	60% to $8,000	$20	$424.63	$849.89	$1,213.58
23	$3,000/$5,000	100% to $3,000	100% to $5,000	$30	$418.21	$840.91	$1,199.47
24	$2,450/$5,000	100% to $3,250	100% to $5,000	Subject to Deductible	$424.63	$849.89	$1,213.58
25	$3,500/$7,000	80% to $5,000	80% to $10,000	Subject to Deductible	$346.37	$692.10	$989.08
26	$4,000/$8,000	100% to $4,000	100% to $8,000	$30	$357.92	$720.32	$1,031.42
27	$5,000/$5,000	100% to $5,000	100% to $10,000	Subject to Deductible	$284.79	$577.93	$823.59

* Two person and family co-insurance maximums are higher. Prescription drug coverage is included in base plans, subject to deductible and 50% co-insurance. For Plan Options 21 through 23, there is a $3,000 individual and $6,000 family out-of-pocket maximum.

Small Group Health Insurance Rates (continued)

MVP HEALTH PLAN

The following is a selection of plans and benefits offered by MVP Health Plan. While rates in the table are effective January 1, 2010 to March 31, 2010, check with the insurer to ensure product availability, and for more plan options and updated rates.

HMO Plans

PLANS	VISIT CO-PAYS	INPATIENT CO-PAYS	SINGLE MONTHLY RATE	2-PERSON MONTHLY RATE	FAMILY MONTHLY RATE
Plan 10	$10	$240	$642.03	$1,284.05	$1,699.26
Plan 10+	$10	$0	$644.20	$1,288.40	$1,674.93
Plan 15	$15	$240	$632.90	$1,265.80	$1,645.54
Plan 15+	$15	$0	$634.98	$1,269.95	$1,650.94
Plan 25	$25	$500	$618.03	$1,236.05	$1,606.86
Plan 25+	$25	$0	$620.95	$1,241.90	$1,614.48

For information about adding Point of Service Plan (POS) options to HMO plans to provide additional out-of-network benefits, contact MVP Health Plan directly for benefits and rates.

HMO Prescription Drug Plan Riders

RIDER OPTIONS	CO-PAYS/COINSURANCE (GENERIC/BRAND/ NON-FORMULARY)	SINGLE MONTHLY RATE	2-PERSON MONTHLY RATE	FAMILY MONTHLY RATE
R152-V	50%	$41.39	$82.78	$107.61
R203-V	$5/$20/$40	$74.75	$149.50	$194.35
R234-V	$10/$30/$50	$67.59	$135.18	$175.73
R264-V	$15/$35/$50	$56.73	$113.46	$147.50
R256-V	$10/30%/50%	$64.35	$128.70	$167.31

Small Group Health Insurance Rates (continued)

MVP HEALTH PLAN

The following is a selection of plans and benefits offered by MVP Health Plan. While rates in the table are effective January 1, 2010 to March 31, 2010, check with the insurer to ensure product availability, and for more plan options and updated rates.

High Deductible Health Plans

PLANS	DEDUCTIBLE (INDIVIDUAL/ FAMILY	CO-INSURANCE (AFTER DEDUCTIBLE)	ANNUAL OUT-OF-POCKET MAXIMUM (INDIVIDUAL/ FAMILY	SINGLE MONTHLY RATE	2-PERSON MONTHLY RATE	FAMILY MONTHLY RATE
HMO VHHD01	$1,500/$3,000	10%	$3,000/$6,000	$471.30	$942.60	$1,225.38
HMO VHHD02	$1,500/$3,000	20%	$3,000/$6,000	$448.45	$896.90	$1,165.98
HMO VHHD03	$2,000/$4,000	10%	$4,000/$8,000	$396.13	$792.25	$1,029.93
HMO VHHD04	$2,000/$4,000	20%	$4,000/$8,000	$373.94	$747.88	$972.24
HMO VHHD05	$2,500/$5,000	10%	$5,000/$10,000	$342.89	$685.78	$891.51
HMO VHHD06	$2,500/$5,000	20%	$5,000/$10,000	$325.78	$651.55	$847.01
HMO VHHD07	$1,500/$3,000	0%	$1,500/$3,000	$515.04	$1,030.08	$1,339.10
HMO VHHD08	$2,000/$4,000	0%	$2,000/$4,000	$435.43	$870.85	$1,132.10
HMO VHHD09	$2,500/$5,000	0%	$2,500/$5,000	$378.51	$757.03	$984.14

Out-of-network deductibles, coinsurance and out-of-pocket maximums are higher for the high-deductible Point of Service (POS) Plans.

Small Group Health Insurance Rates (continued)

MVP HEALTH PLAN

The following is a selection of plans and benefits offered by MVP Health Plan. While rates in the table are effective January 1, 2010 to March 31, 2010, check with the insurer to ensure product availability, and for more plan options and updated rates.

PPO Plans

PPO PLANS	VISIT CO-PAYS	IN-NETWORK DEDUCTIBLE (INDIVIDUAL/ FAMILY)	OUT-OF-NETWORK DEDUCTIBLE (INDIVIDUAL/ FAMILY)	IN-NETWORK ANNUAL OUT-OF-POCKET MAXIMUM (INDIVIDUAL/ FAMILY)	OUT-OF-NETWORK ANNUAL OUT-OF-POCKET MAXIMUM (INDIVIDUAL/ FAMILY)	SINGLE MONTHLY RATE	2-PERSON MONTHLY RATE	FAMILY MONTHLY RATE
PPO VS-1	$10	$200/ $400	$400/ $800	$600/ $1,200	$1,200/ $2,400	$536.40	$1,072.80	$1,394.65
PPO VS-2	$10	$200/ $400	$400/ $800	$600/ $1,200	$1,200/ $2,400	$521.36	$1,042.73	$1,355.54
PPO VS-3	$10	$500/ $1,000	$1,000/ $2,000	$1,500/ $3,000	$3,000/ $6,000	$489.69	$979.37	$1,273.19
PPO VS-4	$15	$500/ $1,000	$1,000/ $2,000	$1,500/ $3,000	$3,000/ $6,000	$483.79	$967.57	$1,257.84
PPO VS-5	$15	$1,000/ $2,000	$2,000/ $4,000	$3,000/ $6,000	$6,000/ $12,000	$442.61	$885.22	$1,150.79
PPO VS-6	$15	$2,500/ $5,000	$5,000/ $10,000	$7,500/ $15,000	$15,000/ $30,000	$434.41	$868.81	$1,129.46
PPO VS-7	$25	$1,000/ $2,000	$2,000/ $4,000	$3,000/ $6,000	$6,000/ $12,000	$366.05	$732.10	$951.73
PPO VS-8	$25	$2,500/ $5,000	$5,000/ $10,000	$7,500/ $15,000	$15,000/ $30,000	$342.25	$684.50	$889.85
PPO VS-9	$25	$5,000/ $10,000	$10,000/ $20,000	$5,000/ $10,000	$15,000/ $30,000	$536.40	$1,072.80	$1,394.65

30% coinsurance for out-of-network services.

Prescription Drug Riders

PLANS	CO-PAYS (GENERIC/BRAND/ NON-FORMULARY)	SINGLE MONTHLY RATE	2-PERSON MONTHLY RATE	FAMILY MONTHLY RATE
48 P-V	$5/$20/$40	$76.34	$152.68	$198.48
49 P-V	$10/$30/$50	$69.03	$138.06	$179.48
83 P-V	$10/30%/50%	$57.94	$115.88	$150.64

Small Group Health Insurance Rates (continued)

MVP HEALTH PLAN

The following is a selection of plans and benefits offered by MVP Health Plan. While rates in the table are effective January 1, 2010 to March 31, 2010, check with the insurer to ensure product availability, and for more plan options and updated rates.

