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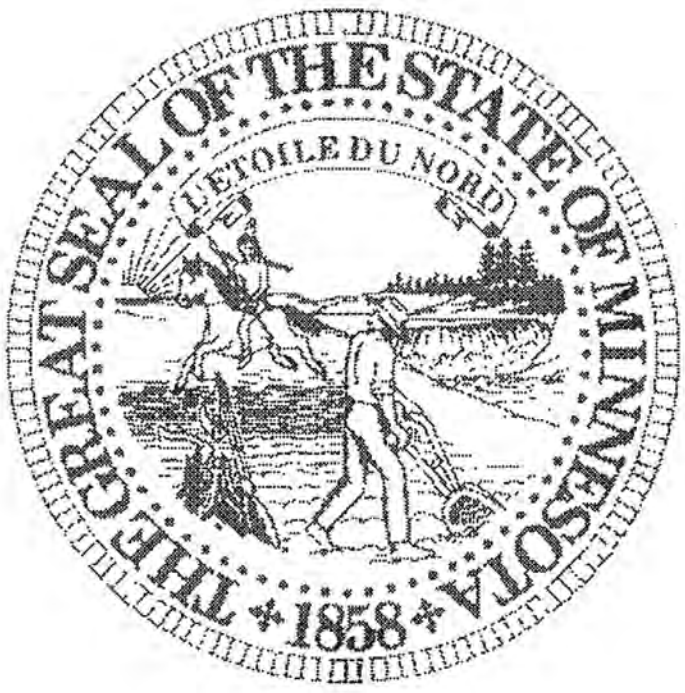
AFFILIATE TRANSACTIONS AND ADMINISTRATIVE EXPENSES



Office of Minnesota Attorney General
Mike Hatch

VOLUME III: AFFILIATE TRANSACTIONS AND ADMINISTRATIVE EXPENSES

EXECUTIVE SUMMARY

BCBSM has roughly 20 affiliates. BCBSM enters into administrative service agreements with virtually all of its affiliates. As a result, the affiliates do not have any employees and BCBSM provides all administrative and other services for the affiliated companies. BCBSM entered into a number of transactions with its affiliates during the review period which do not appear to be in the interest of policyholders. In addition, BCBSM has made questionable statements about the total amount of its administrative expenses.

Dividends. BCBSM transferred almost $30 million in dividends to its parent, Aware Integrated Inc. ("AII") since 2000. AII in turn transferred at least $11 million of these monies to its for-profit affiliates. For example, $4.2 million was used by AII to capitalize a bank in Utah.

Gift Certificates. BCBSM is also a party of several agreements with Care Delivery Management Inc. ("CDMI"), a for-profit subsidiary of AII. These agreements appear to have limited value to policyholders. For instance, in one contract CDMI provides "Healthy Start" services to all fully-insured subscribers of BCBSM. The Healthy Start program is a pre-term birth prevention program which basically involves a nurse contacting a pregnant woman once a month. Women who participate in the Healthy Start program receive one $50 gift certificate for WalMart or Target when they sign-up for the program and another $50 gift certificate upon the woman's six week post-partum visit. Accordingly, each woman who participates in the Healthy Start program receives $100 in gift certificates. BCBSM pays CDMI 30¢ per member per month out of insurance premiums. It is estimated that BCBSM paid CDMI more than $6 million between 2002 and 2004 under this arrangement.

BCBSM Foundation. BCBSM also transferred significant sums of money to its affiliate, BCBSM Foundation, Inc. (the "Foundation"). The Foundation operates as a charity pursuant to section 501(c)(3) and is almost entirely funded by BCBSM. Between 2001 to 2004, BCBSM contributed $21,500,000 to the Foundation. This amount represents more than the total amount of grants issued by the Foundation in the 20 years it has been in existence. As of December 31, 2004, the Foundation's equity exceeded $51 million.

North Dakota Transactions. BCBSM also entered into an arrangement with Dakota Clinic during the review period. Dakota Clinic is a medical clinic system based in North Dakota. BCBSM and Dakota Clinic formed a "managed care joint venture corporation" whose purpose was "improving [the] quality and reducing [the] cost" of health care. The venture collapsed and, in 2003, BCBSM terminated its affiliation with Dakota Clinic. BCBSM and its subsidiary Blue Plus invested in the venture and paid to Dakota Clinic roughly $46 million as a result of this failed eight year venture.

BCBSM joined with Dakota Clinic in constructing a hospital in Fargo, North Dakota. This is unusual in that BCBSM is a Minnesota company that does not issue policies in North Dakota. BCBSM invested at least $10 million in the construction of the hospital. While BCBSM and Dakota Clinic each had a 50 percent interest in the ownership of the hospital, BCBSM "resigned" its interest in the hospital in June 2005. In exchange for the resignation of its interest, BCBSM received only the repayment of amounts it had loaned the hospital plus interest. It is not clear how BCBSM's financing of a North Dakota hospital benefited Minnesota subscribers.

Administrative Expenses. BCBSM has claimed that its administrative expenses have remained "flat" over the past five years. In fact, the amounts BCBSM reports as administrative expenses increased by over 67% from 2000 to 2004, totaling $582,418,000 as of December 31, 2004. The most significant portion of BCBSM's administrative costs relate to payroll. In fact, the average annual salary of a BCBSM employee was more than $91,000 in 2004. Other BCBSM activities which do not relate to the direct reimbursement of health care costs include the following:

- Spent more than $9 million on the "do" campaign to encourage physical activity;
- Conducted "Minnesota Decides Forums" in 2001 and 2004 to "shape the external environment" concerning health care;
- Held "Meet the Candidates Sessions"; and
- Created a diversion of "business intelligence and informatics" and established the "Minnesota local health care information infrastructure" which was intended to "leverage BCBSM's knowledge of transaction clearing and its infrastructure to jump start a community cooperative."

Conclusion. BCBSM's sole responsibility under the Nonprofit Health Service Plan Corporations Act is to provide health care plans that will promote more affordable and available health services for the people of Minnesota. BCBSM's focus has strayed far from this goal. While many of BCBSM's activities may have raised the awareness of certain health care issues or benefited the community, the question is whether BCBSM should be utilizing health care premiums for these purposes.

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AFFILIATE TRANSACTIONS AND ADMINISTRATIVE EXPENSES

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I. OVERVIEW OF FINANCIAL STATEMENTS.

Pursuant to Minnesota Statutes, section 62C.11, subdivision 1 BCBSM is required to submit annual financial statements to the Minnesota Department of Commerce. Selected financial information from statements filed since December 31, 2000 is set forth in Table 1.

The financial statements from which this data was obtained set forth financial data for only BCBSM; they generally do not include financial information relating to any of BCBSM's affiliates.[1]

As reflected in Table 1, BCBSM's revenues and expenses increased steadily from 2000 to 2005. It is important to note that the revenues reflected in Table 1 include only premium revenues. BCBSM does not post, however, the money it receives for providing administrative services to its affiliates or the administrative fees it receives for administering self-insured plans. Rather, payments from affiliates and administrative fees are offset against BCBSM's total administrative expenses, resulting in a "net" amount of administrative expenses that is reported in the financial statement. As stated by BCBSM:

> Under the terms of contractual agreements for reimbursement of administrative expenses, BCBSM acts as the control plan for various national groups, processes claims under administrative service contracts and provides certain operating and administrative services to wholly-owned subsidiaries and affiliated corporations .... *These charges are recorded as reductions in administrative expense in the accompanying financial statements.*

Note 10.F to Annual Statement as of December 31, 2004 of the BCBSM, Inc. d/b/a Blue Cross Blue Shield of Minnesota. (Exhibit 1). The deduction of these service fees from BCBSM's total administrative expenses thus reduces the percentage of the administrative costs of BCBSM on its financial statements.

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[1] BCBSM's statutory financial statements do include the statutory equity of one of BCBSM's affiliates -- MII, Inc.

BCBSM realized substantial net income in four of its five most recent years. Net income per year ranged from $9,451,581 in 2004 to $96,422,929 in 2003. The only year in which BCBSM reported a loss was 2001; this loss was due to a "tobacco loss" of $45,043,000 recorded by BCBSM in 2001.

BCBSM's admitted assets grew 39% from $1,212,467,359 on December 31, 2000 to $1,689,018,194 as of December 31, 2005.[2] BCBSM excludes from its calculation of admitted assets its investments in two nonprofit HMO subsidiaries, a practice inconsistent with standards established by the NAIC. BCBSM acknowledges that this practice is inconsistent with NAIC standards, but notes that, for reasons not understood by the AGO, it obtained the permission of the Minnesota Department of Commerce to exclude such investments.

[2] "Admitted assets" are generally defined under statutory accounting principles as assets which can be readily used to fulfill policyholder obligations. *See* Statements of Statutory Accounting Principles ("SSAP") No. 4, as amended by SSAP No. 87.

Table 1.

SELECTED FINANCIAL INFORMATION*
BCBSM, INC.

	2005	2004	2003	2002	2001	2000
BALANCE SHEET ITEMS						
Total admitted assets	$1,689,018,194	$1,696,824,514	$1,525,446,263	$1,320,871,509	$1,314,990,488	$1,212,467,359
Total liabilities	996,089,306	1,005,053,397	917,034,202	826,038,912	911,524,097	791,388,262
Total capital and surplus	692,928,888	691,771,117	608,412,061	494,832,597	403,466,391	421,079,097
INCOME STATEMENT ITEMS						
Total Revenues	$2,177,118,392	$1,958,282,637	$1,780,376,227	$1,547,262,933	$1,392,557,364	$1,221,332,049
Total medical and hospital expenses	1,898,625,420	1,683,930,676	1,464,253,474	1,282,014,706	1,157,870,098	1,042,050,856
'aims adjustment .penses	102,214,467	91,485,757	66,544,860	68,442,426	63,164,837	88,384,728
Total administrative expenses	178,277,726	171,216,703	144,751,611	128,777,556	135,374,902	84,812,683
Net underwriting gain (loss)	(7,599,221)	(17,050,499)	96,626,282	62,428,245	21,947,527	6,083,782
Net investment gain (loss)	48,915,579	45,270,954	29,769,989	(12,676,826)	8,325,237	53,962,744
Total other income	414,832	(9,682,874)	9,764,658	699,579	(33,655,973)	(8,645,055)
Net income or (loss)	59,523,595	9,451,581	96,422,929	47,711,998	(39,331,209)	42,131,471
ENROLLMENT						
Total members at end of period	743,355	702,083	665,397	633,072	582,230	NA

*Source: Annual Statements of the BCBSM, Inc. d/b/a Blue Cross Blue Shield of Minnesota as of December 31, 2004 and December 31, 2005.

BCBSM's capital and surplus[3] increased steadily from 2000 to 2005. Since December 31, 2000, BCBSM's reported total adjusted capital increased by 65% to a total of $693,895,709 as of December 31, 2005. [4]

Total enrollment in BCBSM also steadily increased during this period. As of December 31, 2004, BCBSM indicates that it had 702,083 fully-insured members. BCBSM also administered self-insured plans for 1,409,813 members as of that date. (Exhibit 2).

II. TRANSACTIONS WITH AFFILIATES.

BCBSM was a party to at least 70 agreements with affiliates that were in effect at some point during the review period. BCBSM has entered into administrative services agreements with virtually all of its affiliates. In addition, it has entered into stop-loss reinsurance agreements, investment advisory agreements, network access agreements and clearinghouse services agreements, among others, with various of its affiliates.

BCBSM is a nonprofit health plan service corporation that operates in an environment where healthcare coverage is unaffordable for many families. If keeping premiums in check is a goal of nonprofit health plan service corporations, then each of the following transactions raises substantial question as to whether BCBSM is carrying out its mission.

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[3] An insurer's surplus under statutory accounting principles is generally equivalent to "net worth" or "shareholders' equity" calculated under generally accepted accounting principles ("GAAP").

[4] The AGO believes that the amount of capital and surplus reported by BCBSM is understated. As discussed in the "Reserves and Surplus" volume of this report, BCBSM's capital and surplus, with certain adjustments, may have been more than $1 billion as of December 31, 2005.

A. Duties of Nonprofit Organizations

Minnesota law is clear that directors and officers of a nonprofit corporation like BCBSM owe fiduciary duties to the corporation, which includes the duties of care, loyalty and obedience to the law. The duty of care to the corporation essentially means that the directors and officers are obligated to make reasonable decisions in the best interest of the corporation. *See* Minn. Stat. § 317A.251, subd. 1 (directors); Minn. Stat. § 317A.361 (officers). The duty of loyalty to the corporation requires a nonprofit director or officer to put the corporation's interest before any competing interest. *E.g., Mid-List Press v. Nora*, 275 F. Supp2d 997, 1003-4 (D. Minn. 2003). In *Shepherd of the Valley Lutheran Church of Hastings v. Hope Lutheran Church of Hastings,* 626 N.W.2d 436 (Minn. Ct. App. 2001), the Minnesota Court of Appeals further explained the fiduciary responsibilities of directors and officers of nonprofits, stating that the "law imposed[s]...the highest standard of integrity" on them. *Id.* at 442.

The transactions discussed below raise concerns that BCBSM's officers and directors did not act in a manner consistent with the duties they owed to BCBSM. As discussed below, BCBSM entered into questionable business partnerships which were of little or no benefit to BCBSM, paid dividends that were routed to its for-profit affiliates, and made questionable payments to its for-profit affiliates. Each of these transactions raises the concern that certain of BCBSM's officers and directors did not act with undivided loyalty or observe the "highest standard of integrity."

B. BCBSM's Payment of Dividends.

Under the Minnesota Nonprofit Corporation Act, a nonprofit corporation may not:

> ...pay dividends or other pecuniary remuneration, directly or indirectly, to its members, other than to members that are nonprofit organization or subdivisions, units, or agencies of the United States or state or local government.[5]

BCBSM issued three dividends during the period covering this compliance review. The first dividend was declared at a meeting of the Board of Trustees of BCBSM on October 4, 2000 in the amount of $10,000,000 to be paid to BCBSM's parent, Aware Integrated, Inc. ("AII"). AII is a nonprofit corporation with five directly-owned for-profit subsidiaries.[6] After receiving the dividend from BCBSM, AII transferred the funds to its subsidiary, Comprehensive Managed Care, Inc. ("CMCI"), a for-profit corporation. At the time of the dividend, CMCI owed BCBSM approximately $7 million. CMCI used the funds it received from AII to repay its loan to BCBSM. In other words, the only purpose of the dividend was to eliminate a debt owed to BCBSM by an affiliated company. (Exhibit 35).

The Department of Commerce indicated that it had no objection to the dividend. (Exhibit 36). Yet, the payment of a dividend under these circumstances does not appear to be consistent with the restrictions on dividends set forth in Minnesota Statutes section 317A.011, subdivision 6, set forth above. While the dividend was paid by BCBSM to its nonprofit parent, the documented purpose of the dividend was for the nonprofit to transfer the funds to its for-profit subsidiary. Remarkably, that for-profit affiliate was then to use the funds to repay BCBSM the monies it owed. This circular transaction essentially allowed a for-profit affiliate of BCBSM to "write-off" over $7 million it owed BCBSM.

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[5] Minn. Stat. § 317A.011, subd. 6 (2004).

[6] Those subsidiaries are Aware Dental Services, LLC; Care Delivery Management, Inc.; Pharmacy Gold, Inc.; Comprehensive Managed Care, Inc.; and Capital Asset Care, Inc.

The second dividend issued by BCBSM during the review period was declared by the BCBSM's Board of Trustees on December 8, 2004 in the amount of $9,000,000. According to BCBSM, the dividend was to be used by its parent, AII, to develop and refine a "suite of consumer engagement tools", health savings account operations for servicing the needs of persons electing higher deductible health plan products, and the development of "new and more responsive care management tools". (Exhibit 37).

In fact, $4.2 million of the dividend was used by AII to capitalize a bank in Utah as discussed further below. (Exhibit 38). BCBSM states that AII has not yet spent the remainder of the dividend.

In 2005, BCBSM reports that it issued a third dividend, in the amount of $9 million, to AII. (Exhibit 55).

BCBSM's sole source of revenue is health insurance premiums and the fees it receives to administer self-insured plans. The fact that at least $11 million of these monies ultimately ended up in the hands of BCBSM's for-profit affiliates, including a start-up bank, is extremely troubling. It also appears to be inconsistent with the responsibilities of a nonprofit organization under the Minnesota Nonprofit Corporation Act as well as BCBSM's unique responsibilities as a health service plan corporation.

C. Agreements with Care Delivery Management, Inc.

Care Delivery Management, Inc. ("CDMI") is a for-profit subsidiary of Aware Integrated, Inc. ("AII"). According to BCBSM's website, CDMI "offers a variety of care

management services."[7] BCBSM is a party to several agreements with CDMI. Two agreements dated June 1, 2002 raise particular concern.

1. Car Seat Gift Certificate Fulfillment.

The first agreement requires CDMI to provide certain services to enrollees of BCBSM's "government programs". (Exhibit 39). Specifically, CDMI agrees to "fulfill car-seat gift certificate requests to covered persons." *(Id.)* In that regard, CDMI is to mail a $50 gift certificate to certain members' home with a letter. *(Id.)* CDMI is paid $55 per gift certificate for performing these services. *(Id.)*

The "car seat program" provides $50 gift certificates to enrollees which can be used for the purchase of a car seat. (Exhibit 51). According to BCBSM, the program is designed to promote the use of child car seats. (*Id.*) The program is available to all Medicaid or MinnesotaCare recipients enrolled with either of BCBSM's affiliated HMOs who have a child two years old or under or who are at least six months pregnant. From 2003 through 2005, BCBSM paid CDMI a total of $418,165 for car seat gift certificates.

It appears that the only service performed under the agreement between BCBSM and CDMI is the verification of eligibility and the mailing of gift certificates. It is unclear why BCBSM or its affiliated HMOs could not provide this service on their own, particularly when considering that CDMI has no employees and that BCBSM provides staffing for CDMI. Indeed, it appears that CDMI contracts with a third party, Gift Certificate Center, Inc., to actually send out the gift certificates. (Exhibit 40). CDMI pays the Gift Certificate Center $54 for each car seat gift certificate mailed in connection with this program.

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[7] *http://www.bluecrossmn.com.*

It is not clear why BCBSM did not contract directly with the Gift Certificate Center, since it would have cost less than contracting with CDMI. Further, while the use of car seats for children is very important, it is questionable whether healthcare dollars should be used to purchase car seats at a time when consumers are being priced out of the health insurance market.

2. "Healthy Start" Gift Certificates.

The second agreement, also dated June 1, 2002, was also between Blue Cross and CDMI. Pursuant to this agreement, CDMI was to provide "Healthy Start" services to all fully-insured subscribers of BCBSM. (Exhibit 41). BCBSM was responsible for publicizing and encouraging covered persons to participate in Healthy Start, which is identified to be a pre-term birth prevention program. CDMI's responsibilities under the second agreement include:

- Communication materials such as posters, postcards, magnets, and various "promotional trinkets".
- Program components including nurse phone calls once per month, a nurse resource line and the distribution of gift certificates. (Based on a similar contract between First Plan and CDMI, it appears that one $50 gift certificate for WalMart or Target is sent by CDMI upon a member's first prenatal visit and another $50 gift certificate is sent upon confirmation from the member that she attended a six-week post-partum visit. Accordingly, each member who participates receives $100 in gift certificates.)
- Certain other promotional and accounting services.

(Id.)

In exchange for the services, BCBSM pays CDMI 30¢ per member per month. Since BCBSM had 633,072 fully-insured members during 2002, BCBSM would have paid CDMI approximately $2,279,000 for this service. BCBSM would have paid CDMI an additional $2,395,000 in 2003 and approximately $2,500,000 in 2004 under the terms of this agreement.

The second agreement sets forth no standards by which the effectiveness of this program will be measured nor does it require CDMI to report to BCBSM with respect to the number of

individuals participating in the program. The agreement simply provides that CDMI will provide information to BCBSM, but only if specifically requested by BCBSM. And, as with the car seat gift certificate program discussed above, CDMI appears to have entered into an agreement with the Gift Certificate Center to actually process and mail the gift certificates to be issued in connection with this program. (Exhibit 40).

This agreement is troubling for a number of reasons. First, it does not appear that BCBSM issued any RFPs with respect to this contract; it simply awarded the contract to its affiliate. Second, without regular reporting from CDMI, it is unclear how BCBSM is able to assess whether this program is beneficial to its members. Third, it not clear from the description in the agreement what services are being provided by CDMI that would not otherwise be provided by a member's healthcare provider. The payment by BCBSM of over $7 million in three years to a for-profit affiliate under these circumstances does not appear to be consistent with the principles governing a nonprofit health organization.

3. Gift Certificates.

BCBSM spends an inordinate amount of money on gift certificates for members participating in the car seat program, the Healthy Start program and other similar programs. From March 1, 2003 through December 31, 2003, BCBSM paid over $491,000 for such gift certificates. (Exhibit 42). In 2004, BCBSM spent $482,220 on gift certificates. (*Id.*)

At a time when healthcare premiums are skyrocketing, the payment of almost $1 million for Target and WalMart gift certificates for members appears to be an unusual use of the healthcare dollar.

D. Payments to BCBSM Foundation, Inc.

BCBSM Foundation, Inc. (the "Foundation") was organized as a nonprofit organization on November 13, 1986 and operates as a charity pursuant to section 501(c)(3) of the Internal Revenue Code. According to BCBSM, the Foundation is the largest grant-making foundation in Minnesota dedicated exclusively to improving community health in the State. (Exhibit 43). BCBSM further states that since 1986, the Foundation has awarded more than $15 million to "make a healthy difference in Minnesotans' lives." (*Id.*) What BCBSM does not indicate on its website is that it funds virtually all of the operations of the Foundation[8] and, in just the four years from 2001 to 2004, BCBSM contributed $21,500,000 to the Foundation[9] -- apparently more than the total amount of grants issued by the Foundation in the 20 years that it has been in existence. (*Id.*) Not surprisingly, the Foundation has a significant net worth which continues to grow. At December 31, 2004, the Foundation's net assets exceeded $51 million. (Exhibit 44).

During the last five years, the average total amount of grants issued per year was only $1,706,727. Despite this, BCBSM continued to contribute heavily to the organization, transferring as much as $12 million to the Foundation in one year. Clearly these contributions exceeded the grant-making abilities of the Foundation. It raises the question as to why BCBSM continues to transfer money to the Foundation when the money is simply being stockpiled and is not being used to promote any healthcare purpose. It seems that BCBSM could better use these funds directly to reduce the cost of healthcare for its subscribers.

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[8] It appears that America Healthways, BCBSM's largest vendor, also contributed to the Foundation during the review period -- a total of $22,000 in 2003 and 2004.

[9] This does not include the $21 million in tobacco litigation settlement funds that BCBSM transferred to the Foundation in 1998. (Exhibit 45).

Further, the administrative costs of the Foundation grew significantly from 2000 to 2004. In 2000, the Foundation incurred $119,892 in operating and administrative expenses and disbursed $1,239,847 in grants. (Exhibit 46). By 2004, the Foundation's operating and administrative expenses had grown by 267% to $440,991. (Exhibit 47). Yet the amount of grants issued by the Foundation during the period grew by just 85%, from $1,239,847 to $2,285,551. *(Id.)* These increases in administrative costs buttress the concern that BCBSM and the Foundation are not efficiently using healthcare dollars.

E. BCBSM's Investment in Dakota Clinic and Innovis Hospital

1. Affiliation with Dakota Clinic.

In 1994, BCBSM entered into a Joint Venture and Affiliation Agreement ("Affiliation Agreement") with Dakota Clinic, a medical clinic system based in Fargo, North Dakota. Dakota Clinic has satellite clinics throughout northeastern North Dakota and northwestern Minnesota. In connection with the Affiliation Agreement, Dakota Clinic agreed to a 20-year covenant-not-to-sell its clinic in exchange for $27 million from BCBSM and Blue Plus. The $27 million was to be paid over 20 years with interest. In addition, BCBSM contributed $3 million to the capital of Dakota Community Health Network ("DCHN"),[10] a "managed care joint venture corporation," and Dakota Clinic also contributed $3 million. As a result, BCBSM and Dakota Clinic became joint owners of the corporation, each owning 50 percent. The purpose of the joint venture was purportedly "improving [the] quality and reducing [the] costs" of healthcare. (Exhibit 29).

In 2001, the venture began collapsing and BCBSM transferred its 50% interest in DCHN to Dakota Clinic. (Exhibit 30). It doesn't appear that BCBSM received any compensation from

[10] It appears that BCBSM and Blue Plus each contributed $1,500,000 to DCHN.

the clinic for this interest, and it also wrote-off the $1,575,000 due from DCHN. *(Id.)* This resulted in a total loss for BCBSM's investment in DCHN equal to $4,575,000.

On April 30, 2003, BCBSM and Blue Plus terminated their affiliation with Dakota Clinic because the relationship "no longer had value" to them. (Exhibit 31). As the terminating parties, BCBSM and Blue Plus paid a termination fee to Dakota Clinic of $29,764,244. *(Id.)* The termination fee included the earned portion of the covenant-not-to-sell, accrued interest and a penalty of $8,750,000 for early termination.

The financial summary of the Dakota Clinic affiliation is set forth in Table 2.

Table 2.

Financial Summary of BCBSM's Affiliation with Dakota Clinic*	
Covenant Paid	$11,250,000
Interest Paid	$21,752,970
Termination Penalty	$8,750,000
Investment in DCHN	$3,000,000
Loan and Forgiven Interest	$1,575,000
Total Expenditures	$46,327,970

* These amounts reflect the combined financial impact on BCBSM and its wholly-owned subsidiary, Blue Plus.

It is not clear how the joint venture could possibly have reduced healthcare costs. As a result of the transaction, BCBSM and Blue Plus together spent more than $46 million. At the end of the affiliation, BCBSM had no tangible or intangible assets to show for the relationship. It is unclear why BCBSM and Blue Plus could not have simply continued their contract with Dakota Clinic as a participating provider instead of expending almost $50 million for a relationship that they abandoned after only eight years.

2. Ownership of Innovis.

In October of 1997, Dakota Clinic announced its plans to build a hospital in Fargo, North Dakota. In March of 1998, BCBSM joined Dakota Clinic as its partner in the planning and development of the non-profit hospital. Reportedly, BCBSM was the first Blues plan in the country to develop a hospital from the ground up. (Exhibit 49).

BCBSM and Dakota Clinic each had a 50% membership interest in the nonprofit organization that was to own the hospital -- Dakota Specialty Institute d/b/a Innovis Health ("Innovis"). In addition to initial planning and development costs, BCBSM provided a $5 million loan to Innovis, an additional $4.9 million for operating capital through a line of credit and an interest bearing note in the amount of $1,605,563. (Exhibit 32). Additionally, BCBSM agreed to guarantee Innovis obligations in connection with a credit agreement with US Bank up to $30 million. *(Id.)*

The ground-breaking for Innovis was held in June 1998 and Innovis' first patient was admitted on November 1, 2000.

In June 2005, BCBSM "resigned" its interest in Innovis. In return, BCBSM was paid the amounts it had loaned to Innovis together with interest and a credit guarantee fee, for a total payment of $17,997,000. (Exhibit 33).

BCBSM indicates that it was paid the amounts it loaned Innovis at the agreed upon market rate. (Exhibit 34). While the building housing Dakota Clinic and Innovis had an assessed value of $54.9 million on land appraised at $3.6 million, it does not appear that BCBSM received any payment for its interest in Innovis. *(Id.)* In fact, it appears that BCBSM received nothing more than the loaned amounts it was already entitled to receive.

At the time of the sale, BCBSM reportedly stated:

> Innovis has grown and stabilized to the point where we felt Blue Cross funds were no longer needed.

(*Id.*)

The 2004 and 2003 audited financial statements of Innovis reported excess revenue over expenses of $6.4 million and $4.7 million, respectively.

BCBSM's responsibility under the Nonprofit Health Service Plan Corporation's Act is to promote the economical and timely availability of healthcare services for the people of Minnesota through its nonprofit prepaid health service plans.[11] It is not clear how BCBSM's participation in the financing of a North Dakota hospital benefited its Minnesota subscribers. BCBSM is not a financial institution. It is not a lender. It is a Minnesota nonprofit organization with a special responsibility to Minnesotans. Yet, it financed a significant share of the costs for the out-of-state hospital and likely committed staff and other resources to the enterprise. Not only does it appear that BCBSM received no overall financial benefit as a result of this transaction, but the venture put premium dollars at risk and appears to have conveyed no benefit to BCBSM subscribers.

F. Creation of a Blues' Bank.

Recent media accounts have indicated that a number of Blue Cross Blue Shield organizations, including BCBSM, are forming a bank -- the Blue Healthcare Bank -- which will administer health savings accounts for their members. (Exhibit 48). In addition to administering health savings accounts, the bank will issue Visa debit cards that can be used by members of the various Blues' plans. (*Id.*) The bank is to be based in Salt Lake City, Utah and is scheduled to

[11] Minn. Stat. § 62C.01, subd. 2 (2004).

open in early 2007. A spokesperson for the Blue Cross Blue Shield Association refused to comment on the cost of launching the bank or the income that it may generate. *(Id.)*

The Blue Healthcare Bank appears to be simply stated, a for-profit financial institution. As a bank engaged in selling financial products, its purpose is to generate profit. The use of BCBSM's premium dollars to underwrite this endeavor does not appear to be consistent with BCBSM's role under Minnesota law as a nonprofit organization charged with making health coverage more available and affordable.

III. ADMINISTRATIVE EXPENSES.

A. Significance of Administrative Expenses

Dramatic increases in premiums for private health insurance have made health coverage unavailable for some and unaffordable for many. In Minnesota and throughout the nation, premiums for private health insurance have been growing at or near double digit rates, substantially outpacing growth in incomes, wages, and general inflation.[12]

In August 2005, the Minnesota Department of Health published an issue brief discussing the trends in health insurance premiums and assessing what accounted for the dramatic increase in premium rates over the past several years.[13] The report stated that administrative spending was the fastest growing category of spending,[14] increasing 14.5% during that two year period. In contrast, the cost of physician services during the same period increased by only 2.8 percent.

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[12] *Trends in Private Health Care Insurance Premiums and Cost Drivers, 2004,* Minnesota Department of Health, Issue Brief 2005-02, August 2005.

[13] *Id.*

[14] The Department's analysis was based on nonpublic data reported to the Department by health plans representing approximately 85 percent of the fully-insured private health insurance market in Minnesota. *Id.*

Because administrative costs appear to be one of the key drivers of premium increases and because of BCBSM's unique duty to "promote a wider, more economical and timely availability of ... health services for the people of Minnesota,"[15] its administrative costs were analyzed as part of this compliance review.

B. BCBSM's Administrative Expenses

1. The administrative expense ratio reported by BCBSM in public documents is misleading.

BCBSM has entered into administrative service agreements with each of its affiliates[16] pursuant to which BCBSM provides the affiliates with the "necessary staff, office space, furniture, equipment, utilities, office supplies and services" for the affiliate to conduct its business.[17] An example of the administrative services agreements is attached. (Exhibit 3).

The administrative services agreements between BCBSM and its affiliates do not set forth a specific payment required to be paid by the affiliates for the services provided by BCBSM. Rather, the agreements state that if an employee performs services for solely BCBSM or solely the affiliate, the cost of the services will be allocated directly to BCBSM or the affiliate. (*Id.*) The agreements go on to state that where such a direct allocation is not made, joint expenses will be allocated between BCBSM and the affiliate "on an appropriate permissible basis." (*Id.*) The "appropriate permissible basis," however, is not defined.

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[15] *See* Minn. Stat. § 62C.01, subd. 2 (2004).

[16] BCBSM has entered into administrative services agreements with Aware Integrated, Inc.; Atrium Health Plan, Inc.; BHSI, Inc.; BCBSM Foundation; Blue Plus; Care Delivery Management, Inc.; Comprehensive Managed Care, Inc; Comprehensive Care Services, Inc.; Employer Provider Network; MII, Inc.; MII Agency, Inc.; MII Life; Minnesota Institute of Public Health; Pharmacy Gold, Inc.; and MII Services, Inc.

[17] The only affiliate which employs its own employees and appears to operate somewhat autonomously is First Plan of Minnesota, a wholly-owned subsidiary of BCBSM which operates as an HMO in northern Minnesota.

There are a number of various administrative services agreements or services agreements between BCBSM and its affiliates or between various affiliates. The purpose of certain agreements is not clear and, in some cases, is counterintuitive. For example, BCBSM had previously entered into administrative services agreements with each of Comprehensive Care Services, Inc. ("CCS") and Care Delivery Management, Inc. ("CDMI"), pursuant to which BCBSM provided all the administrative and support services necessary for each of those companies to operate their businesses. (Exhibits 4 and 5). Yet, on October 28, 2002, CCS and CDMI entered into their own services agreement pursuant to which CCS markets CDMI Services and CCS collects fees on behalf of CDMI. (Exhibit 6). However, neither CCS nor CDMI have their own employees, and BCBSM provides all staff and other administrative support necessary for CCS and CDMI to conduct their businesses. As a result, the purpose of the services agreement between CCS and CDMI is unclear.

As noted above, in the financial statements filed with the Minnesota Department of Commerce, BCBSM offsets its total administrative expenses with the reimbursements it receives from its affiliates under the terms of the administrative service agreements. BCBSM also offsets its administrative expenses with the monies it receives for administering self-insured plans. The "net" amount of administrative expense which is reflected in the annual statements BCBSM filed with the Minnesota Department of Commerce is set forth in Table 3.