Preferred Exclusive Provider Organization (EPO) Plans provide access to MVP's regional and national provider networks. Selection of a PCP (Primary Care Provider) is not required. No referrals are required for specialty care. There are no out-of-network benefits, except for emergency care. TriVantage EPO Plans (see page 22) include three healthy lifestyle options: Active Lifestyle, Family Focus and Healthy Alternatives. All EPO plan options may include tools and services to promote wellness, healthy behaviors and lifestyles. For more information about these plans and options, contact MVP for details.

Preferred EPO Plans

PLANS	VISIT CO-PAYS PCPS/SPECIALISTS	DEDUCTIBLE INDIVIDUAL/FAMILY	OUT-OF-POCKET MAXIMUM	SINGLE MONTHLY RATE	2-PERSON MONTHLY RATE	FAMILY MONTHLY RATE
VE003	$25/$40	$0	$0	$484.92	$969.85	$1,292.32
VE015	$20/$20	$500/$1,250	$1,500/$3,750	$451.00	$902.01	$1,201.93
VE016	$20/$20	$1,000/$2,500	$3,000/$7,500	$419.19	$838.37	$1,117.13
VE018	$20/$20	$3,000/$6,000	$9,000/$18,000	$305.44	$610.87	$813.98
VE031	$25/$40	$500/$1,250	$1,500/$3,750	$441.07	$882.14	$1,175.45
VE054	$30/$50	$3,000/$6,000	$6,000/$12,000	$295.64	$591.27	$787.87
VEHD-02	$0/$0	$2,500/$5,000	$3,500/$7,000	$324.82	$649.64	$844.54
VEHD-03	$0/$0	$5,000/$10,000	$5,000/$10,000	$239.83	$479.66	$623.56

Small Group Health Insurance Rates (continued)

MVP HEALTH PLAN

Tri-Vantage EPO Plans

PLANS	EPO OPTIONS	VISIT CO-PAY PCP/SPECIALISTS	INPATIENT CO-PAY	SINGLE MONTHLY RATE	2-PERSON MONTHLY RATE	FAMILY MONTHLY RATE
VT01	Active Lifestyle	$10/$20	$300	$508.77	$1,017.53	$1,355.86
	Family Focus	$15/$20	$0	$508.77	$1,017.53	$1,355.86
	Healthy Alternatives	$20/$20	$300	$508.77	$1,017.53	$1,355.86
VT02	Active Lifestyle	$10/$20	$100	$509.41	$1,018.82	$1,357.57
	Family Focus	$15/$20	$0	$509.41	$1,018.82	$1,357.57
	Healthy Alternatives	$20/$20	$100	$509.41	$1,018.82	$1,357.57
VT03	Active Lifestyle	$15/$40	$300	$496.22	$992.44	$1,322.42
	Family Focus	$20/$40	$0	$496.22	$992.44	$1,322.42
	Healthy Alternatives	$25/$40	$300	$496.22	$992.44	$1,322.42
VT04	Active Lifestyle	$20/$50	$500	$488.54	$977.07	$1,301.95
	Family Focus	$25/$50	$0	$488.54	$977.07	$1,301.95
	Healthy Alternatives	$30/$50	$500	$488.54	$977.07	$1,301.95
VT05	Active Lifestyle	$20/$50	$750	$486.92	$973.84	$1,297.65
	Family Focus	$25/$50	$0	$486.92	$973.84	$1,297.65
	Healthy Alternatives	$30/$50	$750	$486.92	$973.84	$1,297.65
VT06	Active Lifestyle	$20/$50	$1,000	$474.09	$948.18	$1,263.45
	Family Focus	$25/$50	$1,000	$474.09	$948.18	$1,263.45
	Healthy Alternatives	$30/$50	$1,000	$474.09	$948.18	$1,263.45
VT07	Active Lifestyle	$25/$60	$1,500	$462.65	$925.30	$1,232.96
	Family Focus	$30/$60	$1,500	$462.65	$925.30	$1,232.96
	Healthy Alternatives	$35/$60	$1,500	$462.65	$925.30	$1,232.96

Small Group Health Insurance Rates (continued)

THE VERMONT HEALTH PLAN (TVHP)

The following is a selection of plans and benefits offered by TVHP. While rates in the table are effective January 1, 2010 to March 31, 2010, check with the insurer to ensure product availability, and for more plan options and updated rates.

HMO Plans - BlueCare

PLANS	VISIT CO-PAYS	INPATIENT CO-PAYS	SINGLE MONTHLY RATE	2-PERSON MONTHLY RATE	FAMILY MONTHLY RATE
A	$10/$20	$0	$520.30	$1,040.60	$1,404.81
B	$15/$25	$0	$513.28	$1,026.55	$1,385.85
C	$15/$25	$250/visit	$497.30	$994.61	$1,342.72
D	$20/$30	$500/visit	$486.07	$972.13	$1,312.38
E	$20/$30	$1,000 annual deductible	$469.62	$939.25	$1,267.98

Prescription drug coverage is available as a rider at additional cost.

Point of Service (POS) Plans - BlueCare Options

PLANS	VISIT CO-PAYS	OUT-OF-NETWORK DEDUCTIBLE (INDIVIDUAL)	OUT-OF-NETWORK COINSURANCE TO INDIVIDUAL COINSURANCE MAXIMUM	SINGLE MONTHLY RATE	2-PERSON MONTHLY RATE	FAMILY MONTHLY RATE
A	$10/$20	$500	30% to $2,500	$526.54	$1,053.09	$1,421.67
B	$15/$25	$500	30% to $2,500	$519.88	$1,039.77	$1,403.69
C	$15/$25	$500	30% to $2,500	$504.17	$1,008.34	$1,361.26
D	$20/$30	$1,000	30% to $4,000	$491.01	$982.02	$1,325.72

Two-person (employee plus child) and family co-insurance maximums are higher.
Prescription drug coverage is available as a rider at additional cost.

Small Group Health Insurance Rates (continued)

THE VERMONT HEALTH PLAN (TVHP)

The following is a selection of plans and benefits offered by TVHP. While rates in the table are effective January 1, 2010 to March 31, 2010, check with the insurer to ensure product availability, and for more plan options and updated rates.

High Deductible Health Plans - HSA BlueCare

PLANS*	IN-NETWORK DEDUCTIBLE (INDIVIDUAL)	IN-NETWORK COINSURANCE AFTER DEDUCTIBLE	IN-NETWORK OUT-OF POCKET MAXIMUMS (INDIVIDUAL /FAMILY)	SINGLE MONTHLY RATE	2-PERSON MONTHLY RATE	FAMILY MONTHLY RATE
$1,500	$1,500	0%	$1,500	$437.52	$761.29	$1,102.55
$2,000	$2,000	0%	$2,000	$405.26	$688.95	$996.95
$2,500	$2,500	0%	$2,500	$376.49	$624.97	$903.58
$3,000	$3,000	0%	$3,000	$356.41	$577.38	$833.99

*Certain preventive care services are covered at 100% before the deductible is met. After the deductible is met, all services are covered at 100%, including pharmacy benefits. There are no annual maximum limits on pharmacy benefits, out-of-network benefits or co-payments for office visits.

Section Nine: Exempt Associations

The following is a list of recognized exempt associations in Vermont:

Associated Industries of Vermont (802) 223-3441
P.O. Box 630
Montpelier VT 05601

Associated General Contractors of Vermont (802) 223-2374
148 State Street
P.O. Box 750
Montpelier VT 05602

Automobile Wholesalers Association
of New England (800) 258-5318
P.O. Box 838, 2-4 Main Street (603) 924-9449
Peterborough NH 03458

Barre Granite Association (802) 476-4131
51 Church Street, P.O. Box 481
Barre VT 05641

Danjack Enterprises, Inc. (802) 865-4560
d/b/a Business Resource Services
620 Hinesburg Road, Suite 2C
P.O. Box 9367
South Burlington VT 05407

Dairylea Cooperative Inc. (800) 654-8838
P.O. Box 4844
Syracuse NY 13221-4910

Homebuilders and Remodelers Association (802) 876-6200
of Northern Vermont
136 James Brown Drive
Williston VT 05495

St. Albans Cooperative Creamery, Inc. (802) 524-6581
140 Federal Street (800) 559-0343
St. Albans VT 05478

Vermont Association of Chamber Executives (VACE)
P.O. Box 810
Montpelier VT 05601
(802) 229-2231

Vermont Auto Dealers Association
317 River Street, Suite 2
Montpelier VT 05602
(802) 223-6635

Vermont Bankers Association
City Center
89 Main Street, P.O. Box 587
Montpelier VT 05601
(802) 229-0341

Vermont Bar Association
P.O. Box 100
Montpelier VT 05601-0100
(802) 223-2020

Vermont Brewers Association, Inc.
142 Kirk Meadow Drive
Springfield VT 05156
(802) 885-1262

Vermont Businesses for Social Responsibility
60 Lake Street, Ste. 3G
Burlington VT 05401
(802) 862-8347

Vermont Chiropractors Association
170 Burnham Lane
Colchester VT 05401
(802) 999-9307

Vermont Farm Bureau
117 West Main Street
Richmond VT 05477
(802) 434-5646

Vermont Grocers Association
135 N. Main Street, Suite 5
Rutland VT 05701
(800) 842-8503
(802) 775-5460

Vermont Health Care Association (802) 229-5700
617 Comstock Road, Suite 8
Berlin VT 05602

Vermont Insurance Agents Association (802) 229-5884
P.O. Box 1387
Montpelier VT 05601

Vermont League of Cities & Towns (802) 229-9111
89 Main Street, Suite 4
Montpelier VT 05602-2948

Vermont Retail Association (800) 649-1698 (VT)
P.O. Box 688 (802) 879-6999
Essex Junction VT 05453

Vermont School Boards Insurance Trust (802) 223-5040
79 River Street, Suite 301, 3rd Floor
Montpelier VT 05602

Vermont Ski Areas Association (802) 223-2439
26 State Street, P.O. Box 368
Montpelier VT 05601

Vermont State Dental Society (800) 640-5099
100 Dorset Street, Suite 18 (802) 864-0115
South Burlington VT 05403-6241

Vermont Medical Society (800) 640-8767
P.O. Box 1457 (802) 223-7898
134 Main Street
Montpelier VT 05601

Vermont Bus & Truck Association (802) 479-1778
Box 271
Barre VT 05641

Section Ten: Important Health Insurance Terms

In dealing with health insurance, you may come across a number of unfamiliar terms. This section can help you understand the general terms. You must also read your policy definitions to understand what these and the other terms mean.

Out-of-Pocket Costs

Most policies require that you pay some portion of your health care costs. Three types of cost sharing are typically used in health insurance policies:

Deductible: The deductible is the amount you must pay before the insurance company pays benefits. The health insurance policy may not cover any costs until you have spent the deductible amount. Some policies will cover certain types of benefits (such as preventive care) before you "meet" the deductible. Policies differ on which costs are counted towards the deductible amount. Some policies have a deductible for each family member.

Co-Payment: A co-payment is the set amount you must pay for certain covered health care services. The insurance company pays the rest of the amount for the covered health care services, at least up to an amount that the insurer considers reasonable. It is important to understand that under some circumstances you may be responsible for paying for amounts that exceed what the insurer considers reasonable, especially if the provider of the services does not have a contract with the insurer.

Co-payments may differ by the type of health care service. For example, your policy may have a $10 co-payment for a physician's office visit, a $50 co-payment for emergency room use, and a $100 co-payment for inpatient hospitalization. Some policies have different levels of co-payments for prescription drug benefits, called tiered benefits. In these cases, you may pay the lowest co-payment for generic drugs, a higher co-payment for brand-name drugs that are on the insurer's preferred list (sometimes called a "formulary") and the highest co-payment for brand-name drugs that are not on the insurer's preferred list.

Coinsurance: When a health service is subject to coinsurance, the insurance company pays a portion (typically a percentage) of the health care costs, and you pay the remainder. Sometimes the amount of coinsurance you pay may be different when the health care providers are under contract with the insurer (called "participating providers" or "in-network providers") versus when providers are not under contract with an insurer (called "non-participating providers" or "out-of-network providers"). It is important to understand that the policy may only pay a percentage of the cost of the service that the insurer considers reasonable; if a provider (usually a non-participating provider) charges more than this amount, in some situations you may be responsible for paying the difference, in addition to the coinsurance.

Some policies set dollar limits, also known as ***out-of-pocket maximums***, on the total amount of out-of-pocket costs you must pay. Sometimes these out-of-pocket maximums only apply to certain types of services, while others do not set out-of-pocket maximums. For example, "80/20% with $5,000 maximum" means that after you have met the deductible, the insurance company will pay 80% of your covered health care expenses and you pay for 20% of the expenses. This payment arrangement continues until the total paid by you reaches $5,000. At that point the insurer will pay 100% of the reasonable and customary cost for covered health care services. Be sure you read the policy carefully and make sure you understand its terms.

Pre-existing Condition Exclusions

A pre-existing medical condition is defined as any illness or health condition for which you received medical advice, treatment, diagnosis, or care during the six months prior to the start of your new health insurance coverage. Non-group insurance policies may define all such conditions in the last twelve months as pre-existing conditions. If you receive a recommendation to seek medical attention about a health condition or illness from any health care provider, that condition or illness could also be considered a pre-existing condition. An insurer can exclude coverage for health care costs that are incurred related to a pre-existing condition, but only for a certain period of time. After the "waiting period", the insurance company must cover you for any condition that would otherwise be covered in your policy. In many situations, the law prevents insurance companies from imposing pre-existing condition limitations. Some of the rules are:

- For individual health insurance: If you have health insurance coverage now or recently had health insurance coverage for at least nine months, and no more than 63 days have passed since the prior coverage ended, a new insurance policy cannot exclude pre-existing conditions. It is important to note that some types of limited health insurance coverage may not qualify as prior coverage to prevent the application of a pre-existing condition limitation.
- For small group health insurance: If you have health insurance coverage now or recently had health insurance coverage for at least nine months, and no more than 90 days have passed since the prior coverage ended, a new insurance policy cannot exclude pre-existing conditions. It is important to note that some types of limited health insurance coverage may not qualify as prior coverage to prevent the application of a pre-existing condition limitation.
- Catamount Health has special rules about pre-existing conditions limitations. More information about this is available in the publication, "Shopping for Vermont's Catamount Health Insurance." To obtain a copy, call us at 1-800-631-7788 (toll free) or 802-828-2900 or visit our website at www.bishca.state.vt.us. Information is also available at www.GreenMountainHealth.org.

If you had some prior health insurance coverage, but not for a full 9 months, the insurance company can still exclude coverage for a pre-existing condition. However, you may qualify for credit, equal to the amount of time you had prior coverage, against the pre-existing-condition waiting period.