Table 3.

BCBSM'S REPORTED ADMINISTRATIVE EXPENSES*					
2005	2004	2003	2002	2001	2000
$178,277,726	$171,216,703	$144,751,611	$128,777,556	$135,374,902	$84,812,683
*Source: Annual Statements of the BCBSM, Inc. d/b/a Blue Cross Blue Shield of Minnesota as of December 31, 2004 and December 31, 2005.					

Prior to 2001, BCBSM internally measured administrative costs as a percentage of premium, resulting in an administrative expense ratio. In 2001, the company shifted from assessing its costs as an administrative expense ratio to measuring administrative costs on a per-member per-month ("PMPM") basis.

Based on its calculation of administrative costs on a PMPM basis, BCBSM publicly reports that it has been able to hold administrative costs flat for several years. As reported in the November 17, 2003 issue of *Managed Care Week:*

> [BCBSM] said last week that it would eliminate 130 jobs from its workforce of 4,100 employees, as part of an effort to *hold administrative costs flat on a per member per month basis for the fifth year in a row.*

(Exhibit 8).

Indeed, late last year, BCBSM claimed that administrative expenses were actually going *down*. (Exhibit 9).

In assessing the actual amount of BCBSM's administrative expenses, the AGO reviewed the financial statements that BCBSM filed with the Minnesota Department of Commerce as well as BCBSM's internal financial statements. The findings of that review set forth below.

2. BCBSM's administrative costs have dramatically increased -- by almost 65 percent during the review period.

(a) Expenses attributed to BCBSM's fully insured business have increased.

As noted above, BCBSM determines its administrative costs for its health-related business on a PMPM basis. In the financial statements BCBSM filed with the Department of Commerce, the amount of administrative expenses reported excludes, among other things, administrative expenses attributed to BCBSM's self-insured business. Accordingly, in determining the amount that the reported expenses represent on a per member per month basis, self-insured members are not included. This calculation, as of December 31, 2005, is set forth in Table 4.

Table 4.

BCBSM's 2005 Administrative Expenses Per Member Per Month ("PMPM") Insured Business	
Administrative Expenses as reported in Annual Statement	$178,277,726
Number of Insured Members	743,355
Number of Member Months (743,355 x 12)	8,920,260
Total Administrative Expenses PMPM ($178,277,276 ÷ 8,920,260)	**$19.99**

*Source: *See* Table 1; Exhibit 2.

According to the above, BCBSM spent $19.99 per member per month on administrative costs attributable to its insured business in 2005.

The amount of administrative expenses PMPM for BCBSM's insured members, as of December 31, 2000, was also calculated by the AGO and is set forth in Table 5.

Table 5.

BCBSM's 2000 Administrative Expenses Per Member Per Month ("PMPM")	
Administrative Expenses as reported in Annual Statement	$84,812,683
Number of Insured Members	582,315
Number of Member Months (582,315 x 12)	6,987,780
Total Administrative Expenses PMPM ($84,812,683 ÷ 6,987,780)	**$12.14**

*Source: *See* Table 1; Exhibit 2.

The above reflects that BCBSM spent $12.14 per member per month on administrative costs in 2000. These figures show that, instead of remaining "flat" as reported by BCBSM, BCBSM's administrative expenses per member per month for its insured business actually increased *by approximately 65%* in just five years.

(b) BCBSM's internal documents reveal dramatic increase in total administrative costs.

The Condensed Consolidating Statements of Income of BCBSM's parent, Aware Integrated, Inc., were reviewed to determine BCBSM's overall administrative expenses.[18] (Exhibit 10). The Condensed Consolidating Statements of Income break-out the total amount of administrative expenses incurred by BCBSM as well as the amount of administrative expenses allocated to BCBSM's affiliates. Further, the amount of "administrative expenses" in the consolidating statements appears to include all of BCBSM's administrative expenses, including

[18] The AGO received such statements for the years December 31, 2000 through December 31, 2004.

those attributed to BCBSM's administration of self-insured plans. BCBSM's administrative costs,[19] as reflected in these financial documents, are set forth in Table 5.

Table 5.

BCBSM's Administrative Costs Reflected in Aware Integrated, Inc.'s Condensed Consolidating Statements of Income					
	2004	**2003**	**2002**	**2001**	**2000**
Administrative Expenses	$511,785,000	$329,930,000	$313,084,000	$276,290,000	$261,770,000
Assessments and Surcharges	50,428,000	25,844,000	20,979,000	17,848,000	18,109,000
Brokers' Fees	--[20]	66,056,000	61,307,000	58,709,000	55,229,000
Income Tax Expense	8,155,000	(6,432,000)	21,177,000	7,624,000	11,633,000
Correction of Pension Error	12,050,000	--	--	--	--
Total Administrative Costs	**$582,418,000**	**$415,398,000**	**$416,547,000**	**$360,471,000**	**$346,741,000**

Table 5 shows that BCBSM's overall administrative costs increased from $346,741,000 in 2000 to $582,418,000 in 2004.[21] This increase -- *of over 67 percent* -- is almost identical to the percentage increase in administrative expenses per member per month for BCBSM's insured business. While BCBSM's membership increase during this period would have accounted for

[19] For purposes of this analysis, the monies allocated to administrative and other expenses by BCBSM were taken at face value. As discussed in note 25, however, BCBSM's allocation of certain expenses as "non-administrative" has been questioned by other parties in the past. Any reallocation of such expenses from medical care to administrative expense would obviously increase the percentage of revenue which is attributable to administrative expenses.

[20] Brokers' fees appear to have been included in the general "administrative expenses" account in 2004.

[21] On a per member per month basis, administrative expenses for BCBSM's insured and self-insured business combined increased from $17.73 in 2000 to $22.98 in 2004. *See* Table 5 and Exhibit 2.

part of the increase in administrative costs, BCBSM's membership increased only 29% during the period.[22] Accordingly, it is unclear on what basis BCBSM can claim that its administrative costs have remained flat, let alone gone down.

3. Examples of BCBSM's administrative expenses.

(a) Salaries.

Salaries and benefits represent a significant portion of BCBSM's administrative costs. During 2004, BCBSM's total payroll was $277,889,546,[23] consisting of salaries and benefits for 3,779 employees (or 2,338 FTEs). (Exhibits 11, 12 and 13). While the number of BCBSM employees grew approximately 21% from 2000 to 2004, its total payroll grew *by almost 43%* during the four-year period. (Exhibits 11 and 12). These amounts do not include the millions of dollars BCBSM paid to temporary help agencies and consultants during 2004 to supplement the work of its staff.

Minnesota's health insurance industry ranks second in the nation in terms of the average amount of wages paid to its employees.[24] In other words, in only one state is the average health insurance employee paid more than in the State of Minnesota. A recent study of Minnesota's health insurance industry indicates that the average 2004 wage in Minnesota's health insurance

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[22] BCBSM's total membership in 2000 was 1,630,143; its total members in 2004 were 2,111,896. (Exhibit 2).

[23] This figure appears to represent the total amount of salaries and benefits for employees of BCBSM, including those employees who perform services for BCBSM's affiliates.

[24] *An Economic Pillar: An Analysis of Minnesota's Insurance Carrier Industry*, The Minnesota Department of Employment and Economic Development, September 2005.

industry was $89,829 -- an increase of 60% since 1998.[25] BCBSM's average annual salary in 2004 was even higher, amounting to $91,262.87 per employee.[26]

While health plans routinely point to the costs of medical and hospital care as the reason for increased insurance costs, it is interesting to note that many medical professionals are paid on average far less than the typical BCBSM employee. For example, the average 2004 salary for certain healthcare providers in Minnesota are set forth below:

PRACTITIONER	Mean 2004 Salary
Audiologists	$56,140
EMTs and Paramedics	$29,390
Home Health Aides	$21,580
Licensed Practical Nurses	$34,160
Medical and Clinical Lab Technicians	$36,170
Occupational Therapists	$49,170
Pharmacists	$88,240
Physician Assistants	$70,690
Registered Nurses	$57,130

(Exhibit 14).[27]

There is something intuitively wrong with a healthcare system in which those who perform the administrative work to pay for healthcare services are paid more than the persons who provide the healthcare services. It is questionable whether BCBSM's growth in administrative expenses is consistent with its statutory charge to make health services more economical for the people of Minnesota.[28]

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[25] *Id.*

[26] Based on information provided by BCBSM indicating that it employed 2,338 FTEs in December, 2004 and that the total amount of salaries it paid in 2004 was $213,372,583. (Exhibits 11 and 13).

[27] Information obtained from the United States Census Bureau.

[28] *See* Minn. Stat. § 62C.01, subd. 2 (2004).

(b) Questionable payments classified as medical care costs.

The Attorney General's Office was not able to review each expenditure of BCBSM to determine whether it was appropriately classified as an administrative expense or a medical care cost.[29] Nonetheless, questionable classifications of certain expenses as medical care costs became apparent during the compliance review.

Prior to 2004, BCBSM classified the following expenses as medical claims: fees paid by BCBSM to other Blues' plans so that its members could access their physician networks when traveling out-of-state; payments for pharmacy benefit management; millions paid to "disease management" firms; and payments for BCBSM's "Healthy Start" program in which expectant mothers receive Target and WalMart gift certificates to participate in the care support program. (Exhibit 52). The amount of these payments in 2003 totaled approximately $86 million. (*Id.*) It can be questioned whether these costs should be labeled as medical claim costs. Yet, BCBSM included them in its calculation of medical costs, which would have allowed it to use these costs to justify increases in premiums.

In 2004, BCBSM was required under newly adopted national accounting standards to remove these costs from its calculation of medical claims. (Exhibit 53).

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[29] In at least two audits of BCBSM and its affiliates, however, auditors did identify costs that were inappropriately reported. First, the Office of the Wisconsin Commissioner of Insurance, in its audit of Atrium Health Plan as of December 31, 2002, noted that Atrium was not properly allocating a portion of a capitation expense for its Medicaid population to administrative expenses. According to the Commissioner, "[r]eporting the amount of capitation entirely as medical expenses skews the company's administrative and loss ratios." (Exhibit 15). Second, the financial review of BCBSM conducted by the Blue Cross Blue Shield Association in May 2001 noted that BCBSM was inappropriately recording access fees as an administrative expense reimbursement rather than as income. (Exhibit 16).

(c) Other administrative expenses.

A significant portion of BCBSM's activities do not relate to the direct reimbursement of healthcare costs. Rather, BCBSM devotes a large portion of its resources to other activities including the development of programs, the conducting of surveys, various political and lobbying activities, and a number of projects whose purpose is difficult to ascertain. Some of these costs are designated by BCBSM as "administrative expenses"; others are classified as "other expenses" or paid out of funds BCBSM transferred to its affiliated foundation. Examples of activities conducted by BCBSM during the review period include:

- Conducted the *"do"* campaign, a multi-year campaign to encourage physical activity which cost more than $9 million. (Exhibit 50). Part of the program included having a "do crew" scout neighborhoods looking for residents who were being physically active, such as shoveling snow or raking their lawns. When they spotted such activity, the "do crew" handed out "rewards" such as T-shirts, water bottles and ice scrapers. (Exhibit 19).

- Conducted "Minnesota Decides Forums" in 2001 and 2004. While the public purpose of the forums -- which were chaired by a former congressman who announced his candidacy for governor just months after the 2001 forums were held -- was to "discover what Minnesotans think about the healthcare system," BCBSM's internal documents state that the purpose of the forums was to "shape the external environment," *i.e.* the public debate, concerning healthcare. (Exhibit 17). During the 2004 forums, twenty communities were visited by BCBSM staff. Each forum was preceded by meetings between BCBSM staff and local groups, businesses and the media. (*Id.*)

- Held "Meet the Candidates" sessions through "Citizen Blue," BCBSM's grassroots employee organization "promoting good citizenship and political education." (Exhibit 18).

- Established "Dollars for Doers" pursuant to which BCBSM forwards $200 to each nonprofit organization where one of its employees volunteered at least 40 hours of time. (Exhibit 20). Organizations that received funds through this program include the North East Soccer Association, Rainbow Animal Rescue, Inc., the White Bear Lake Area Historical Society, the Boy Scouts of America, the Chameleon Theatre Circle, and The Eagan Heights Figure Skating Club. (Exhibit 21).

- Annually compensated employees for up to 20 hours each for volunteering their time to charities. (Exhibit 22). In 2003, BCBSM paid for 7,000 hours of such time -- this is roughly the equivalent of three full-time employees. (*Id.*)

- Created a division of "Business Intelligence and Informatics" responsible for the "acquisition, analysis, and communication of member, clinical and business information." (Exhibit 23).

- Established the "Minnesota Local Health Care Information Infrastructure," intended to "leverage BCBSM's knowledge of transaction clearing and its infrastructure to jump start a community cooperative". (Exhibit 24).

- Established "Champions of Health," a program pursuant to which BCBSM's "prize patrol" provides a $500 health-related donation on behalf of individuals and organizations that go "above and beyond" to promote "health and wellness". (Exhibit 25).

- Surveyed at least 9,000 members per month in addition to performing other surveys regarding a variety of subjects including the incidence, consequences and public attitudes towards obesity. (Exhibits 26 and 27).

- Commissioned a survey by "Decision Resources" regarding whether Minnesotans supported a dollar boost in the cigarette tax and, thereafter, launched a drive to persuade legislators and the Governor to approve a $1 a pack increase in the cigarette tax. (Exhibit 28).

Many of the above projects have likely educated Minnesotans on various health-related issues. Other programs have recognized individuals or organizations that provide an important health-related benefit or service. In conducting this compliance review of BCBSM, however, the issue is not whether the above programs are worthwhile. Rather, the issue is whether these projects should be funded by BCBSM -- an organization whose sole source of operating revenue is healthcare premiums.

4. Summary.

There is no transparency to BCBSM's administrative costs. BCBSM's allocation of these costs to various affiliates and its practice of "netting" its reported administrative expenses by deducting amounts received from self-insured plans and others make it very difficult to determine what are BCBSM's actual administrative costs and whether BCBSM is efficiently using its healthcare dollars. Based on the information obtained in this compliance review, it

appears, at a minimum, that BCBSM's actual administrative costs are significantly higher than it has publicly reported.

IV. CONCLUSION.

As noted elsewhere in this report, BCBSM is organized under the Nonprofit Health Service Plan Corporations Act, the purpose of which is "to promote a wider, more economical and timely availability of hospital, medical-surgical, dental and other health services for the people of Minnesota, through nonprofit, prepaid health service plans, and thereby advance public health and the art and science of medical and health care within the state". Minn. Stat. § 62C, subd. 2 (2004). Accordingly, there is one single responsibility of nonprofit health service plan corporations:

- They will provide prepaid health service plans that will promote more affordable and available health services for the people of Minnesota.

It is this standard, and those generally borne by nonprofit organizations, by which BCBSM's activities should be judged.

Based on this compliance review, it is clear that BCBSM's focus has strayed from the goal of providing affordable prepaid health service plans. This is a regulatory concern in that BCBSM does not appear to be focusing on its statutorily-defined purpose. It is also a public concern in that, at this time of skyrocketing healthcare premiums, BCBSM does not appear to be efficiently using healthcare dollars.

Individuals, small businesses and large businesses alike are feeling the devastating impacts of rising healthcare costs. While many of BCBSM's activities described in this report may have raised the awareness of certain healthcare issues and had a general community benefit, the question is whether BCBSM should be utilizing healthcare premiums for these purposes. It would be interesting to ask BCBSM's subscribers if they want their premium dollars used for

Target and WalMart gift certificates; for contributions to various nonprofit and charitable organizations; for the holding of forums to "shape the healthcare environment" or to "promote good citizenship and political education." Do subscribers want their premiums used for layer upon layer of healthcare bureaucracy including not only the direct provider of healthcare but "disease management companies," "care support programs," "utilization reviewers" and similar programs which have not been proven to reduce healthcare costs but clearly add to both the cost and complexity of our current healthcare system.[30] While the answers to these questions are beyond the scope of this review, further examination of these issues is clearly needed.

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[30] *See, e.g.* Congressional Budget Office, *An Analysis of the Literature on Disease Management Programs*, October 13, 2004; Feldstein, Mary Jo, *Disease Management Falls Short as Means to Control Costs*, St. Louis Post-Dispatch, October 2, 2004.

Notes to Financial Statement

an interest bearing note in the amount of $1,605,563. Additionally, BCBSM and Dakota Clinic have agreed to guarantee Innovis obligations in connection with a credit agreement by and between U.S. Bank, BCBSM and Dakota Clinic in an amount not to exceed $60,000,000. Innovis pays a fee to BCBSM and Dakota Clinic under the terms of the credit agreement. With accrued interest the total due to BCBSM from Innovis was $17,221,000 as of December 31, 2004. An allowance of $9,702,000 has been recorded for potential impairment, including $1,312,000 and $1,361,000 charged to income in 2004 and 2003, respectively.