Riders

A rider is a form that changes the terms of your policy. Sometimes the rider will add coverage (such as prescription drugs), but sometimes a rider is used to limit coverage. Premiums may be adjusted if the rider(s) adds benefits. Riders used only to clarify coverage should not affect the premium. Riders may contain co-payments or deductibles that differ from the base policy.

Usual and Customary

Usual and Customary typically means the standard rate in a certain geographic area for identical or similar health care services. Many insurance companies base the portion of service costs they will pay, sometimes called "allowed amount" on "usual and customary" or "reasonable and customary" charges. These terms are defined in the policy.

Appendix 4

Examination and Oversight

I. Commissioner Decision, Docket No. 09-131-H

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

In re: Blue Cross Blue Shield of Vermont	)	
Request for Increase in Subscriber Rates	)	Docket No. 09-131-11
Filing Nos. 45346 and 45347	)	

Commissioner's Decision

Based upon consideration of the entire record in this matter, the Commissioner hereby issues the following Findings of Fact:

Findings of Fact

1. Blue Cross Blue Shield of Vermont ("the Company") filed a request for an overall 34.6% increase in its rates for the insured members of Business Resource Services ("BRS"), a business association exempt from certain requirements of Vermont's community rating law under 8 V.S.A. § 4080a(h)(3) and (4). The proposed rate increases vary from 7.4% to 47%, depending upon the product chosen by the association member or subscribers. Exhibit A (2010 Rate Development Filing for BRS, No. 45347)

2. The Company also filed a request for an overall 24.9% in its rates for the insured members of the Vermont Health Services Group Association ("VHSG"), a business association exempt from certain requirements of Vermont's community rating law under 8 V.S.A. § 4080a(h)(3) and (4). The proposed rate increases vary from – 4.3% to 49.6%, depending upon the product chosen by the association member or subscriber. Exhibit B (2010 Rate Development Filing for VHSG, No. 45346).

3. The Company's proposed rate increases were calculated using a base trend factor approved by the Department of 8.4% for combined medical and pharmacy claims. Applied to the BRS and VHSG association experience pools, however, the trend factor results in a 10.9% trend factor for BRS, and an 11.1% trend factor for VHSG. Exhibit C (1Q 2010 Trend Factor Filing No. 44507); Exhibits A and B.

4. The Company's proposed rate increases were also calculated using an overall 5% annual administrative cost trend approved by the Department. Applied to the BRS association and the VHSG association, however, the trend factor results in a significantly higher increase in administrative costs for BRS and VHSG. Exhibit D (2010 Admin Charge Schedule and Contribution to Reserve Filing No. 44670); Exhibits A and B.

5. Three additional factors have contributed to the magnitude of the Company's proposed rate increases. First, for many years the Company failed to measure and timely file benefit relativity factors on a regular basis. Benefit relativity factors are needed in order that premiums charged to subscribers accurately reflect the cost of the benefit design included in the subscriber's insurance product. Because of this failure, the Company is essentially "catching up" for years when benefit relativity factors were not applied as they should have been, resulting in significant rate increases in the current year. These significant rate increases resulted notwithstanding the application of a

formula designed to mitigate the impact on rates in the first year. Exhibit E (Benefit Relativity Methodology Filing).

6. The second additional factor contributing to the significant rate impact on the BRS and VHSG associations is the decision of the Company to reduce the number of the Company's insurance product offerings in order to reduce the Company's administrative costs. For many years the Company's administrative costs have been higher than necessary because of the multiplicity of insurance products offered to subscribers. The reduction in insurance products is in accordance with recommendations of the Company's auditor, in September 2007 (Exhibits F, Report and Analysis of the Administrative Expenses of Blue Cross Blue Shield of Vermont, Deloitte Consulting LLP), but because of its historical decision to maintain a multiplicity of insurance products, and because of the manner and timing in which the number of products offered to BRS and VHSG have been reduced, the results are a substantial impact on subscriber rates. Exhibits A and B.

7. The Department has supported, and continues to support the Company's efforts to reduce the number of its insurance product offerings in order to reduce the Company's administrative costs which are included in subscriber rates. Exhibit G (Commissioner's letter dated November 2, 2007). The Department also has supported, and continues to support, the Company's decision to measure and apply benefit relativity factors to the various benefit plans offered by the Company, so that the premiums charged to subscribers will more accurately reflect subscribers claims and costs. Exhibit H (Department's approval of the Benefit Relativity Methodology Filing, July 22, 2009). Nevertheless, the impact of implementing these decisions has contributed to significant rate increases for most of the BRS and VHSG members. While the Company's Benefit Relativity Methodology Filing includes a transition methodology, the Filing does not provide adequate notice to the Department that applying the benefit relativity factors contribute in a substantial manner to rate increases of 34.6% and 24.9% for the respective associations. 1,943 of the total of 2,941 subscribers face rate increases in excess of 40% under the Company's BRS filing, and 1,340 of the total of 2,382 subscribers face rate increases in excess of 40% under the Company's VHSG filing. Exhibits A and B

8. The third additional factor contributing to the significant rate impact on the BRS members is a combination of volatility and adverse selection in the BRS association experience pool. As explained by the Department's actuarial consultant, BRS subscriber contracts insured by the Company have decreased from 4,460 at the 2009 renewal date to 2,941 at the 2010 renewal date. While subscribers have been leaving the BRS association, the subscriber claims per month has increased from $745.34 to $933.19. This phenomena is a classic demonstration of adverse selection, where healthier members leave a group, leaving behind less healthy and more expensive insured subscribers. Exhibit I (Harrington letter of October 22, 2009).

9. Rate increases of these magnitudes are likely to produce two equally undesirable results: either the significant rate increases will exacerbate the existing volatility in the association and small group markets, as employers seek ways to mitigate significant

increases in their business costs by migrating to another association or market; or, faced with business cost increases that cannot be absorbed, the employer will choose to drop coverage for his or her employees and their dependents. While employers who drop coverage face an adjustable assessment of $365 annually per uncovered full time equivalent employee (21 V.S.A. §§ 2001-2003), if the Company's proposed rate increase request for the BRS association is approved, annual subscriber plan premiums will range from $7,116.52 (single, $2,250 deductible)/$18,474.48 (family, $4,500 deductible) for the lowest cost HSA plan, to $8,136.12 (single)/ $21,966.84 (family) for a preferred provider organization product with a $500 deductible, $2,500 annual out of pocket maximum, $30 office co-payment. Assuming that a typical employer contributes 83% of the cost of single coverage, and 63% of the cost of family coverage[1], the business cost to the employer if the Company's rate increases are allowed to be implemented is $5,906.71/$11,638.92 for HSA coverage or $6,752.98/$13,839.10 for PPO coverage, far in excess of the cost of the $365 annual FTE assessment.

10. The Company's other rate increases in its other lines of business are relatively modest when compared to the rate increases proposed by the Company for its BRS and VHSG subscribers. See Exhibit J (TVHP approved filing).

11. The Company's current reserves, which must be adequate in order for an insurance company to be financially stable, are at a level representing a 18.2% SAPOR ratio. This level of reserves is adequate. Exhibit K (Department's calculation of the Company's SAPOR ratio).

Based upon the Commissioner's Findings of Fact and the applicable law, the Commissioner hereby issues the following Conclusions of Law:

Conclusions

12. Pursuant to 8 V.S.A. §§ 4062, 4513(b), and 4584(a), the Company is prohibited from using rates and premiums without the approval of the Commissioner. The Commissioner may disapprove requested rates if the Commissioner finds that such rates are unjust, unfair, inequitable, excessive, inadequate, or discriminatory.

13. The Company, as a hospital and medical service corporation, has special statutory obligations and responsibilities to its subscribers which the Legislature has not expressly imposed on other health insurance companies. See 8 V.S.A. § 4512(a) ("It [the Company] shall be maintained and operated solely for the benefit of the subscribers thereof * * *.") See also 8 V.S.A. § 4513(c) ("In connection with a rate decision, the commissioner may also make reasonable supplemental orders to the corporation and may attach reasonable conditions and limitations to such orders as he finds, on the basis of competent and substantial evidence, necessary to insure that benefits and services are provided at minimum cost under efficient and economical management of the corporation.") As was explained by the Vermont Supreme Court, " * * * Blue Cross is not a private business operating freely within the competitive marketplace; it is a quasi-

[1] Employer Health Benefits, 2009 Annual Survey, Kaiser Family Foundation-Health Research and Educational Trust. Section 6, Worker and Employer Contributions for Premiums.

public business subject to the regulation of the commissioner." In re Vermont Health Service Corporation, 144 Vt. 617 (1984).

14. The Commissioner is authorized to consider factors other than strictly actuarial analysis in determining whether the Company's proposed rates are "excessive." While other states have enacted statutes different from Vermont's, the consensus of courts reviewing the exercise of an insurance commissioner's rate decisions is that a wide variety of factors beyond the mathematical and actuarial can and should be considered by an insurance commissioner. See Blue Cross and Blue Shield of Michigan, 139 Mich. App. 109, 112-116 (1985); Insurance Commissioner of the State of Maryland v. Carefirst of Maryland, 816 A.2d at 135-136; In re Rate Filing of Blue Cross Hospital Service, Inc., 158 W.Va. 725, 730 (1975).

15. The Commissioner concludes that the overall 34.6% rate increase filed by the Company for BRS subscribers, as well as the significantly higher increases for some association members, is excessive, unjust, unfair, and inequitable. Among the relevant facts and circumstances, the rate increases are primarily attributable to factors in the control of the Company: (a) the failure of the Company for many years to use approved benefit relativity factors for its association products, and the application of a transition formula that has a significant rate impact in the first year of implementation; (b) the multiplicity of insurance products offered by the Company for many years, the decision by the Company to reduce the number of insurance products offered to its subscribers, and the application of an inadequate transition period has a significant rate impact on the associations subscribers; and (c) the decision of the Company to apply its administrative cost charge, reserve charge, and medical and pharmacy trend to BRS association rates in a manner, and at a time when those rates are already under considerable stress as a result of the other factors described herein. While each of these decisions may be reasonable when viewed in isolation, as applied collectively to BRS subscribers, the resulting rates are excessive, unjust, unfair and inequitable.

16. The Commissioner concludes that the 24.9% rate increase filed by the Company for VHSG subscribers, as well as the significantly higher increases for some association members, is excessive, unjust, unfair, and inequitable. Among the relevant facts and circumstances, the rate increases are primarily attributable to factors in the control of the Company: (a) the failure of the Company for many years to use approved benefit relativity factors for its association products and the application of a transition formula that has a significant rate impact in the first year of implementation; (b) the multiplicity of insurance products offered by the Company for many years, the decision by the Company to reduce the number of insurance products offered to its subscribers and the application of an inadequate transition period has a significant rate impact on the association subscribers; and (c) the decision of the Company to apply its administrative cost charge, reserve charge, and medical and pharmacy trend to VHSG association rates in a manner, and at a time when those rates are already under considerable stress as a result of the other factors described herein. While each of these decisions may be reasonable when viewed in isolation, as applied collectively to VHSG subscribers the resulting rates are excessive, unjust, unfair and inequitable.

17. As an alternative to imposing excessive, unjust, unfair and inequitable rates on its subscribers, the Company can moderate the rate impact on these associations' subscribers by (i) modifying its Benefit Relativity Methodology to include a longer transition period or different transition formula; (ii) temporarily suspend its contribution to reserves for these two pools of subscribers; and (iii) temporarily increase its contribution to reserves in other lines of business, and thereby diminish its impact on the associations' subscribers. The Commissioner concludes based on the entire record in this matter the Company's rates for the BRS and VHSG associations are excessive, unjust, unfair and inequitable if any subscriber's rate increase for the product he or she purchases exceeds 25%.

18. The Commissioner recognizes that rate decisions must not result in significant negative financial consequences for the Company. Vermont needs efficiently operated, financially stable and sustainable health insurance companies, including the Company, in order to offer Vermonters access to health insurance and affordable health care. 18 V.S.A. § 9401(a). The Commissioner concludes, however, that the decision made herein will not result in any significant or materially negative financial consequences for the Company.

19. The Commissioner acknowledges that her rate decisions with respect to these two filings do not address more fundamental problems facing the Company and the association-small group health insurance market in general. These problems include persistent medical inflation, and a segmented small group and association market that invites adverse selection and manipulation. The Commissioner also continues to be exceedingly troubled by the award to the Company's former Chief Operating Officer of over $6 million upon his retirement in December 2008. The Commissioner concludes that there is cause to believe that this excessive monetary award is contrary to the insurance laws of this state, contrary to the laws regulating the Company and its obligations to subscribers, and contrary to the Company's obligations to its subscribers as a non-profit corporation. The Commissioner acknowledges and supports the continuing efforts of the current management of the Company to reduce the total retirement compensation paid to the Company's former Chief Operating Officer.

20. In order to insure that the Company is maintained and operated solely for the benefit of its subscribers, and to insure that benefits and services are provided at minimum cost under efficient and economical management of the Company, the Commissioner concludes that the Company should be subject to supplemental orders designed to address the above-referenced fundamental problems.

Rate Order

Wherefore, based upon the Commissioner's consideration of the entire record in this matter and the applicable law, the Company's rate increase filings for the BRS and VHSG association are hereby DENIED. The Commissioner intends to reconsider rate filings for these two associations if the filings are consistent with the criteria established in Para. 17, above, or if the filings moderate the rate impact on these subscribers in a similar manner.

Order to Show Cause, and
Notice Relating to Supplemental Orders

Now comes the Commissioner, pursuant to her authority under 8 V.S.A. § 15, and 8 V.S.A. §§ 4513(c) and 4584(c), and hereby ORDERS the Company to SHOW CAUSE why the Commissioner should not issue the following reasonable supplemental orders, terms and conditions necessary to insure that benefits and services are provided to subscribers at minimum cost under efficient and economical management of the Company, and to insure that the Company is maintained and operated solely for the benefit of subscribers. The Company is hereby given NOTICE that a hearing will be held on a date to be scheduled by the Commissioner on or after November 13, 2009, to offer the Company the opportunity to be heard concerning the issues set forth below, following which, and after consideration of the evidence offered by the Company and the Department, and the entire record in this matter, the Commissioner may thereafter issue one or more supplemental orders:

A. Should the Company be ordered to file a plan approved by the Commissioner designed to lower the Company's trend for health care costs? The Commissioner acknowledges that a similar order issued in January 2007, but the Company's efforts to lower trend to a reasonable and sustainable level have not been successful. Should the Company's plan include cost containment benchmarks proposed by the Company and approved by the Commissioner?

B. Should the Company be ordered to file an actuarial adjustment methodology approved by the Commissioner to reduce volatility in membership and rates in the association and small group markets?

C. Should the Company be ordered to file an approved plan to recover that portion of post-employment compensation of the Company's former Chief Executive Officer deemed by the Commissioner to be excessive under the insurance laws of this state, under the health insurance laws specifically applicable to the Company, and under Vermont's non-profit corporation laws?

D. Should the Commissioner assert continuing jurisdiction over this proceeding, and issue such further supplemental orders as are necessary to insure that benefits and services are provided to subscribers at minimum cost under efficient and economical management of the Company?