In 2002 BCBSM, Blue Plus and Dakota Clinic, Ltd. reached a decision to terminate the Joint Venture and Affiliation Agreement ("Affiliation Agreement") that the parties entered into on December 30, 1994. As a result of such decision and the fact that the covenant for the Dakota Clinic to continue to operate independently under that agreement no longer had value to BCBSM and Blue Plus, a total of $16,200,000 was written off in 2002. BCBSM's share of the loss was $8,100,000. On April 30, 2003 the parties formally terminated the Affiliation Agreement. Other covenants and agreements between the parties relating to the purposes of the affiliation, including a commitment from Dakota Clinic to continue to operate independently in return for a financial commitment from BCBSM and Blue Plus through 2014, were terminated on that date. BCBSM and Blue Plus as the terminating parties paid a termination payment to Dakota Clinic in the amount of $29,764,244 in 2003 in accordance with the termination provisions of the Affiliation Agreement. This final payment, including repayment of a $27,000,000 note payable and interest, resulted in BCBSM reporting a net gain in 2003 equal to $3,468,591. BCBSM's share of the termination payment and the final payment are $14,882,122 and $13,500,000, respectively. Dakota Clinic continues as a participating provider with BCBSM and Blue Plus.

During 1999, BCBSM along with its joint venture partner Affiliated Community Medical Centers, P.A. (ACMC) agreed to guarantee the repayment of up to $15,000,000 of term debt of their joint venture, Affiliated Community Health Network, Inc. (ACHN). In January 2005, BCBSM agreed to guarantee the obligations of ACHN under a refinanced loan of approximately $14,800,000. While the terms of the guarantee provide for the joint and several liability of BCBSM and ACMC, the two have executed a related contribution agreement whereby each pledges to contribute equally to any payments that would be required under the guarantee.

On December 20, 2002 BCBSM revised its guarantee of the obligation of Riverbend Community Health Network, Inc. in connection with the financing of costs related to the development of a medical office campus in Mankato, Minnesota to be leased by Mankato Clinic, Ltd. and Orthopedic & Fracture Clinic, P.A. together with an ambulatory surgery center to be operated by Mankato Ambulatory Surgery Center, LLC, so that BCBSM's guarantee is now $5,600,000. Mankato Clinic has agreed to share liability for the obligation in an amount equal to 50%, leaving BCBSM with a liability of up to $2,800,000.

F. Material Management, Service Contracts, or Cost Sharing Arrangements

Under terms of contractual agreements for reimbursement of administrative expenses, BCBSM acts as the control plan for various national groups, processes claims under administrative service contracts and provides certain operating and administrative services to wholly-owned subsidiaries and affiliated corporations and served as the writing carrier for the Minnesota Comprehensive Health Association in 2003. BCBSM charged $429,570,000 in 2004 and $386,277,000 in 2003 for services performed under these agreements. These charges are recorded as reductions in administrative expense in the accompanying financial statements.

Included in the total charges for services are charges of $86,494,000 and $88,282,000 in 2004 and 2003, respectively, that were allocated to its wholly-owned subsidiaries and affiliated corporations and other Aware subsidiaries.

BCBSM

		Dec 2000	Dec 2001	Dec 2002	Dec 2003	Dec 2004
Fully Insured						
	Minnesota	531,252	528,705	530,514	551,833	583,994
	Non Minnesota	51,063	53,525	102,558	113,564	118,089
	NAIC Filing total	**582,315**	**582,230**	**633,072**	**665,397**	**702,083**
Self Insured	Minnesota	662,401	669,960	623,817	635,743	604,777
	Non Minnesota	385,427	434,894	662,583	772,089	805,036
Self Insured	CCS	195,252	252,168	238,921	260,361	283,451
	Grand Total	1,825,395	1,939,252	2,158,393	2,333,590	2,395,347

ADMINISTRATIVE SERVICES AGREEMENT
between
BCSBM FOUNDATION, INC. d/b/a BLUE CROSS AND BLUE SHIELD OF MINNESOTA FOUNDATION
and
BCBSM, INC. d/b/a BLUE CROSS AND BLUE SHIELD OF MINNESOTA

CONFIDENTIAL

This Agreement is made and entered into on this 7th day of FEB., 2000, by and between BCBSM Foundation, Inc. d/b/a Blue Cross and Blue Shield of Minnesota Foundation, a Minnesota nonprofit corporation (hereinafter referred to as the "**Foundation**"), and BCBSM, Inc. d/b/a Blue Cross and Blue Shield of Minnesota, a Minnesota nonprofit health service plan corporation (hereinafter referred to as "**BCBSM**").

WITNESSETH

WHEREAS, BCBSM has amassed considerable administrative and operational experience and has necessary equipment and staff to carry on diverse corporate activities; and

WHEREAS, the Foundation seeks the most cost effective and economical means to accomplish its charitable, religious, educational and scientific purposes; and

WHEREAS, the Foundation desires to enter into an agreement with BCBSM to enable it to take advantage of the administrative and operational experience of BCBSM in order to achieve its corporate objectives.

NOW, THEREFORE, it is hereby agreed as follows:

1. BCBSM agrees to provide the Foundation with necessary staff, office space, furniture, equipment, utilities, office supplies and services for the Foundation to conduct its activities.

2. BCBSM further agrees, to the extent allowable by law without jeopardizing the Foundation's tax-exempt status, to:

a. Permit financial reviews of BCBSM's books and records relating to this Agreement by the Foundation Board or an outside accounting firm identified by the Foundation Board or such governmental agencies as required by law;

b. Invest Foundation funds to the extent not required for operation in accordance with the financial policies adopted by the Foundation;

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c. Prepare and file reports with governmental agencies as may be required by law;

d. Procure and maintain such policies of general liability, professional liability and other insurance, naming the Foundation as a named insured, necessary for the reasonable protection of the interests of the Foundation, its employees, officers and directors; and

e. Provide such other services necessary for the successful operation of the Foundation as mutually agreed upon between the Foundation and BCBSM.

3. The Foundation Board shall retain ultimate and exclusive control over all matters relating to the management and operation of Foundation. and BCBSM shall be considered as an independent contractor herein. Nothing herein shall be construed to create any agency relationship between the parties.

4. The Foundation and BCBSM shall, directly or through independent auditors selected by each at its own expense, have access to the records, accounts and files maintained by the other in connection with this Agreement, with the right to make copies.

5. The Foundation shall pay BCBSM for any personal services provided by BCBSM under this Agreement based upon the actual expenses and costs of these services. The total combined personal services expenses and costs of BCBSM and the Foundation shall be allocated to BCBSM and the Foundation through the application of cost accounting procedures applicable to a joint operation. In general, the cost accounting procedures and allocations are to conform with the instructions contained in the Examiner's Handbook, National Association of Insurance Commissioners. Accordingly, whenever possible, salaries of employees whose work is solely in connection with BCBSM or the Foundation will be allocated directly to BCBSM or the Foundation, respectively. Similarly, other personal services expense items incurred for the primary benefit of BCBSM or the Foundation will be allocated directly to either BCBSM or the Foundation. When a direct allocation to either BCBSM or the Foundation is not made, such items of expense will be considered a joint expense of BCBSM and the Foundation to be allocated to both BCBSM and the Foundation on an appropriate permissible basis.

6. The allocation of costs and expenses to the Foundation are understood to fall within the scope of examination of the independent public accountants employed by BCBSM and the Foundation as well as the State of Minnesota Department of Commerce, Department of Health, Department of Labor and Industry, Internal Revenue Service, and other authorized government agencies. For convenience, BCBSM may pay all of the expenses and costs of both BCBSM and the Foundation, so that allocations will be from BCBSM to the Foundation only, provided that any personal services related to investment services performed directly for the benefit of the Foundation will be paid directly by the Foundation. However, the Foundation shall have sole discretion to pay

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directly any distribution or expenditure made in furtherance of its charitable, religious, educational and scientific purposes.

7. Nothing in this Agreement shall be construed or interpreted so as to require the Foundation to use the services provided by BCBSM if such use would jeopardize the Foundation's tax exempt status.

8. The Foundation agrees to hold BCBSM harmless from any claims whatsoever made against BCBSM or the Foundation by any party who alleges injuries resulting from BCBSM's compliance with the terms and conditions of this Agreement. BCBSM agrees to hold the Foundation harmless from any claims whatsoever made against the Foundation by any party who alleges injuries resulting from BCBSM's breach of the terms and conditions of this Agreement.

9. In the event that notice of intent to terminate this Agreement is given, BCBSM agrees to deliver to the Foundation at least three (3) months prior to the date of termination all applications, contracts, records, documents and papers pertaining to the operations of the Foundation at the request of the Foundation, provided that if any such applications, contracts, records, documents or other papers shall also pertain to any other business operated by BCBSM, then BCBSM may furnish copies or facsimiles thereof.

10. This Agreement constitutes the entire administrative services agreement between the Foundation and BCBSM related to the services described herein and all prior or contemporaneous agreements, whether written or oral, are hereby superseded.

11. This Agreement may be amended at any time if the amendment is mutually agreed upon and executed by BCBSM and the Foundation.

12. Either party may terminate this Agreement by giving notice of such intent to terminate in writing twelve (12) months before the effective date of such termination.

IN WITNESS WHEREOF, the parties have executed this Agreement as of the date first above written.

BCBSM Foundation, Inc. d/b/a Blue Cross and Blue Shield of Minnesota Foundation

By: Daniel J. [illegible]
Its: Executive Director

BCBSM, Inc. d/b/a Blue Cross and Blue Shield of Minnesota

By: Timothy M. Peterson
Its: VP Finance, CFO

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December 30, 1999

ADMINISTRATIVE SERVICE AGREEMENT

between

CC SYSTEMS CORPORATION

and

BLUE CROSS AND BLUE SHIELD OF MINNESOTA

COPY

This agreement, made this 1st day of January, 1987, by and between CC Systems Corporation, a corporation organized under the laws of the State of Minnesota (hereinafter referred to as "CCSC"), and Blue Cross and Blue Shield of Minnesota, a non-profit health service corporation organized under the laws of the State of Minnesota (hereinafter referred to as "BCBSM").

CONFIDENTIAL

WITNESSETH:

WHEREAS, BCBSM has amassed considerable administrative and operational experience and has necessary equipment and staff to carry on diverse corporate activities; and

WHEREAS, BCBSM has employed personnel formerly associated with CCSC and is willing to provide CCSC with the services of such staff; and

WHEREAS, CCSC desires to enter into an agreement with BCBSM to enable it to take advantage of the administrative and operational experience of BCBSM in order to achieve its corporate objectives;

NOW THEREFORE, IT IS HEREBY AGREED AS FOLLOWS:

1. BCBSM agrees to provide all staff, office space, furniture, equipment, utilities, office supplies and services necessary for CCSC to conduct its activities;

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2. BCBSM further agrees to:

a. Permit financial reviews by the CCSC Board or an outside accounting firm identified by the CCSC Board or such governmental agencies as required by law.

b. Invest CCSC funds to the extent not required for operation in accordance with the financial policies adopted by CCSC.

c. Prepare and file reports with governmental agencies as may be required by law.

d. Procure and maintain such policies of general liability, professional liability and other insurance, naming CCSC as a named insured, necessary for the reasonable protection of the interests of CCSC, its employees, officers and directors.

e. Provide such other services necessary for the successful operation of CCSC as mutually agreed upon between CCSC and BCBSM.

3. The CCSC Board shall retain ultimate and exclusive control over all matters relating to the management and operation of CCSC, and BCBSM shall be considered as an independent contractor herein. Nothing herein shall be construed to create any agency relationship between the parties.

4. CCSC and BCBSM shall, directly or through independent auditors selected by each at its own expense, have access to the records, accounts and files maintained by the other in connection with this agreement, with the right to make copies.

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5. CCSC shall pay BCBSM for the services described in this agreement based upon the expenses and costs of these services. The total combined expenses and costs of BCBSM and CCSC shall be allocated to BCBSM and CCSC through the application and cost accounting procedures applicable to a joint operation. In general, these allocations are to conform to the instructions contained in the Examiner's Handbook, National Association of Insurance Commissioners. Accordingly, whenever possible, salaries of employees whose work is solely in connection with BCBSM or CCSC will be allocated directly to BCBSM or CCSC, respectively. Similarly, other expense items incurred for the primary benefit of BCBSM or CCSC will be allocated directly. When a direct allocation to either BCBSM or CCSC is not made, such items of expense will be considered as a joint expense of BCBSM and CCSC to be allocated to both BCBSM and CCSC on an appropriate permissible basis.

The allocation of costs and expenses to CCSC are understood to fall within the scope of examination of the independent public accountants employed by BCBSM and CCSC as well as any authorized government agency. For convenience, BCBSM may continue to pay all of the expenses and costs of both BCBSM and CCSC, so that allocations will be from BCBSM to CCSC only except that investment expenses incurred directly for the benefit of CCSC will be paid directly by CCSC.

To facilitate monthly settlements, estimated charges may be rendered by BCBSM to CCSC subject to final settlement to recognize the cost of allocations referred to above.

BCBSM may offset payments due to CCSC against amounts that BCBSM may be currently owed from CCSC under this or any other agreement. CCSC may offset payments due to BCBSM against amounts that CCSC may be currently owed from BCBSM under this or any other agreement.

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6. CCSC agrees to hold BCBSM harmless from any claims whatsoever made against BCBSM or CCSC by any party who alleges injuries resulting from BCBSM's compliance with the terms and conditions of this agreement.

7. In the event notice of intent to terminate this agreement is given, BCBSM agrees to deliver to CCSC at least three (3) months prior to the date of termination all applications, contracts, records, documents and papers pertaining to the operations of CCSC at the request of CCSC, provided that if any such applications, contracts, records, documents or other papers shall also pertain to any other business operated by BCBSM, then BCBSM may furnish copies, photostats or facsimiles thereof and the cost of preparing such copies, photostats and facsimiles shall be shared equally by CCSC and BCBSM.

8. This agreement constitutes the entire agreement between CCSC and BCBSM and all prior or contemporaneous agreements, whether written or oral, are hereby superseded.

9. This agreement may be amended at any time if the amendment is mutually agreed upon and executed by BCBSM and CCSC.

10. Either party may terminate this agreement by giving notice of such intent to terminate in writing three (3) months before the effective date of said termination.

CC SYSTEMS CORPORATION	BLUE CROSS AND BLUE SHIELD OF MINNESOTA
By:	By:
Name:	Name:
Position:	Position:
Date: 12/20/86	Date:

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Jim Benefits Lawyer

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ADMINISTRATIVE SERVICE AGREEMENT

between

CARE DELIVERY MANAGEMENT, INC.

and

BLUE CROSS AND BLUE SHIELD OF MINNESOTA

This agreement, made this 1st day of July, 1994, by and between Care Delivery Management, Inc., a corporation organized under the laws of the State of Minnesota (hereinafter referred to as "CDMI"), and Blue Cross and Blue Shield of Minnesota, a nonprofit health service corporation organized under the laws of the State of Minnesota (hereinafter referred to as "BCBSM").

WITNESSETH:

WHEREAS, BCBSM has amassed considerable administrative and operational experience and has necessary equipment and staff to carry on diverse corporate activities; and

WHEREAS, CDMI is newly organized and without staff or facilities, and desires to enter into an agreement with BCBSM to enable it to take advantage of the administrative and operational experience of BCBSM in order to achieve its corporate objectives;

NOW, THEREFORE, IT IS HEREBY AGREED AS FOLLOWS:

1. BCBSM agrees to provide all staff, office space, furniture, equipment, utilities, office supplies and services necessary for CDMI to conduct all of its activities;

2. BCBSM further agrees to:

   a. Permit financial reviews by the CDMI Board or an outside accounting firm identified by the CDMI Board or such governmental agencies as required by law.

   b. Invest CDMI funds to the extent not required for operation in accordance with the financial policies adopted by CDMI.

   c. Prepare and file reports with governmental agencies as may be required by law.

   d. Procure and maintain such policies of general liability, professional liability and other

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insurance, naming CDMI as a named insured, necessary for the reasonable protection of the interests of CDMI, its employees, officers and directors.

e. Provide such other services necessary for the successful operation of CDMI as mutually agreed upon between CDMI and BCBSM.

3. The CDMI Board shall retain ultimate and exclusive control over all matters relating to the management and operation of CDMI, and BCBSM shall be considered as an independent contractor herein.

4. CDMI and BCBSM shall, directly or through independent auditors selected by each at its own expense, have access to the records, accounts and files maintained by the other in connection with this agreement, with the right to make copies.

5. CDMI shall pay BCBSM for the services described in this agreement based upon the expenses and costs of these services. The total combined expenses and costs of BCBSM and CDMI shall be allocated to BCBSM and CDMI through the application and cost accounting procedures applicable to a joint operation. In general, these allocations are to conform to the instructions contained in the Examiner's Handbook, National Association of Insurance Commissioners.

Accordingly, whenever possible, salaries of employees whose work is solely in connection with BCBSM or CDMI will be allocated directly to BCBSM or CDMI, respectively. Similarly, other expense items incurred for the primary benefit of BCBSM or CDMI will be allocated directly. When a direct allocation to either BCBSM or CDMI is not made, such items of expense will be considered as a joint expense of BCBSM and CDMI to be allocated to both BCBSM and CDMI on an appropriate permissible basis.

The allocation of costs and expenses to CDMI are understood to fall within the scope of examination of the independent public accountants employed by BCBSM and CDMI as well as the State of Minnesota Department of Commerce, Department of Health, Department of Labor and Industry, and any other authorized government agency. For convenience, BCBSM may pay all of the expenses and costs of both BCBSM and CDMI, so that allocations will be from BCBSM to CDMI only except that investment expenses incurred directly for the benefit of CDMI will be paid directly by CDMI.

To facilitate monthly settlements, estimated charges may be rendered by BCBSM to CDMI subject to final settlement to recognize the cost of allocations referred to above.

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6. CDMI agrees to hold BCBSM harmless from any claims whatsoever made against BCBSM or CDMI by any party who alleges injuries resulting from BCBSM's compliance with the terms and conditions of this agreement. BCBSM agrees to hold CDMI harmless from any claims whatsoever made against CDMI by any party who alleges injuries resulting from BCBSM's breach of the terms and conditions of this agreement.

7. In the event notice of intent to terminate this agreement is given, BCBSM agrees to deliver to CDMI at least three (3) months prior to the date of termination all applications, contracts, records, documents and papers pertaining to the operations of CDMI at the request of CDMI, provided that if any such applications, contracts, records, documents or other papers shall also pertain to any other business operated by BCBSM, then BCBSM may furnish copies, photostats or facsimiles thereof and the cost of preparing such copies, photostats and facsimiles shall be shared equally by CDMI and BCBSM.

8. This agreement constitutes the entire agreement between CDMI and BCBSM and all prior or contemporaneous agreements, whether written or oral, are hereby superseded.

9. This agreement may be amended at any time if the amendment is mutually agreed upon and executed by BCBSM and CDMI.

10. Either party may terminate this agreement by giving notice of such intent to terminate in writing twelve (12) months before the effective date of said termination.

IN WITNESS WHEREOF, the parties have executed this agreement as of the date first above written.

CARE DELIVERY MANAGEMENT, INC.

By: Norman C. Storbakken

Name: Norman C. Storbakken

Position: Chief Executive Officer

Date: July 11, 1994

BLUE CROSS AND BLUE SHIELD OF MINNESOTA

By:

Name: Andrew P. Czajkowski

Position: President

Date: July 11, 1994

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SERVICE AGREEMENT

between

COMPREHENSIVE CARE SERVICES, INC.

and

CARE DELIVERY MANAGEMENT, INC.

This Agreement is made this 28th day of October 2002, by Comprehensive Care Services, Inc., a corporation organized under the laws of the State of Minnesota (hereinafter referred to as "CCS") and Care Delivery Management, Inc., a corporation organized under the laws of the State of Minnesota (hereinafter referred to as "CDMI").

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WITNESSESTH:

WHEREAS, CCS is an experienced third party administrator having a considerable number of self-insured clients, and CCS also integrates third party services to its clients; and

WHEREAS, CDMI performs a broad array of managed care interface support services for insured and self-insured health plans; and

WHEREAS, CDMI and CCS desire to enter into an agreement by which CCS markets CDMI's services to CCS' clients and collects fees on behalf of CDMI; and

WHEREAS, CDMI and CCS are affiliated corporations and both have entered into Administrative Service Agreements with Blue Cross and Blue Shield of Minnesota dealing with their financial reviews, audit procedures, policies of liability insurance, legal services and other support staffing, office space, furniture, equipment and other business services;

NOW THEREFORE, THE PARTIES AGREE AS FOLLOWS:

A. CCS agrees to:

1. Train CCS marketing staff on the services that CDMI makes available to its self-insured employers and other self-insured entities;
2. Present CDMI proposals for third party administration including managed care interface support services, pricing and informational literature to self-insured employers and other self-insured entities as a component of the integrated services CCS provides;
3. Enter into third party administrator services contracts with self-insured employers and other self-insured entities that include provision of CDMI managed care interface support services to such self-insured employers and other entities and also include language that clearly states that the self-insured employer or other entity retains sole authority and responsibility to determine eligibility for benefits, adjudicate claims and construe their plan documents;
4. Enroll self-insured employers' and other self-insured entities' eligible members with indicators as to which self-insured employers and other self-insured entities have purchased

CDMI managed care interface support services for their eligible members and make such member information available to CDMI;

5. Bill and collect payment from self-insured employers and other self-insured entities for third party administration services including CDMI's managed care interface support services at the rates reflected in part B below, as they may be adjusted from time to time by one hundred twenty (120) days prior written notice from CDMI to CCS, such revised fees to take effect for existing CCS customers at time of their renewal; and
6. Transfer to CDMI that portion of the total third party administration fees collected for managed care interface support services provided by CDMI.

B. CDMI agrees to:

1. Hire and train licensed healthcare professionals skilled in performing managed care interface support services for self-insured employers and other self-insured entities;
2. Obtain and use guidelines such as the Milliman and Roberts protocol, adopted by CDMI from time to time, for determining medically necessary and appropriate lengths of stay, taking into account the recommendations of each patient's physician or other service provider;
3. Make services available via telephone access during the hours of 8:00 a.m. through 4:30 p.m. Central Time, Monday through Friday with the exception of CCS and CDMI holidays as published by CCS and / or CDMI from time to time and communicated to the clients in writing;
4. Verify coverage for eligible members prior to performing managed care interface support services; and
5. Perform the appropriate managed care interface support services as detailed in and at the initial fees stated in Options 1 and 2 below for the eligible members.

   a. Option 1 Services at $2.25 per employee per month (or such other fee or percent of total administrative fee as agreed upon by CDMI and CCS for a specific client or group of clients):

      Preadmission Notification
      Concurrent Review / Discharge Planning
      Medical Review / Prior Authorization
      Case Management
      Medical Policy / Technology Assessment Services
      Utilization Review
      Program Integrity (Fraud and Abuse)
      Mental Health Review
      Chemical Dependency Review

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b. Option 2 Services at $2.00 per employee per month (or such other fee or percent of total administrative fee as agreed upon by CDMI and CCS for a specific client or group of clients):
All of the services in Option 1 except for mental health / chemical dependency review

6. Provide CCS with one hundred twenty (120) days advance written notice of any changes to the fees stated in part 5 above, such revised fees to take effect for existing CCS customers at time of their renewal.

C. Relationship of the Parties

The CCS Board shall retain ultimate and exclusive control over all matters relating to the management and operation of CCS, and the CDMI Board shall retain ultimate and exclusive control over all matters relating to the management and operation of CDMI. The relationship between CCS and CDMI shall be that of independent contractors, and nothing herein shall be construed to create any agency relationship between CCS and CDMI.

D. Independent Audit

CCS and CDMI shall, directly or through independent auditors selected by each at its own expense, have access to the records, accounts and files maintained by the other in connection with this Agreement, with the right to make copies.

E. Compensation

1. CDMI shall be compensated according to the fees set forth in part B above and collected by CCS on behalf of CDMI. Such fees may be adjusted by CDMI from time to time and take effect as self-insured employers and other self-insured entities first become effective or renew their third party administrator agreements with CCS. CCS shall owe no additional amounts to CDMI, nor shall CDMI attempt to collect any further amounts on the basis of this Agreement from CCS and / or the self-insured employer or other self-insured entity.
2. CCS shall be compensated according to the third party administration handling or processing fees, less any amounts paid to CDMI and/or other entities for which CCS bills and collects fees, that CCS negotiates with the self-insured employers or other self-insured entities. CCS shall not bill to or attempt to collect any fees from CDMI for work performed on behalf of CDMI pursuant to this Agreement.

F. Hold Harmless

1. CDMI agrees to hold CCS harmless from any claims whatsoever made against CCS or CDMI by any party who alleges injuries resulting from CCS' compliance with the terms and conditions of this Agreement.
2. CCS agree to hold CDMI harmless from any claims whatsoever made against CCS or CDMI by any party who alleges injuries resulting from CDMI's compliance with the terms and conditions of this Agreement.

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G. Termination

1. Either party may terminate this Agreement at any time by giving the other party written notice of intent to terminate at least three (3) months in advance of the effective date of said termination.
2. In the event notice of termination this Agreement is given, CCS and CDMI shall deliver to each other, at least three (3) months prior to the date of termination, all applications, contracts, records, documents and papers pertaining to their operations as described herein and as requested by CCS and / or CDMI, provided that if any such applications, contracts, records, documents and papers also pertain to any other business of CCS and / or CDMI, then CCS and CDMI may furnish copies, photostats and facsimiles thereof and the cost of preparing such copies, photostats and facsimiles shall be shared equally by CCS and CDMI.

H. Entire Agreement

This Agreement constitutes the entire agreement between CCS and CDMI as to self-insured employers and other self-insured entities, and all prior or contemporaneous agreements, whether written or oral, are hereby suspended.

I. Amendment

This Agreement may be amended from time to time by mutual written agreement of the parties executed by CCS and CDMI.

CCS and CDMI accept this Agreement as indicated below:

COMPREHENSIVE CARE SERVICES, INC.	CARE DELIVERY MANAGEMENT, INC.
By: Lois J Stevens (Signature)	By: Gregory Larson (Signature)
Lois Stevens (Typed Name)	Gregory Larson (Typed Name)
Title: President	Title: President
Date: 10-28-02	Date: 10-31-02

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APPROVED

COPY

RECIPROCAL ADMINISTRATIVE SERVICE AGREEMENT BETWEEN FIRST PLAN OF MINNESOTA AND BLUE CROSS AND BLUE SHIELD OF MINNESOTA

THIS AGREEMENT, made this 5th day of October, 2000, by and between First Plan of Minnesota (formerly known as Community Health Center, Inc. of Two Harbors, Minnesota) (FP), a Minnesota nonprofit corporation, and Blue Cross and Blue Shield of Minnesota (BCBSM), a Minnesota nonprofit health service plan corporation:

RECITALS

Whereas, FP and BCBSM are nonprofit corporations engaged in providing, or making arrangements for the provision of, high quality health care services on an economic and timely basis to the residents of the state of Minnesota and others;

Whereas, FP operates a health maintenance organization (HMO) and provides HMO services to its enrollee members pursuant to HMO contracts administered by a staff of officers, managers, health care providers and other administrative and health care employees

Whereas, BCBSM has a large staff with considerable administrative and operational experience in the health care field; and

Whereas, FP and BCBSM entered into a Reciprocal Service Agreement on or about February 14, 1990, as amended, to enable each party, at its discretion, to take advantage of the administrative and operational experience of the other party, to provide for a loan and reserve guarantee arrangement from BCBSM to FP which will permit a return to BCBSM on the cost of any funds advanced to FP, and to otherwise provide the terms of the administrative services and financial arrangements between FP and BCBSM. FP and BCBSM desire that this agreement supersede such Reciprocal Service Agreement now in effect and dated February 14, 1990, as amended.

NOW, THEREFORE, in consideration of, and subject to, the following terms and conditions, the parties hereto agree as follows:

1. At the request of one of the parties to the other, the other party agrees to make available any or all of, without limitation, the following administrative services or provider contracts:

1.1. Marketing and sales support, including the marketing of FP's HMO contracts with various BCBSM health services contracts, and various health maintenance

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and insurance contracts available through BCBSM's HMO and insurance affiliates and subsidiaries.

1.2 Accounting and financial services, including cost accounting services, and underwriting, actuarial and statistical services.

1.3 Printing of contracts, brochures and other documents, including multicolored printing.

1.4 Computer services and data processing support services as may be necessary to prepare and maintain enrollee files and billing procedures, claims adjudication and payment, and other required functions.

1.5 Make adjustments necessary for payment from responsible third parties for health care services rendered to the enrollees of each party hereto.

1.6 Receive, maintain records of, and attempt to resolve any complaints or grievances about either party in accordance with the grievance procedures established by the respective parties.

1.7 Conduct negotiations with health care professionals and organizations for their participation with each party, and periodically provide such participating health care professionals and organizations with information about each party.

1.8 Prepare and file reports with governmental agencies as may be required by law.

1.9 Prepare and provide eligibility information to health care professionals and organizations that have entered into contracts with either party for the provision of health care services, and to other organizations which require such information.

1.10 Investment services for funds in accordance with the financial policies adopted by the board of directors or board of trustees of each party.

1.11 Management information system support services that will generate information needed for reports required by the State of Minnesota, the federal government and management. Such reports shall include financial reports, utilization data, enrollment and eligibility data, and quality of care data.

1.12 Procure and maintain such policies of general liability, professional liability and other insurance, naming the party for whose protection the insurance is obtained as a named insured, necessary for the reasonable protection of the interest of the party, its employees, officers and directors.

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1.13 Make available for use by the other party or by its affiliates all provider contracts on a contract by contract basis, subject to the authority of each party to make such contracts available by assignment or otherwise, and subject further to the terms and conditions of such contracts.

1.14 Provide such other services as may be necessary for the operation of one of the parties and as mutually agreed to between the parties.

1.15 Provide an individual BCBSM health service contract, without requiring evidence of good health, to FP enrollees whose coverage under their FP contract has terminated, to enrollees who relocate outside a FP service area, or to enrollees in the event of dissolution or liquidation of FP. FP enrollees shall be given the choice of selecting a Qualified Plan 1,2, or 3 as provided by Minnesota Statutes Section 62E.06, Subdivisions 1 to 3.

2. All FP officers, managers, doctors and other administrative and health care employees shall, after this Agreement is executed, continue as administrative or health care employees of FP in accordance with any employment contract entered into between FP and the employee, or in the absence of an employment contract, shall otherwise continue employment at the discretion of the FP President in accordance with FP's personnel policies and procedures, as may be established by FP from time to time. Provided, however, at the request of the FP President, BCBSM will consider employment of one or more of FP administrative or health care employees, and BCBSM may, in its discretion, employ such person or persons in such capacity as may be agreed to between BCBSM and the FP President.

The President of FP shall be appointed by the President of BCBSM to the BCBSM senior management group and shall be entitled to participate as a member of the senior management group and shall be eligible, so long as the senior management group remains eligible, to attend regular BCBSM Board of Trustees' meetings, and as required by the President of BCBSM, shall attend BCBSM Executive Committee and other Board or Committee meetings.

3. The FP board of directors shall retain ultimate and exclusive control over all matters relating to the management and operation of FP and BCBSM shall be considered an independent contractor herein. Without limiting the generality of the foregoing, the FP board of directors shall have the exclusive right to determine:

3.1 FP's marketing plan, including the content of marketing literature and publicity material.

3.2 The terms and conditions of any contract/certificate issued by FP.

3.3 Underwriting policies and decisions, including rating and the subscription charges for each such contract/certificate issued.

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3.4 The persons or groups eligible to subscribe to such contracts/certificates and become enrollees of FP.

3.5 Financial policies, including matters dealing with reserves and investments.

3.6 Arrangements between FP and independent marketers.

3.7 The validity of any claim made for the payment for services rendered to any enrollee or beneficiary.

4. FP and BCBSM shall have access, directly or through independent auditors selected by each at its own expense, to the records, accounts and files maintained by the other exclusively for use in connection with this Agreement, with the right to make copies.

5. Each party shall perform the services specified in this Agreement in such a manner that the confidentiality of health records of the enrollees or subscribers of the other party will be maintained.

6. Each party shall pay the other party for the administrative services provided pursuant to the Agreement based upon the expenses and costs of these services, except as provided hereinafter. The total combined expenses and costs of BCBSM and FP shall be allocated to BCBSM and FP through the application and cost accounting procedures applicable to a joint operation. In general, these allocations are to conform to generally accepted cost accounting standards and/or any other agreed upon procedures. Accordingly, whenever possible, salaries of employees whose work is solely in connection with BCBSM or FP will be allocated directly to BCBSM or FP, respectively. Similarly, other expense items incurred for the primary benefit of BCBSM or FP will be allocated directly. When a direct allocation to either BCBSM or FP is not made, such items or expense will be considered as a joint expense of BCBSM and FP to be allocated to both BCBSM and FP on an appropriate permissible basis.

In consideration of advancement of funds by BCBSM to FP in accordance with this Agreement, except as provided in another loan agreement or other obligation between the parties, FP shall pay to BCBSM an amount as a cost of investment based on the annual average return on BCBSM short term investments during each calendar year under this Agreement times the outstanding balance of funds advanced.