Dated at Montpelier, Vermont this 3rd day of November, 2009.

Paulette J. Thabault, Commissioner

Appendix 5

I. Work Plan and Time Line

GOAL: Effective rate review in all insurance markets

Estimated date of established funding agreement with State: August 9, 2010 to September 30, 2011

Task or milestone	Person responsible for carrying out task	How long will this task take to complete	How does task contribute to project completion
Insurers notified of Department's intention to establish procedures for annual rate review of large group market	Rate and Forms Director	1 month	An initial step in moving forward with new filing requirements; Insurers must be notified of new rating requirements pertaining to the large group market
Department request for information and comment from interested parties and regulators	Rate and Forms Director	3 months	Groundwork necessary to develop appropriate rate procedures for rate review of Vermont's large group market.
1st draft of Department rate filing requirements and procedures	Rate and Forms Director	1 month	Essential step in the process of developing Department rate procedures for rate review of the large group market.
Review and comment on Department's 1st draft of rate filing requirements and procedures	Rate and Forms Director	2 months	Essential step in the process of developing Department rate procedures for rate review of the large group market.
2nd draft of rate filing requirements and procedures	Rate and Form Director	1 month	Essential step in the process of developing Department rate procedures for rate review of the large group market.
Final rate filing requirements and procedures posted on Department website	Rate and Forms Director	13 months	Final result of the completion of tasks #1 through # 5 above; necessary to have completed for rate review begins January 2012.

GOAL: Rate review of minor insurance lines

Estimated date of established funding agreement with State: August 9, 2010 to September 30, 2011

Task or milestone	Person responsible for carrying out task	How long will this task take to complete	How does task contribute to project completion
Insurers notified of Department's intention to establish procedures for rate review of minor lines of insurance	Rate and Forms Director	1 month	An initial step in moving forward with new filing requirements; Insurers must be notified of new rating requirements pertaining to minor lines of insurance.
Department request for information and comment from interested parties and regulators	Rate and Forms Director	3 months	Groundwork necessary to develop appropriate rate procedures for rate review of some minor lines of insurance.
1st draft of Department rate filing requirements and procedures	Rate and Forms Director	1 month	Essential step in the process of developing Department rate procedures for rate review of minor lines of insurance.
Review and comment on Department's 1st draft of rate filing requirements and procedures	Rate and Forms Director	2 months	Essential step in the process of developing Department rate procedures for rate review of minor lines of insurance.
2nd draft of rate filing requirements and procedures	Rate and Form Director	1 month	Essential step in the process of developing Department rate procedures for rate review of minor lines of insurance.
Final rate filing requirements and procedures posted on Department website	Rate and Forms Director	11 months	Final result of the completion of tasks #1 through # 5 above; necessary to have completed for rate review beginning October 1, 2011.

GOAL: Adopt standards for carrier rate filings

Estimated date of established funding agreement with State: August 9, 2010 to September 30, 2011

Task or milestone	Person responsible for carrying out task	How long will this task take to complete	How does task contribute to project completion
Insurers notified of Department's intention to establish standards for carrier rate filings	Rate and Forms Director	1 month	An initial step in moving forward with new filing standards; Insurers must be notified of new rating filing standards.
Department request for information and comment from interested parties and regulators	Rate and Forms Director	3 months	Groundwork necessary to establish appropriate standards for carrier rate filings.
1st draft of Department rate filing requirements and procedures	Rate and Forms Director	1 month	Essential step in the process of establishing appropriate standards for carrier rate filings.
Review and comment on Department's 1st draft of rate filing requirements and procedures	Rate and Forms Director	2 months	Essential step in the process of establishing appropriate standards for carrier rate filings.
2nd draft of rate filing requirements and procedures	Rate and Form Director	1 month	Essential step in the process of establishing appropriate standards for carrier rate filings.
Final rate filing requirements and procedures posted on Department website	Rate and Forms Director	11 months	Final result of the completion of tasks #1 through # 5 above; necessary to have completed for implementation of standards by July 1, 2011.

GOAL: Informational filings by Third Party Administrators

Estimated date of established funding agreement with State: August 9, 2010 to September 30, 2011

Task or milestone	Person responsible for carrying out task	How long will this task take to complete	How does task contribute to project completion
Insurers notified of Department's intention to establish and publish annual informal filings by 3rd party administrators	Rate and Forms Director	1 month	An initial step in moving forward with the establishment and publishing of annual informational filings by 3rd party administrators; Insurers must be notified of Department's intention.
Department request for information and comment from interested parties and regulators	Rate and Forms Director	3 months	Groundwork necessary to establish appropriate informational filings by 3rd party administrators.
1st draft of Department standards for annual informational filings	Rate and Forms Director	1 month	Essential step in the process of establishing appropriate informational filings by 3rd party administrators.
Review and comment on Department's 1st draft of standards	Rate and Forms Director	2 months	Essential step in the process of establishing appropriate informational filings by 3rd party administrators.
2nd draft of standards for annual informational filings	Rate and Form Director	1 month	Essential step in the process of establishing appropriate informational filings by 3rd party administrators.
Final standards established and published on Department website	Rate and Forms Director	13 months	Final result of the completion of tasks #1 through # 5 above; necessary to have completed for establishment and publication of standards by September 30, 2011.

GOAL: Examine claims experience based on new federal requirements

Estimated date of established funding agreement with State: August 9, 2010 to September 30, 2011

Task or milestone	Person responsible for carrying out task	How long will this task take to complete	How does task contribute to project completion
Department data collection procedures established	Rate and Form Director	2 months	An initial step in for examining claims data.
Data collection of early claims data	Rate and Form Director	6-8 months	Necessary task for examination (achievement of identified goal).
Preliminary data analysis of claims data	Rate and Form Director	3 months	Essential task in the process of performing an appropriate and accurate examination.
Preliminary Report drafted	Rate and Form Director	1 month	Essential task in the process of performing an appropriate and accurate examination.
Report finalized and conclusions drawn	Rate and Form Director	2 months	Result of the completion of tasks #1 through # 4 above; final task necessary to accomplish goal by July 1, 2011.

GOAL: Migration analysis

Estimated date of established funding agreement with State: August 9, 2010 to September 30, 2011

Task or milestone	Person responsible for carrying out task	How long will this task take to complete	How does task contribute to project completion
Department data collection procedures established	Rate and Form Director	2 months	An initial step for examining claims data.
Data collection of early claims data	Rate and Form Director	6-8 months	Necessary task for analysis (achievement of identified goal).
Preliminary data analysis of claims data	Rate and Form Director	3 months	Essential task in the process of performing an appropriate and accurate analysis.
Preliminary Report drafted	Rate and Form Director	1 month	Essential task in the process of performing an appropriate and accurate analysis.
Report finalized and conclusions drawn	Rate and Form Director	2 months	Result of the completion of tasks #1 through # 4 above; final task necessary to accomplish goal by July 1, 2011.

GOAL: Targeted data verification examinations

Estimated date of established funding agreement with State: August 9, 2010 to September 30, 2011

Task or milestone	Person responsible for carrying out task	How long will this task take to complete	How does task contribute to project completion
Department examination procedures and timelines established	Rate and Form Director	2 months	An initial step for examining claims data.
Examinations conducted	Rate and Form Director	6-8 months	Necessary task for examination (achievement of identified goal).
Preliminary data analysis of examinations	Rate and Form Director	3 months	Essential task in the process of performing an appropriate and accurate examination.
Preliminary Report drafted	Rate and Form Director	1 month	Essential task in the process of performing an appropriate and accurate examination.
Report finalized and conclusions drawn	Rate and Form Director	2 months	Result of the completion of tasks #1 through # 4 above; final task necessary to accomplish goal by July 1, 2011.