The allocations of costs and expenses to each party are understood to fall within the scope of examination of the independent public accountants employed by BCBSM and FP, as well as the State of Minnesota Department of Commerce, the Minnesota Department of Health, the United Stated Department of Health and Human Services, and any other authorized government agency. At the request of FP, BCBSM will pay all of

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the expenses and costs of both BCBSM and FP so that the allocations will be from BCBSM to FP only, except that investment expenses incurred directly for the benefit of FP will be paid directly by FP.

To facilitate monthly settlements, estimated charges may be rendered by one party to the other party subject to final settlement to recognize the cost of allocations referred to above.

7. BCBSM agrees to provide funds as may be requested by FP to enable FP to satisfy FP's net worth, deposit and free reserve requirements set forth in Minnesota Statutes, Chapter 62D. In the event of operating deficits which may be incurred by FP, BCBSM agrees to make necessary contributions or advancements to FP to maintain FP's free reserve for future care and contingencies at the greater of $500,000 or at such level as may be required for FP to meet statutory or regulator reserve requirements, if any.

In the event of an order for rehabilitation or liquidation of FP, BCBSM shall, unconditionally and upon demand, make any additional contributions to FP which are necessary during the period which it was in rehabilitation or prior to termination of business upon liquidation to allow FP to fund any contractual or other financial obligations FP has entered into, including, but not limited to any contractual obligation to provide coverage to enrollees under the terms and conditions of the enrollee's contract with FP. BCBSM shall pay or reimburse the Commissioners of Health and Commerce for all costs and expenses, including reasonable attorney's fees and costs, incurred by the Commissioners in connection with the protection, defense, or enforcement of the guarantee.

Provided, however, at no time shall BCBSM be obligated to advance funds or make additional contributions to FP if BCBSM does not meet its statutory reserve requirements under Minnesota Statutes Chapter 62C, if the advancement or contribution of such funds would cause BCBSM to fall below 2.2 months of its statutory reserve requirements, or if the issuance of a Surplus Note or advancement or contribution of funds is not authorized by law or regulatory authority.

If BCBSM would not have statutory reserves of at least 2.75 months after advancement of funds in consideration for any such Surplus Note pursuant to this Agreement, the Surplus Note shall not be issued until 30 days after the Commissioners of Commerce and Health have received notice of it, or a shorter period the Commissioners permit, and the Commissioners have not disapproved the issuance of the Surplus Note within that time.

In consideration of advancement of funds by BCBSM to FP, except as provided in another loan agreement or other obligation between the parties, FP shall issue one or more Surplus Notes to BCBSM, upon request of BCBSM, in such form substantially similar to the attached Exhibit A and on such terms agreed to between the parties. Such Contribution Notes shall provide for repayment for all or a portion of these funds to

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BCBSM- 025322

BCBSM, provided that repayment shall be made only at such times as FP's funds exceed any minimum statutory requirements, including deposit requirements and reserve requirements, as determined by FP.

FP agrees that to the extent it receives future transfers, advances or other contributions form BCBSM or any affiliate where BCBSM or the affiliate expects repayment, FP shall have the authority to repay BCBSM or the affiliate only if such sums are fully reflected as legal obligations on the books, records and financial statements of FP. FP agrees that it will issue no notes, certificates, guarantees or other agreements for the repayment of money to BCBSM or an affiliate which have or will purport to have retroactive effect.

8. BCBSM shall waive all defenses and claims it may have or FP may have pertaining to the guarantee, including, but not limited to, waiver, release, res judicata, statute of frauds, lack of authority, usuary and illegality. BCBSM shall also waive present demand for payment, notice of dishonor or nonpayment and protest, and the Commissioners of Commerce and Health shall not be required to first resort for payment to other sources or other means before enforcing the guarantee. BCBSM waives its rights under the Federal Bankruptcy Code, United States Code, title 11, section 303, to initiate involuntary proceedings against FP and agrees to submit to the jurisdiction of the Commissioners of Commerce and Health and Minnesota state courts in any rehabilitation or liquidation of FP. The guarantee will not be waived, modified, amended, terminated, released, or otherwise changed except as provided by this Agreement, and as provided by applicable statutes.

9. BCBSM shall pay or reimburse the Commissioners of Health and Commerce for all costs and expenses, including reasonable attorney's fees and costs, incurred by the Commissioners in connection with the protection, defense, or enforcement of Section 7 of this Agreement.

10. FP agrees to indemnify and hold BCBSM harmless from any claims whatsoever made against BCBSM or FP by any party who alleges injuries resulting from the rendering by anyone of health care services to enrollees of FP. FP shall provide adequate insurance, or shall require that each health care professional organization under contract to provide health care services to FP's enrollees have adequate insurance, against any liability claims arising from the provision of health services to FP enrollees.

11. In the event notice of intent to terminate this Agreement is given at the request of FP, BCBSM agrees to deliver to FP as least three (3) months prior to the date of termination, all applications, contracts, records, documents, and papers pertaining to the operations of FP in BCBSM's possession, provided, that if any such documents also pertain to any other business operated by BCBSM, then BCBSM may furnish copies, Photostats or facsimiles thereof, and the cost of preparing such copies, Photostats and facsimiles shall be shared equally by FP and BCBSM.

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12. This Agreement shall be governed by and construed and enforced according to the laws of the state of Minnesota, and must be approved by the Commissioner of Health. This agreement constitutes the entire agreement between FP and BCBSM and all prior or contemporaneous agreements, whether written or oral, are hereby superseded. This agreement may be amended at any time if the amendment is mutually agreed upon and executed by BCBSM and FP, provided that a copy of the amendment shall be filed with the Minnesota Department of Health.

13. Either party may terminate this Agreement at the end of any calendar year by giving written notice to the other and to the Minnesota Department of Health of such intent to terminate at least twelve (12) months before the effective date of termination.

IN WITNESS WHEREOF, the parties have executed this Agreement as of the date first written above.

FIRST PLAN OF MINNESOTA

By: _____
Its: President / CEO

BLUE CROSS AND BLUE SHIELD OF MINNESOTA

By: _____
Its: President & CEO

COMMISSIONER OF HEALTH
OF THE STATE OF MINNESOTA

By: _____

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BCBSM- 025324

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Insurers Ratchet Down Admin. Spending Via Layoffs, Reduced Commissions, IT Efforts

Reprinted from the Nov. 17, 2003 issue of MANAGED CARE WEEK, the industry's leading source of business, financial and regulatory news of HMOs, PPOs, and POS plans. Visit the MANAGED CARE WEEK page for more information.

Only a few insurers that release **administrative** spending statistics report the figure has dipped below 10% of operating revenue. But some firms said they are narrowing the gap, aided by work-force reductions and a sharper focus on other costs, including broker commissions, claims-processing expenses and real estate fees.

Sierra Health Services, Inc. said it reduced **administrative** spending to 8.7% of revenue from

Disease Management
Blue Cross and Blue Shield
Managed Medicare
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10.4% for the third quarter of 2002 and from 9.1% for the second quarter of 2002. CFO Paul Palmer said the lower rate of spending was partly driven by higher revenue. Premium revenue grew 11% during the third quarter of 2003 to $243 million from $218 million for the same period last year.

Blue Cross and Blue Shield of **Minnesota** also has whittled spending to below the 10% mark. In fact, that insurer said last week that it would eliminate 130 jobs from its work force of 4,100 employees, as part of an effort to hold **administrative** costs flat on a **per-member per-month** basis for the fifth year in a row. The **Minnesota** Blues plan said it expects an **administrative** expense ratio of 6.4% in 2004, down from 9.2% in 2000.

Both Sierra and the **Minnesota** Blues plan may be aided by the fact that they can leverage **administrative** spending over a relatively large membership base in a narrow geographic area. But competitors in other areas also are coming closer to the goal of reducing the **administrative** expense ratio to below 10%.

Coventry Health Care, Inc. spent 11.9% of revenue on **administrative** items during the third quarter of 2003, compared with 12.2% for the same period in 2002. "Over the longer view, it has to get to single digits," said CEO Allen Wise. "The single biggest uncontrolled piece [of **administrative** spending] continues to be the broker commission area, where we're making scant progress." The other two cost increase drivers are financial incentives paid to executives and internal sales staff members, he said.

But Wise cautioned that **administrative** spending as a percentage of revenue wouldn't cross the 10% line immediately. "We have to continue to grow and have to find a way to pay the brokers fairly, but halt the escalation [in spending], and that's work in progress," Wise said. "Like everything else [that] has happened here, it will be progress over years, not weeks or months."

Oxford Health Plans, Inc. also is within striking distance of 10%. That insurer had a third-quarter 2003 **administrative** expense ratio of 10.7%, excluding a recovery of $14.3 million related to securities litigation. That's an improvement from 10.9% during the same period last year.

One-third of that insurer's spending comes from broker commissions and premium taxes, amounting to $48 million during the third quarter of 2003, compared with $43 million in the 2002 quarter. Next year, these items could comprise 35% of total **administrative** spending, said CFO Kurt Thompson.

It's not driven so much by aggressive increases in broker commissions as by the fact that the company's product mix has changed, said CEO Charles Berg. "There is some pretty aggressive broker compensation going on out there," he said, "but, you know, we've pretty much held the line. I think we're at the sweet spot, if you will, for a plan of our type in the marketplace."

The insurer also is focusing on driving up electronic claims processing and other high-tech customer service functions. About 70% of claims are processed electronically, Thompson said.

Falling Membership Drives Up Ratio

Companies in transition have a more complex **administrative** cost picture. Aetna, Inc., which has shed 6.3 million members since Dec. 31, 2000, has a higher **administrative** cost ratio than some competitors, in part because reductions in overhead spending haven't kept pace with plummeting enrollment.

The company spent 22.1% of revenue on operating expenses for the third quarter of 2003, compared with 21.8% in the same period last year. But it has realized a $172 million decline in **administrative** spending reductions in the first nine months of 2003, compared with the prior year, and said it's on track to remove about $200 million in annual spending by the end of 2003. Over the past three years, Aetna has cut $700 million in operating expenses, or nearly 15% of the 2000 spending level.

For 2004, Aetna said it should cut spending on sales, general and **administrative** items by another $50 million. The company will increase expenses associated with direct sales to members by $100 million as it adds a projected 400,000 to 650,000 new members during the course of the year. But that should be more than offset by a $150 million cut in **administrative** spending.

Some of the savings will come from real estate initiatives, said CFO Alan Bennett. The company is

restructuring its leasing arrangements to emphasize higher occupancy levels and fewer square feet per person.

Similarly, CIGNA Corp. has said a key priority of its ongoing turnaround effort is "improving operating efficiency and our **administrative** cost position," according to CEO Edward Hanway. But as CIGNA's total enrollment continues to fall, the insurer must continue to reduce operational expenses to keep them in line. To do so, the company is using attrition and layoffs, undergoing a system conversion and working to cut the cost of outside purchased services.

The company expects the 2004 **administrative** cost ratio for **administrative**-services-only HMO customers to be about 13% for full-year 2003.

Executives made their comments during separate conference calls to discuss third-quarter 2003 financial results with investors and analysts.

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Good News for Small Business: Premium Increases at Blue Cross Are the Lowest in Years

Generic drugs, disease management, HSAs, internal efficiencies slowing the increases

EAGAN, Minn., Aug. 27 /PRNewswire/ -- While health care costs continue to spiral upwards nationally -- a Hewitt study for 2004 cited 12-15 percent increases -- small businesses with **Blue Cross** and Blue Shield of **Minnesota** health plans will pay, on average, only 7 to 8 percent more for renewals beginning in October.

"This is great news for small businesses," said Sandy Shapiro, vice president for community accounts at **Blue Cross**. "Small businesses, those with 50 or fewer employees, have been hit with double-digit increases every year for the past five or six years, and now we're seeing some solid payoff for our efforts to reign in the costs."

Although specific rates will vary depending upon claims histories and benefit changes, Shapiro said that **Blue Cross'** average rates are now among the lowest in the market. The 7 to 8 percent increase compares with 13 percent verage increases for 2003 and 2004.

Blue Cross attributes the drop in premium increases to both external and internal factors including efforts by **Blue Cross** to curb the rising cost of health care through disease management, consumer-directed health plans, lower pharmaceutical trends and **administrative** efficiencies.

What's causing **Blue Cross'** to have lower premiums than other plans?

-- Disease management programs: **Blue Cross** supports people with any of more than 30 chronic conditions ranging from heart disease and cancer to asthma and low back pain. It is the country's most extensive disease management program and saw significant cost savings and improved health for members in the first year. Members in the program endured fewer emergency room visits and hospital stays, and enjoyed better health. By helping people live healthier, the program saved more than two dollars for every dollar invested in the program.

-- Consumer-directed health plans: **Blue Cross** was the first health plan locally to offer HSA accounts earlier this year, to go along with HRA accounts that empower consumers with spending accounts and cost and quality tools about providers, while offering employers a means to share some of the rising costs instead of dropping coverage altogether.

-- Prescription Drugs: The availability of some drugs as generics (Prozac) or over-the-counter (Claritin) has helped to slow the increase in pharmaceutical costs. For example, Prozac became available as a generic (fluoxetine) in August of 2001. In only a year's time, **Blue Cross'** total spending on Prozac dropped by $11 million. Generic drugs contain the same active ingredient as brand name drugs, but cost much less. In addition, the use of certain drugs, such as hormone replacement for

women, has slowed as a result of new information about these drugs.

-- **Administrative** efficiencies: **Blue Cross** has worked to maintain among the lowest **administrative** costs in the industry, holding **administrative** costs flat, on a **per member per month** basis, for five years. It's currently less than 7 percent. One way we've done that is through electronic claims processing. For every one percent increase in the rate that claims come in and pass through our system electronically, we save about $500,000.

-- Passing along financial successes: Also, because **Blue Cross** has enjoyed strong operating results in 2003 and 2004, we are able to be more optimistic with our rate projections, effectively passing these favorable results back to our members.

"We've been working hard to identify some of the key drivers of health care costs and address them -- whether it's helping people live healthier with chronic conditions, providing new products for businesses, or using technology to reduce health care costs," said Shapiro. "Health plans need to get ahead of these causes, and we're starting to see results at **Blue Cross**."

Blue Cross and Blue Shield of **Minnesota**, with headquarters in the St. Paul suburb of Eagan, was chartered in 1933 as **Minnesota's** first health plan and continues to carry out its charter mission today: to promote a wider, more economical and timely availability of health services for the people of **Minnesota**. A not-for-profit, taxable organization, **Blue Cross** is the largest health plan based in **Minnesota**, covering 2.6 million members in **Minnesota** and nationally through its health plans or plans administered by its affiliated companies. **Blue Cross** and Blue Shield of **Minnesota** is an independent licensee

of the **Blue Cross** and Blue Shield Association, headquartered in Chicago.

Editors note: Attached is a fact sheet describing some of the key drivers of health care costs. Please contact us for more information or interview.

Key Factors Driving Health Care Costs

Several factors help to explain the increase in underlying health care spending, which is ultimately reflected in soaring health care premiums. Unlike the pricing of consumer products, which is based on supply and demand, health care premium pricing is much more complicated. Health care premium increases are currently driven by consumers using more services, and higher prices charged by doctors, hospitals, and other providers.

A PricewaterhouseCoopers analysis for 2002 found that the 13.7 percent increase in health care costs that year broke out this way: Three percent for technology and pharmaceutical advancements; 2.5 percent for rising provider expenses; 2.5 percent for general inflation; 2 percent for increased consumer demand; 2 percent for government mandates and inflation; 1 percent for litigation; and .7 percent for fraud, abuse and other costs. Let's set the stage and then examine some of those key areas.

Health care costs nationally

-- Americans spent $1.4 trillion on health care in 2003 -- 14 percent of the country's economy (BCBSA).

-- Employers face premium increases averaging 12.6 percent in 2004 after 14.7 percent jump in 2003 (Hewitt Associates).

-- Yearly premiums in 2003 averaged $3,383 for a single person and $9,068 for a family (Kaiser Foundation).

-- For each dollar an employee pays for health insurance, their employer

typically pays $4-$5. Still, the average contribution by employees for family coverage has gone up 50 percent -- up to $2,412 -- over the cost three years ago.

– Medical inflation is rising more than five times as fast as the prices for other goods and services (WSJ); however, it is less than in previous years, due primarily to lower pharmaceutical increases, and less hospital utilization.

Health care costs in **Minnesota**

– Minnesotans spent more than $23 billion on health care in 2003 (MDH). For that investment, **Minnesota** is the healthiest state in the country, according to UnitedHealth Foundation, and premium increases here continue to be lower than national trends.

-- Private sector costs for health care in **Minnesota** rose 10.5 percent in 2003, slowing after a 15.5 spike the year before.

– Health care costs for Twin Cities employers increased about 12.5 percent in 2004 (Hewitt Associates).

-- Consumers are being asked to share more of the burden, paying almost 12 percent of the total premium costs in 2003, up from 9 percent in 1997 (MDH).

-- Contrary to public perception, **administrative** expenses have decreased over the past three years and constitute less than 7 cents of each premium dollar at **Blue Cross** -- among the lowest in the country.

Technology

Medical technology saves lives, improves health, decreases pain, increases function and enhances lifestyles. But it also accounts for a significant and

growing portion of total health care costs. According to a 2001 report by the Project HOPE Center for Health Affairs, medical technology was responsible for 39 percent of U.S. health care costs in 1999, up from 12 percent in 1994. And it continues to grow. For example, **Blue Cross'** commercial business' payments related to several cardiovascular and orthopedic devices increased by 19.2 percent in 2002. With coated stents and other innovations now reaching the market, these costs will continue to grow.

- Increased use and cost of pharmaceuticals
  - -- **Blue Cross'** expenditures for prescriptions in 2002 grew 17.7 percent per member, compounding a 22.7 percent increase in 2001.
  - -- We're getting more prescriptions: Nationally, the average number of prescriptions per person in the U.S. population rose from 7.3 in 1992 to more than 10 per person in 2002 (BCBSA). Medications are now used more aggressively to manage chronic diseases such as high cholesterol, diabetes, and many other previously untreatable conditions.
  - -- Each prescription costs more: The average cost of each prescription grew 10.1 percent in 2001, the second straight year of double-digit increases.
    - Use of name-brand drugs is up, due to direct-to-consumer advertising and increased marketing to physicians. While Pepsi spent $125 million advertising its soda in 2000, the manufacturer of Vioxx, a nonsteriodal anti-inflammatory, spent $160 million. Not surprisingly, the average prescription for a name-brand drug costs $72; the average FDA-approved generic equivalent costs $22 (2003, BCBSA).
    - Mergers and acquisitions within the pharmaceuticals industry are

driving up the cost of many highly prescribed drugs. Four drug companies control more than 85 percent of the market for antidepressants, antihistamines, anti-anxiety drugs and beta-blockers for hypertension.

– Fortunately, a few blockbuster drugs such as Claritin, Glucophage, Prilosec, Prinivil, and Prozac, recently have become available over-the-counter or lost their exclusive patent -- allowing less expensive equivalents to enter the market.

Rising clinic/hospital costs

-- Physician and hospital services accounted for 32 and 35 percent of growth in health care spending in 2003, respectively (MDH). More than half of **Blue Cross'** total trend increases over the past three years have been due to increases in the provider payments and changes in the types of services.

– Inpatient hospital services are the biggest component of health care spending, comprising nearly one-third of each dollar spent.

-- Rising clinic/hospital costs are due in part to inadequate reimbursement from Medicare and other government programs, which forces hospitals and clinics to charge more to commercial payers to make up the difference -- an estimated $281 million for **Minnesota's** hospitals in 2000 (MHA).

-- Other factors for providers: rising labor costs (nursing shortages), malpractice insurance premiums, and energy costs; new medical technologies and consolidation leading to less competition and increasing leverage for hospitals and clinics to negotiate higher

payments from health plans.

-- **Minnesota** hospitals are in the midst of a building boom (more than $1.45 billion new or remodeled facilities announced as of October 2002) that dwarf the amount from previous years and has contributed to increases in payments, raising questions about whether there is a medical arms race in areas such as cancer, heart, and orthopedic care.

Increased patient demand

-- More conditions are treatable than ever before. For example, inpatient and outpatient surgeries, including such procedures as knee surgery, hip replacements, etc., rose by 14.1 and 9.2 percent respectively in 2002 from the previous year, pushing up the rates of X-ray and lab services by more than 7 percent.

-- One example: Twenty years ago, there wasn't much doctors could do for a torn ACL (knee). But with better treatments and increasing participation in youth sports, knee surgeries for young men and women (under age 18) increased 16.8 and 10.4 percent, respectively, from 1998-2000 among **Blue Cross** members. Another example: Preventive services, such as mammograms and vaccinations, increased nearly 5 percent in 2002.

-- An aging population: People in general are living longer and using more services. **Blue Cross'** experience shows that the cost of claims for people 50-64 years old are 2.3 times the cost of claims for people 0-49 years old. Keep in mind that the first Baby Boomers turned 57 this year. During the next 10 years, the number of Minnesotans age 45 and older is expected to balloon 25 percent (NIHP).

– Chronic diseases: The Centers for Medicare and Medicaid Services (CMS) predicts a 10-percent increase over the next 10 years in the number of people with chronic illnesses.

- **Blue Cross** has targeted a number of chronic conditions/diseases that affect between 17 percent of a commercial, the sufferers of which account for nearly half of all expenditures by a health plan.

- **Blue Cross** has been able to support members with these conditions and save an estimated $36 million in claims costs in just 12 months -- mostly by helping people avoid preventable hospital stays and trips to the emergency room. Projecting over 18 months, **Blue Cross'** overall annual trend for the fully insured commercial population will improve 2-3 percent as a result of the program.

Government mandates and taxes

Employers pay up to 8 percent of their premium dollar just for taxes on the health care system. In fact, between 20-25 percent of premiums paid for state-regulated health care in **Minnesota** are due to state taxes and mandates, which fall disproportionately on small employers (MCHP).

Fraud/Abuse

Between 3 and 5 percent of the $1.4 trillion spent on health care in the United States each year is lost to fraud -- $35 billion to $60 billion annually (BCBSA). In 2003, **Blue Cross** and Blue Shield of **Minnesota** stopped payment on more than $8.7 million in fraudulent claims through fraud investigations.

+++

Aware Integrated, Inc.

Condensed Consolidating Balance Sheet

December 31, 2000
(In Thousands)

	BCBSM, Inc.	First Plan	Blue Plus	Atrium	MII, Inc.	Eliminating Entries	Consolidated BCBSM	For-Profit Entities	Aware Integrated
Assets									
Investments available for sale:									
Fixed maturities	$ 284,318	$ 5,040	$113,291	$5,592	$43,464	$ –	$ 451,705	$ –	$ 451,705
Equity securities	245,668	–	17,338	–	11,564	–	274,570	–	274,570
	529,986	5,040	130,629	5,592	55,028	–	726,275	–	726,275
Cash and cash equivalents	364,316	3,343	15,799	654	69	–	384,181	2,229	386,410
Accounts receivable	164,617	2,713	18,562	687	4,049	(4,827)	185,801	1,450	187,251
Tobacco settlement receivable	96,014	–	–	–	–	–	96,014	–	96,014
Property and equipment, net	128,897	4,826	7,374	–	–	–	141,097	–	141,097
Other assets	145,463	693	6,072	191	588	(139,187)	13,820	8,776	22,596
Deferred income taxes	44,663	–	–	–	921	–	45,584	(308)	45,276
Intangible assets	12,383	–	19,983	–	–	–	32,366	–	32,366
Total assets	$1,486,339	$16,615	$198,419	$7,124	$60,655	$(144,014)	$1,625,138	$12,147	$1,637,285
Liabilities and equity									
Liabilities:									
Claims and claim adjustment expenses	268,673	3,692	86,320	2,592	3,649	(5,144)	359,782	–	359,782
Active life reserves	98,600	–	–	–	–	–	98,600	–	98,600
Tobacco cessation reserve	117,416	–	–	–	–	–	117,416	–	117,416
Advance premiums	81,303	432	7,067	561	810	–	90,173	229	90,402
Accounts payable and accrued expenses	145,747	2,790	6,774	14	7,568	–	162,893	1,269	164,162
Accrued payroll and benefits	55,190	–	–	–	–	–	55,190	–	55,190
Notes payable	16,216	3,235	16,216	–	–	(1,243)	34,424	–	34,424
Other liabilities	27,061	–	3,321	91	43	(9,122)	21,394	34	21,428
Total liabilities	810,206	10,149	119,698	3,258	12,070	(15,509)	939,872	1,532	941,404
Minority interest in net assets of subsidiaries	–	2,133	–	–	7,000	–	9,133	–	9,133
Equity:									
Paid-in capital	–	–	–	–	12,229	(12,229)	–	402	402
Accumulated earnings (deficit)	–	–	–	–	29,356	(29,356)	–	10,213	10,213
Equity in not-for-profit affiliates	669,659	4,333	78,721	3,866	–	(86,920)	669,659	–	669,659
Accumulated other comprehensive income	6,474	–	–	–	–	–	6,474	–	6,474
Total equity	676,133	4,333	78,721	3,866	41,585	(128,505)	676,133	10,615	686,748
Total liabilities and equity	$1,486,339	$16,615	$198,419	$7,124	$60,655	$(144,014)	$1,625,138	$12,147	$1,637,285

BCBSM - 59788

Aware Integrated, Inc.

Condensed Consolidating Statement of Income

Year ended December 31, 2000
(In Thousands)

	BCBSM, Inc.	First Plan	Blue Plus	Atrium	MII, Inc.	Eliminating Entries	Consolidated BCBSM	For-Profit Entities	Aware Integrated
Revenues									
Premiums earned	$2,923,284	$33,693	$395,957	$35,945	$20,880	$ –	$3,409,759	$ –	$3,409,759
Other revenue	9,074	1,337	19,511	–	10,581	(15,778)	24,725	9,962	34,687
	2,932,358	35,030	415,468	35,945	31,461	(15,778)	3,434,484	9,962	3,444,446
Expenses									
Claims incurred	2,598,988	30,840	359,528	32,862	12,440	(14,518)	3,020,140	–	3,020,140
Assessments and surcharges	18,109	–	3,854	16	359	–	22,338	–	22,338
Brokers' fees	55,229	–	5,018	517	2,235	–	62,999	–	62,999
	2,672,326	30,840	368,400	33,395	15,034	(14,518)	3,105,477	9,962	3,105,477
Gross margin	260,032	4,190	47,068	2,550	16,427	(1,260)	329,007	9,962	338,969
Other operating revenue and expenses									
Net investment income	21,749	492	8,462	381	3,079	751	34,914	111	35,025
Net realized gain on investments	18,751	–	893	–	(1,853)	–	17,791	–	17,791
Administrative expenses	(261,770)	(3,502)	(29,352)	(2,612)	(16,830)	1,481	(312,585)	(8,200)	(320,785)
Tobacco settlement income, net	21,502	–	–	–	–	499	22,001	–	22,001
Other expenses	(6,590)	144	(1,693)	–	(166)	(1,471)	(9,776)	1,670	(8,106)
Income before income taxes	53,674	1,324	25,378	319	657	–	81,352	3,543	84,895
Income tax expense (benefit)	11,633	–	(10)	–	(224)	–	11,399	997	12,396
Net income before minority interest	42,041	1,324	25,388	319	881	–	69,953	2,546	72,499
Minority interest in gain of consolidated subsidiaries	–	662	–	–	–	–	662	–	662
Net income	$42,041	$ 662	$25,388	$ 319	$ 881	$ –	$ 69,291	$2,546	$ 71,837

BCBSM - 59789

MPLS:W07990104-MN

Aware Integrated, Inc.

Condensed Consolidating Balance Sheet

December 31, 2001
(In Thousands)

	BCBSM, Inc.	First Plan	Blue Plus	Atrium	MII, Inc.	Eliminating Entries	Consolidated BCBSM	For-Profit Entities	Aware Integrated
Assets									
Investments available for sale:									
Fixed maturities	$ 413,449	$ 7,275	$ 178,691	$ 9,247	$ 49,758	$ –	$ 658,420	$ –	$ 658,420
Equity securities	220,576	–	16,706	–	11,932	–	249,214	–	249,214
	634,025	7,275	195,397	9,247	61,690	–	907,634	–	907,634
Cash and cash equivalents	347,971	4,411	(9,845)	(717)	(138)	–	341,682	4,425	346,107
Accounts receivable	227,218	3,038	10,453	1,045	4,897	–	246,651	1,752	248,403
Tobacco settlement receivable	50,621	–	–	–	–	–	50,621		50,621
Property and equipment, net	154,056	7,250	7,130	–	–	–	168,436	–	168,436
Other assets	174,582	1,639	18,837	901	764	(153,888)	42,835	10,155	52,990
Deferred income taxes	57,571	–	–	–	167	–	57,738	(549)	57,189
Total assets	$1,646,044	$23,613	221,972	10,476	67,380	(153,888)	1,815,597	15,783	1,831,380
Liabilities and equity									
Liabilities:									
Claims and claim adjustment expenses	242,665	5,248	77,712	3,538	3,297	(103)	332,357	–	332,357
Gross premium reserve	88,700	2,300	15,100	–	–		106,100	–	106,100
Tobacco cessation reserve	–	–	–	–	–	–	–	–	–
Advance premiums	97,902	335	8,005	1,015	1,020		108,277	423	108,700
Accounts payable and accrued expenses	200,044	2,554	8,323	26	10,828	–	221,775	724	222,499
Other liabilities	108,211	–	6,808	84	73	(8,743)	106,433	218	106,651
Notes payable	16,200	6,730	16,200	–	–	(1,320)	37,810	–	37,810
Tobacco settlement liabilities	160,000	–	–	–	–	–	160,000	–	160,000
Total liabilities	913,722	17,167	132,148	4,663	15,218	(10,166)	1,072,752	1,365	1,074,117
Minority interest in net assets of subsidiaries	–	2,123	–	–	8,400	–	10,523	–	10,523
Equity:									
Paid-in capital	–	–	–	–	12,229	(12,229)	–	402	402
Accumulated earnings (deficit)	–	–	–	–	31,533	(31,533)	–	14,016	14,016
Equity in not-for-profit affiliates	730,460	4,323	89,824	5,813	–	(99,960)	730,460	–	730,460
Accumulated other comprehensive income	1,862	–	–	–	–	–	1,862	–	1,862
Total equity	732,322	4,323	89,824	5,813	43,762	(143,722)	732,322	14,418	746,740
Total liabilities and equity	$1,646,044	$23,613	$221,972	$10,476	$67,380	$(153,888)	$1,815,597	$15,783	$1,831,380

BCBSM - 59790

Aware Integrated, Inc.

Condensed Consolidating Statement of Income

Year ended December 31, 2001
(In Thousands)

	BCBSM, Inc.	First Plan	Blue Plus	Atrium	MII, Inc.	Eliminating Entries	Consolidated BCBSM	For-Profit Entities	Aware Integrated
Revenues									
Premiums – fully insured	$1,378,559	$47,431	$466,793	$25,219	$23,517	$ –	$1,941,519	$ –	$1,941,519
Premium equivalents – self insured	2,035,452	–	–	35,837	–	–	2,071,289	–	2,071,289
Claims processed – self insured	(1,883,239)	–	–	(35,000)	–	–	(1,918,239)	–	(1,918,239)
Other revenue	9,914	569	13,016	–	11,186	(9,279)	25,406	14,048	39,454
	1,540,686	48,000	479,809	26,056	34,703	(9,279)	2,119,975	14,048	2,134,023
Costs									
Claims incurred – fully insured	1,148,363	43,339	422,394	21,110	14,127	(7,545)	1,641,788	1,491	1,643,279
Brokers fees	58,709	–	4,617	739	2,411	–	66,476	–	66,476
Assessments and surcharges	17,848	–	4,810	86	401	–	23,145	–	23,145
	1,224,920	43,339	431,821	21,935	16,939	(7,545)	1,731,409	1,491	1,732,900
Gross margin	315,766	4,661	47,988	4,121	17,764	(1,734)	388,566	12,557	401,123
Other operating revenue and expenses									
Net investment income	19,472	627	7,788	302	3,145	920	32,254	128	32,382
Net realized gain on investments	(19,487)	–	463	5	(895)	–	(19,914)	–	(19,914)
Administrative expenses	(276,290)	(3,433)	(33,754)	(2,189)	(17,453)	215	(332,904)	(9,688)	(342,592)
Tobacco settlement income, net	(36,651)	–	–	–	–	599	(36,052)	–	(36,052)
Other expenses	45,195	(1,875)	(5,831)	(1)	(290)	–	37,198	1,741	38,939
Income before income taxes	48,005	(20)	16,654	2,238	2,271	–	69,148	4,738	73,886
Income tax expense (benefit)	7,624	–	–	78	302	–	8,004	935	8,939
Net income before minority interest	40,381	(20)	16,654	2,160	1,969	–	61,144	3,803	64,947
Minority interest in gain of consolidated subsidiaries	–	(10)	–	–	–	–	(10)	–	(10)
Net income	$ 40,381	$ (10)	$ 16,654	$ 2,160	$ 1,969	–	$ 61,154	$ 3,803	$ 64,957

Aware Integrated, Inc.
Condensed Consolidating Balance Sheet

December 31, 2002
(In Thousands)

	BCBSM, Inc.	First Plan	Blue Plus	Atrium	MII, Inc.	Eliminating Entries	Consolidated BCBSM	For-Profit Entities	Aware Integrated
Assets									
Investments available for sale:									
Fixed maturities	$ 345,481	$ 9,913	$164,755	$13,002	$56,787	$ -	$ 589,938	$ -	$ 589,938
Equity securities	164,868	-	11,493	-	11,048	-	187,409	-	187,409
	510,349	9,913	176,248	13,002	67,835	-	777,347	-	777,347
Cash and cash equivalents	452,512	3,586	32,017	12	7,738	-	495,865	7,444	503,309
Accounts receivable	230,697	3,108	11,369	1,143	4,163	-	250,480	1,405	251,885
Tobacco settlement receivable	717	-	-	-	-	-	717	-	717
Property and equipment, net	183,741	7,257	6,273	-	-	-	197,271	-	197,271
Other assets	169,858	1,748	9,472	-	1,374	(159,206)	23,246	11,718	34,964
Deferred income taxes	43,670	-	-	-	29	-	43,699	(789)	42,910
Total assets	$1,591,544	$25,612	$235,379	$14,157	$81,139	$(159,206)	$1,788,625	$19,778	$1,808,403
Liabilities and equity									
Liabilities:									
Claims and claim adjustment expenses	256,666	6,204	85,919	4,525	3,768	-	357,082	-	357,082
Policy reserves	94,300	1,300	16,500	-	-	-	112,100	-	112,100
Advance premiums	108,512	431	8,565	1,263	928	-	119,699	595	120,294
Accounts payable and accrued expenses	283,422	3,045	9,463	33	22,291	-	318,254	201	318,455
Other liabilities	18,168	-	7,443	840	568	(8,762)	18,257	314	18,571
Notes payable	16,182	6,713	16,182	-	-	(1,397)	37,680	-	37,680
Tobacco settlement liabilities	60,000	-	-	-	-	-	60,000	-	60,000
Total liabilities	837,250	17,693	144,072	6,661	27,555	(10,159)	1,023,072	1,110	1,024,182
Minority interest in net assets of subsidiaries	-	2,859		-	8,400	-	11,259	-	11,259
Equity:									
Paid-in capital	-	-	-	-	12,229	(12,229)	-	402	402
Accumulated earnings (deficit)	-	-	-	-	32,955	(32,955)	-	18,266	18,266
Equity in not-for-profit affiliates	764,488	5,060	91,307	7,496	-	(103,863)	764,488	-	764,488
Accumulated other comprehensive (loss) income	(10,194)	-	-	-	-	-	(10,194)	-	(10,194)
Total equity	754,294	5,060	91,307	7,496	45,184	(149,047)	754,294	18,668	772,962
Total liabilities and equity	$1,591,544	$25,612	$235,379	$14,157	$81,139	$(159,206)	$1,788,625	$19,778	$1,808,403

BCBSM - 59792

Aware[illegible]grated, Inc.