GOAL: Increase professional resources for rate review

Estimated date of established funding agreement with State: August 9, 2010 to September 30, 2011

Task or milestone	Person responsible for carrying out task	How long will this task take to complete	How does task contribute to project completion
Department posts positions	Rate and Form Director	1 month	Initial and required task necessary to fill all positions.
Posting period closed and applications evaluated for interviewing	Rate and Form Director	1-2 months	Essential task in the process of hiring the best possible candidates for each position.
Applicant interviews	Rate and Form Director	1 month	Essential task in process of hiring the best candidates for each position.
Offers to qualified applicants	Rate and Form Director	2 months	Essential task in the process of hiring the best candidates for each position.
Positions filled	Rate and Form Director	2 months	Essential task that culminates the hiring process.

GOAL: Enhanced rate data collection and reporting

Estimated date of established funding agreement with State: August 9, 2010 to September 30, 2011

Task or milestone	Person responsible for carrying out task	How long will this task take to complete	How does task contribute to project completion
Department data collection procedures established	Rate and Form Director	2 months	An initial task in the process of improving the information technology (IT) analysis and reporting capacity of the Department with respect to rate review.
Data collection of early claims data	Rate and Form Director	6-8 months	Necessary task for enhancing IT capacity and ultimately rate review.
Preliminary data analysis of claims data	Rate and Form Director	3 months	Essential task in the process of enhancing IT capacity and ultimately rate review.
Preliminary Report drafted	Rate and Form Director	1 month	Essential task in the process of enhancing IT capacity and ultimately rate review.
Report finalized and conclusions drawn	Rate and Form Director	2 months	Result of the completion of tasks #1 through # 4 above; final task necessary to accomplish goal by September 30, 2011.

GOAL: Integration of historical and current rate data

Estimated date of established funding agreement with State: August 9, 2010 to September 30, 2011

Task or milestone	Person responsible for carrying out task	How long will this task take to complete	How does task contribute to project completion
Department data collection procedures established	Rate and Form Director	2 months	An initial task in the process of collecting and integrating historical rate information, in order to better understand rate and market trends over time.
Data collection of early claims data	Rate and Form Director	6-8 months	Necessary task for building the process of collecting and integrating historical rate information to better understand rate and market trends over time.
Preliminary data analysis of claims data	Rate and Form Director	3 months	Essential task in the process of collecting and integrating historical rate information to better understand rate and market trends over time.
Preliminary Report drafted	Rate and Form Director	1 month	Essential task in the process of collecting and integrating historical rate information to better understand rate and market trends over time.
Report finalized and conclusions drawn and publicized.	Rate and Form Director	2 months	Result of the completion of tasks #1 through # 4 above; final task necessary to accomplish goal by September 30, 2011.

GOAL: Customize VHCURES reporting to support rate review

Estimated date of established funding agreement with State: August 9, 2010 to September 30, 2011

Task or milestone	Person responsible for carrying out task	How long will this task take to complete	How does task contribute to project completion
Convene discussions between VHCURES staff, rate analysts, and actuarial consultant.	Rate and Forms Director, Director of Analysis	2 month	Convening experts will lead to identification of useful and meaningful claims data categorizations.
Identify alternative claims data categorizations.	Rates and Forms Director, Director of Analysis	6 months	Alternative claims data categorizations inform and support customized reporting.
Execute contract with VHCURES Contractor to implement customized reporting.	Director of Analysis	9 months (Complete by September, 2011)	Establishes mechanism for customized reporting.
Implement customized reporting and enhanced evaluation.	Rate and Forms Director, Director of Analysis	12 months	Implements customized reporting, resulting in enhanced evaluation of insurer filings, trends and cost drivers.

GOAL: Consolidate carrier "carve-out" data

Estimated date of established funding agreement with State: August 9, 2010 to September 30, 2011

Task or milestone	Person responsible for carrying out task	How long will this task take to complete	How does task contribute to project completion
Develop an inventory of carrier "carve-out" relationships and identify how carve-out data is submitted to VHCURES.	Director of Analysis, Director of Rates and Forms, Director of Health Care Quality Improvement	2 months	Cross checking among different data sources ensures accuracy of information about carve-out relationships.
Determine contents of consolidated reports from VHCURES data to reflect carve-out relationships.	Director of Analysis, Director of Rates and Forms	6 months	Content of consolidated reports supports accurate and informative reporting when there are carve-out relationships.
Execute contract with VHCURES Contractor to implement consolidated expenditure and utilization reports.	Director of Analysis	9 months (Complete by September, 2011)	Establishes mechanism for producing consolidated reports.
Implement consolidation of expenditure and utilization reports.	Rate and Forms Director, Director of Analysis	12 months	Implementation of consolidated reports leads to stronger rate review for carriers with carve-outs.

GOAL: Claims reporting by product type

Estimated date of established funding agreement with State: August 9, 2010 to September 30, 2011

Task or milestone	Person responsible for carrying out task	How long will this task take to complete	How does task contribute to project completion
Develop an inventory of carrier product types and identify how product-level data is submitted to VHCURES.	Director of Analysis, Director of Rates and Forms, Director of Health Care Quality Improvement	2 months	Cross checking among different data sources ensures accuracy of information about carrier product types.
Determine contents of reports by product type from VHCURES data.	Director of Analysis, Director of Rates and Forms	6 months	Content of reports supports accurate and informative product type reporting.
Execute contract with VHCURES Contractor to implement reporting by product type.	Director of Analysis	9 months (Complete by September, 2011)	Establishes mechanism for product type reporting.
Implement product type reporting.	Rate and Forms Director, Director of Analysis	12 months	Implementation of product type reporting leads to stronger rate review for carriers with multiple product types.

GOAL: Claims reporting by provider

Estimated date of established funding agreement with State: August 9, 2010 to September 30, 2011

Task or milestone	Person responsible for carrying out task	How long will this task take to complete	How does task contribute to project completion
Develop a Master Provider Index for facility claims and professional claims.	Director of Analysis	6 months	A Master Provider Index allows for accurate attribution of claims to providers.
Determine contents of reports by provider from VHCURES data.	Director of Analysis, Director of Rates and Forms	9 months	Identifying appropriate content for reports supports accurate and informative provider-level reporting.
Execute contract with VHCURES Contractor to implement reporting by provider.	Director of Analysis	11 months (Complete by September, 2011)	Establishes mechanism for provider-level reporting.
Implement provider-level reporting.	Rate and Forms Director, Director of Analysis	13 months	Implementation of provider-level reporting leads to stronger rate review by allowing for identification of cost drivers.

GOAL: Layperson summaries of rate filings

Estimated date of established funding agreement with State: August 9, 2010 to September 30, 2011

Task or milestone	Person responsible for carrying out task	How long will this task take to complete	How does task contribute to project completion
Insurers and interested parties notified of Department's intention to establish requirements for carrier to file layperson friendly summaries for rate filings	Rate and Forms Director	1 month	An initial task in process of achieving goal; Insurers must be notified of the Department's intention to establish a new rate filing requirement.
Department request for information and comment from interested parties and regulators	Rate and Forms Director	3 months	Groundwork necessary to develop appropriate layperson friendly summaries of rate filings.
1st draft of Department requirements for carrier filings of layperson friendly summaries of rate filings	Rate and Forms Director	1 month	Essential step in the process of developing appropriate layperson friendly summaries of rate filings.
Review and comment on Department's 1st draft summary requirements	Rate and Forms Director	2 months	Essential step in the process of developing appropriate layperson friendly summaries of rate filings.
2nd draft of summary requirements	Rate and Form Director	1 month	Essential step in the process of appropriate layperson friendly summaries of rate filings.
Final requirements are established and published on Department website	Rate and Forms Director	13 months	Final result of the completion of tasks #1 through # 5 above; necessary to have completed for the implementation of the requirement beginning July 1, 2011.

GOAL: Ratepayer comment opportunity

Estimated date of established funding agreement with State: August 9, 2010 to September 30, 2011

Task or milestone	Person responsible for carrying out task	How long will this task take to complete	How does task contribute to project completion
Interested parties notified of Department's intention to offer establish requirements for carrier to file layperson friendly summaries for rate filings	Rate and Forms Director	1 month	An initial task in process of achieving goal; interested parties are to notified of the Department's intention to offer a ratepayer comment forum opportunity for carrier rate increase requests.
Department request for information and comment from interested parties and regulators	Rate and Forms Director	3 months	Groundwork necessary to develop an appropriate ratepayer comment forum opportunity for carrier rate increase requests.
1st draft of Department requirements for carrier filings of layperson friendly summaries of rate filings	Rate and Forms Director	1 month	Essential step in the process of developing an appropriate ratepayer comment forum opportunity for carrier rate increase requests.
Review and comment on Department's 1st draft summary requirements	Rate and Forms Director	2 months	Essential step in the process of developing an appropriate ratepayer comment forum opportunity for carrier rate increase requests.
2nd draft of summary requirements	Rate and Form Director	1 month	Essential step in the process of developing an appropriate ratepayer comment forum opportunity for carrier rate increase requests.
Final requirements are established and published on Department website	Rate and Forms Director	13 months	Final result of the completion of tasks #1 through # 5 above; Ratepayer comment functionalities become part of the Department's rate portion of its website beginning established by January 1, 2012.

Rate Review Grant – Vermont Application – Time Line

August 9, 2010 to September 30, 2011 Timeline

2010-2011	Months																							
	2010												2011											
Activity	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D
Effective rate review in all insurance markets																								
Rate review of minor insurance lines																								
Adopt standards for carrier rate filings																								
Informational filings by Third Party Administrators																								
Examine claims experience based on new federal requirements																								
Migration analysis																								
Targeted data verification examinations																								
Increase professional resources for rate review																								
Enhanced rate data collection and reporting																								
Integration of historical and current rate data																								

Rate Review Grant – Vermont Application – Time Line

2010-2011																								
Activity	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D
Customize VHCURES reporting to support rate review																								
Consolidate carrier "carve-out" data																								
Claims reporting by product type																								
Claims reporting by provider																								
Layperson summaries of rate filings																								
Ratepayer comment opportunity																								

Appendix 6

I. The Project Director is Christine Oliver, Deputy Commissioner, Division of Health Care Administration, Vermont Department of Banking, Insurance, Securities and Health Care Administration, 89 Main Street, Montpelier, VT 05620-3101; 802-828-2900 - christine.oliver@state.vt.us. The Deputy Commissioner's job description and abbreviated resume is attached.

II. Assistant Project Director is Sean P. Londergan, Assistant General Counsel, Director of Rates and Forms, Health Care Administration, Vermont Department of Banking, Insurance, Securities and Health Care Administration, 89 Main Street, Montpelier, VT 05620-3101; 802-828-2963 - sean.londergan@state.vt.us. Mr. Londergan's resume is attached.

Current Position Description and Abbreviated Resume for Christine M. Oliver
Deputy Commissioner of the Division of Health Care Administration (HCA)
Vermont Department of Banking, Insurance, Securities & Health Care Administration

As Deputy Commissioner, serves as the managerial head of the state division responsible for regulating health insurance (including rates and forms), quality of health care services, and related consumer education and protection. The division also has statutory responsibility for reviewing hospital budgets and issuing "certificates of need" for hospital expenditures. She was appointed Deputy in July 2006.

Previously:

- Executive Assistant for Health and Human Services to Ohio Governor Bob Taft. She was the senior policy advisor and acted as a direct liaison to the Governor for six state agencies: Health, Job and Family Services (including Medicaid), Mental Retardation and Developmental Disabilities, Aging, Alcohol and Drug Addiction Services, and Mental Health.

- General Counsel for the Ohio Department of Mental Retardation and Developmental Disabilities. The agency serves 60,000 individuals through 12 state-operated developmental centers, 88 county boards of mental retardation and developmental disabilities, and 1300 private providers regulated by the State.

- Associate with the Ohio law firm of Delligatti, Hollenbaugh & Briscoe Co., L.P.A. Her focus was on business and health care litigation.

Obtained law degree from the Ohio State University, College of Law and Bachelor of Science in Business Administration, *magna cum laude*, from Youngstown State University.

SEAN P. LONDERGAN
19 Loomis Street, Apt. 6, Montpelier, VT 05602

BAR ADMISSION & MEMBERSHIPS

State of Vermont

United States District Court, District of Vermont

Vermont Bar Association, Member

EDUCATION

Vermont Law School, South Royalton, VT JD, May 2005

University of Minnesota, Minneapolis, MN MPH, Community Health and Education, 1997

Springfield College, Springfield, MA MS, Exercise Physiology, 1991

University of Rhode Island, Kingston, RI BS, Health, 1988

LEGAL EXPERIENCE

Vt. Department of Banking, Insurance, Securities and Health Care Administration, Montpelier, VT
Assistant General Counsel, Director of Rates and Forms, August 2009 – presently

- Oversees the Division's Rates and Forms section, provides legal support to the Division on regulatory issues, policy development and legislation.

Vermont Legal Aid, Inc., Springfield, VT
Staff Attorney, Medicare Advocacy Project, August 2005 – August 2009; and Senior Citizens Law Project, May 2007 – August 2009

- Represent dual eligibles in the Medicare Part A and B appeal process advocating for Medicare coverage for home health services.
- Represent seniors (60 years or older) in a range of civil law matters, including landlord tenant disputes, denial of benefits, debt collection and guardianships.
- Provide legal support to advocates for the elderly.
- Advise seniors on civil matters at free legal advice clinics.
- Oral and written advocacy in administrative and civil law proceedings.

Native American Protection and Advocacy Program, Farmington, NM *Law Clerk*,
Summer 2004

- Research and writing on matters such as the IDEA, jurisdiction and Indian law.

Law Offices of Griffin, Marsiovertere & Wilkes P.C., White River Junction, VT *Law Clerk*,
Summer 2003

- Research and writing on a range of criminal law issues for court appointed public defenders.
- Interviewed clients.

PROFESSIONAL EXPERIENCE **University of Minnesota, Division of Epidemiology**, Minneapolis, MN *Evaluation Coordinator,* May 1999 – August 2002

- Coordinated data collection and data processing efforts for two community-based public health research projects funded by the National Institutes of Health.

Massachusetts Prevention Center, Brockton, MA *Prevention Specialist,* August 1998 – May 1999

- Assisted youth groups, community coalitions and Boards of Health participating in the Massachusetts Tobacco Control Program with the development, implementation and evaluation of tobacco control initiatives in southeastern Massachusetts.

Massachusetts Department of Public Health, Boston, MA *Research Analyst,* February 1998 - June 1998

- Responsible for conducting a focus group study of community coalitions participating in a state wide teenage pregnancy prevention program.

Minnesota Department of Health, Minneapolis, MN

Employee Health Promotion Program, December 1995 – May 1997

- Assisted in the development, implementation and evaluation of the Minnesota Department of Health's work-site health promotion.

COMPUTER SKILLS WordPerfect, WESTLAW, Electronic Legal Databases, Pika, MS Applications, Internet Applications.