Condensed Consolidating Statement of Income

Year ended December 31, 2002
(In Thousands)

	BCBSM, Inc.	First Plan	Blue Plus	Atrium	MII, Inc.	Eliminating Entries	Consolidated BCBSM	For-Profit Entities	Aware Integrated
Revenues									
Premiums – fully insured	$1,539,897	$52,552	$568,933	$35,917	$23,006	$	$2,220,305	$	$2,220,305
Premium equivalents – self insured	2,674,404	–	–	48,015	30,790	–	2,753,209	–	2,753,209
Claims processed – self insured	(2,483,934)	–	–	(46,869)	(29,565)	–	(2,560,368)	–	(2,560,368)
Other revenue	5,138	796	6,002		12,141	(2,061)	22,016	14,396	36,412
	1,735,505	53,348	574,935	37,063	36,372	(2,061)	2,435,162	14,396	2,449,558
Costs									
Claims incurred – fully insured	1,270,337	48,441	520,019	31,226	17,115	–	1,887,138	885	1,888,023
Brokers fees	61,307	–	4,247	1,011	2,284	–	68,849	–	68,849
Assessments and surcharges	20,979	20	5,362	214	243	–	26,818	–	26,818
	1,352,623	48,461	529,628	32,451	19,642	–	1,982,805	885	1,983,690
Gross margin	382,882	4,887	45,307	4,612	16,730	(2,061)	452,357	13,511	465,868
Other operating revenue and expenses									
Net investment income	23,625	621	9,153	628	3,502	1,110	38,639	95	38,734
Net realized loss on investments (36,022) →	(30,022)	–	(3,415)	–	(482)	–	(39,919)	–	(39,919)
Administrative expenses	(313,084)	(3,887)	(40,067)	(3,409)	(17,289)	227	(377,509)	(9,597)	(387,106)
Tobacco settlement income, net	4,962	–	–	–	–	724	5,686	–	5,686
Other revenue (expenses)	(13,791)	(148)	(8,353)	–	202	–	(22,090)	2,103	(19,987)
Income before income taxes	48,572	1,473	2,625	1,831	2,663	–	57,164	6,112	63,276
Income tax expense	21,177	–	10	151	642	–	21,980	1,862	23,842
Net income before minority interest	27,395	1,473	2,615	1,680	2,021	–	35,184	4,250	39,434
Minority interest in gain of consolidated subsidiaries	–	736	–	–	–	–	736	–	736
Net income	$ 27,395	$ 737	$ 2,615	$ 1,680	$ 2,021	$	$ 34,448	$ 4,250	$ 38,698

BCBSM - 59793

Aware Integrated, Inc.
Condensed Consolidating Balance Sheet

December 31, 2003
(In Thousands)

	BCBSM, Inc.	First Plan	Blue Plus	Atrium	MII, Inc.	Eliminating Entries	Consolidated BCBSM	For-Profit Entities	Aware Integrated
Assets									
Investments available for sale:									
Fixed maturities	$ 510,920	$10,685	$173,310	$16,731	$57,971	$ –	$ 769,617	$ –	$ 769,617
Equity securities	248,858	–	17,252	–	11,929	–	278,039	–	278,039
	759,778	10,685	190,562	16,731	69,900	–	1,047,656	–	1,047,656
Cash and cash equivalents	350,064	9,110	7,761	1,216	3,035	–	371,186	9,542	380,728
Accounts receivable	279,984	3,644	22,592	954	7,122	–	314,296	1,756	316,052
Property and equipment, net	198,819	6,731	5,908	–	–	–	211,458	–	211,458
Other assets	211,784	1,192	47,342	–	1,150	(217,209)	44,259	12,892	57,151
Deferred income taxes	56,865	–	–	–	115	–	56,980	(789)	56,191
Total assets	$1,857,294	$31,362	$274,165	$18,901	$81,322	$(217,209)	$2,045,835	$23,401	$2,069,236
Liabilities and equity									
Liabilities:									
Claims and claim adjustment expenses	270,198	8,630	93,081	5,000	3,742	–	380,651	–	380,651
Policy reserves	102,600	1,000	20,750	–	–	–	124,350	–	124,350
Advance premiums	115,220	3,073	41,670	2,287	1,042	–	163,292	793	164,085
Accounts payable and accrued expenses	304,295	2,925	2,076	77	22,458	–	331,831	405	332,236
Other liabilities	54,523	–	5,387	827	1,691	(46,483)	15,945	138	16,083
Notes payable	2,663	5,898	2,663	–	–	(1,471)	9,753	–	9,753
Tobacco settlement liabilities	71,250	–	–	–	–	–	71,250	–	71,250
Total liabilities	920,749	21,526	165,627	8,191	28,933	(47,954)	1,097,072	1,336	1,098,408
Minority interest in net assets of subsidiaries	–	3,818	–	–	8,400	–	12,218	–	12,218
Equity:									
Paid-in capital	–	–	–	–	12,229	(12,229)	–	402	402
Accumulated earnings (deficit)	–	–	–	–	31,760	(31,760)	–	23,263	23,263
Equity in not-for-profit affiliates	910,557	6,018	108,538	10,710	–	(125,266)	910,557	(1,600)	908,957
Accumulated other comprehensive income	25,988	–	–	–	–	–	25,988	–	25,988
Total equity	936,545	6,018	108,538	10,710	43,989	(169,255)	936,545	22,065	958,610
Total liabilities and equity	$1,857,294	$31,362	$274,165	$18,901	$81,322	$(217,209)	$2,045,835	$23,401	$2,069,236

BCBSM - 59794

Aware Integrated, Inc.

Condensed Consolidating Statement of Income

Year ended December 31, 2003
(In Thousands)

	BCBSM, Inc.	First Plan	Blue Plus	Atrium	MII, Inc.	Eliminating Entries	Consolidated BCBSM	For-Profit Entities	Aware Integrated
Revenues									
Premiums – fully insured	$1,771,443	$57,867	$623,687	$47,798	$24,200	$ –	$2,524,995	$ –	$2,524,995
Premium equivalents – self insured	3,263,725	–	–	53,706	106,027	–	3,423,458	–	3,423,458
Claims processed – self insured	(3,031,262)	–	–	(52,425)	(101,616)	–	(3,185,303)	–	(3,185,303)
Other revenue	5,631	759	6,299	–	10,828	(2,688)	20,829	14,623	35,452
	2,009,537	58,626	629,986	49,079	39,439	(2,688)	2,783,979	14,623	2,798,602
Costs									
Claims incurred – fully insured	1,468,228	53,154	582,915	40,509	16,299	–	2,161,105	883	2,161,988
Brokers fees	66,056	–	4,065	1,265	2,791	–	74,177	–	74,177
Assessments and surcharges	25,844	470	5,883	316	543	–	33,056	–	33,056
	1,560,128	53,624	592,863	42,090	19,633	–	2,268,338	883	2,269,221
Gross margin	449,409	5,002	37,123	6,989	19,806	(2,688)	515,641	13,740	529,381
Other operating revenue and expenses									
Net investment income	19,727	(79)	6,974	532	3,061	1,209	31,424	86	31,510
Net realized gain (loss) on investments	9,854	–	(873)	–	(67)	–	8,914	–	8,914
Administrative expenses	(329,930)	(2,885)	(34,335)	(3,817)	(19,724)	922	(389,769)	(9,481)	(399,250)
Tobacco settlement income, net	(22,547)	–	–	–	–	557	(21,990)	–	(21,990)
Other revenue (expenses)	(2,809)	5	3,759	–	(55)	(4,784)	(3,884)	2,410	(1,474)
Income before income taxes	123,704	2,043	12,648	3,704	3,021	(4,784)	140,336	6,755	147,091
Income tax (benefit) expense	(6,432)	34	(1)	308	533	–	(5,558)	1,758	(3,800)
Net income before minority interest	130,136	2,009	12,649	3,396	2,488	(4,784)	145,894	4,997	150,891
Minority interest in gain of consolidated subsidiaries	–	1,005	–	–	–	–	1,005	–	1,005
Net income	$ 130,136	$ 1,004	$ 12,649	$ 3,396	$ 2,488	$(4,784)	$ 144,889	$ 4,997	$ 149,886

BCBSM - 59795

Aware Integrated, Inc.

Condensed Consolidating Statement of Income

Year ended December 31, 2004
(In Thousands)

	BCBSM, Inc.	First Plan	Blue Plus	Atrium	MII, Inc.	Eliminating Entries	Consolidated BCBSM	For-Profit Entities	Aware Integrated
Revenues									
Premiums – fully insured	$1,929,583	$58,351	$576,703	$65,131	$ 23,003	$ –	$2,652,771	$ –	$2,652,771
Premium equivalents – self insured	3,651,226	–	–	55,071	175,434	–	3,881,751	–	3,881,751
Claims processed – self insured	(3,349,236)	–	–	(53,916)	(169,662)	–	(3,572,814)	–	(3,572,814)
Other revenue	4,083	283	3,760	–	15,557	(5,028)	18,655	15,112	33,767
	2,235,656	58,634	580,463	66,286	44,352	(5,028)	2,980,363	$15,112	$2,995,475
Costs									
Claims incurred – fully insured	1,676,281	50,215	491,090	56,958	16,827	–	2,291,371	741	2,292,112
Assessments and surcharges	50,428	990	12,119	438	220	–	64,195	–	64,195
	1,726,709	51,205	503,209	57,396	17,047	–	2,355,566	741	2,356,307
Other operating revenue and expenses									
Net investment income	26,797	303	8,202	820	3,659	(7,977)	31,804	9,139	40,943
Net realized gain (loss) on investments	17,911	–	1,197	4	29	–	19,141	–	19,141
Administrative expenses	(511,785)	(2,933)	(43,041)	(7,123)	(28,065)	3,557	(589,390)	(10,441)	(599,831)
Tobacco settlement income, net	(12,415)	–	–	–	–	448	(11,967)	–	(11,967)
Correction of pension error	(12,050)	–	–	–	–	–	(12,050)	–	(12,050)
Other revenue (expenses)	7,773	–	219	–	(379)	–	7,613	(924)	6,689
Income before income taxes	25,178	4,799	43,831	2,591	2,549	(9,000)	69,948	12,145	82,093
						–	–	–	–
Income tax (benefit) expense	8,155	72	1	229	595	–	9,052	4,838	13,890
Net income before minority interest	17,023	4,727	43,830	2,362	1,954	(9,000)	72,946	7,307	68,203
Minority interest in gain of consolidated subsidiaries	–	2,364	–	–	–	–	2,364	–	2,364
Net income	$ 17,023	$ 2,363	$ 43,830	$ 2,362	$ 1,954	$(9,000)	$ 70,582	7,307	$ 65,839

BCBSM - 59797

Aware Integrated, Inc.

Condensed Consolidating Balance Sheet

December 31, 2004

(In Thousands)

	BCBSM, Inc.	First Plan	Blue Plus	Atrium	MII, Inc.	Eliminating Entries	Consolidated BCBSM	For-Profit Entities	Aware Integrated
Assets									
Investments available for sale:									
Fixed maturities	$ 565,026	$12,697	$175,509	$21,650	$69,528	$ –	$ 844,410	$ –	$ 844,410
Equity securities	373,377	–	30,213	–	15,957	–	419,547	–	419,547
	938,403	12,697	205,722	21,650	85,485	–	1,263,957	–	1,263,957
Cash and cash equivalents	326,970	9,697	20,278	2,522	(3,196)	–	356,271	21,637	377,908
Accounts receivable	263,867	3,718	41,576	1,081	9,515	–	319,757	1,616	321,373
Property and equipment, net	190,512	6,378	5,633	–	–	–	202,523	–	202,523
Other assets	251,961	1,266	46,302	–	4,429	(269,297)	34,661	11,642	46,303
Deferred income taxes	52,806	–	–	–	124	–	52,930	(4,094)	48,836
Total assets	$2,024,519	$33,756	$319,511	$25,253	$96,357	$(269,297)	$2,230,099	$30,801	$2,260,900
Liabilities and equity									
Liabilities:									
Claims and claim adjustment expenses	315,130	4,601	84,168	7,722	4,553	–	416,224	–	416,224
Policy reserves	131,300	1,400	29,700	–	–	–	162,400	–	162,400
Advance premiums	123,121	2,932	42,920	3,151	911	–	173,035	897	173,932
Accounts payable and accrued expenses	318,464	3,427	1,690	219	32,637		356,437	415	356,852
Other liabilities	57,748	1,106	4,778	970	149	(46,464)	18,287	117	18,404
Notes payable	2,643	5,647	2,643	–	–	(1,552)	9,381	–	9,381
Tobacco settlement liabilities	71,250	–	–	–	–	–	71,250	–	71,250
Total liabilities	1,019,656	19,113	165,899	12,112	38,250	(48,016)	1,207,014	1,429	1,208,443
Minority interest in net assets of subsidiaries	–	6,222	–	–	12,000	–	18,222	–	18,222
Equity:									
Paid-in capital	–	–	–	–	12,229	(12,229)	–	402	402
Accumulated earnings (deficit)	–	–	–	–	33,878	(33,878)	–	30,570	30,570
Equity in not-for-profit affiliates	968,699	8,421	153,612	13,141	–	(175,174)	968,699	(1,600)	967,099
Accumulated other comprehensive income	36,164	–	–	–	–	–	36,164	–	36,164
Total equity	1,004,863	8,421	153,612	13,141	46,107	(221,281)	1,004,863	29,372	1,034,235
Total liabilities and equity	$2,024,519	$33,756	$319,511	$25,253	$96,357	$(269,297)	$2,230,099	$30,801	$2,260,900

BCBSM - 59796

AG Administrative Audit Request: Number 36
June 17, 2005

BCBSM - 59784

BCBSM	**2004**	**2003**	**2002**	**2001**	**2000**
Salaries	$ 213,372,583	$ 207,300,955	$ 193,750,864	$ 174,857,292	$ 156,417,348
Benefits	$ 64,516,963	$ 53,969,522	$ 49,657,810	$ 37,841,537	$ 38,097,402
Total Payroll	$ 277,889,546	$ 261,270,477	$ 243,408,674	$ 212,698,829	$ 194,514,750
First Plan					
Salaries	$ 8,044,247	$ 8,069,028	$ 7,657,058	$ 6,357,188	$ 5,542,981
Benefits	$ 3,018,030	$ 3,109,103	$ 2,538,563	$ 1,991,400	$ 1,408,988
Total Payroll	$ 11,062,277	$ 11,178,131	$ 10,195,621	$ 8,348,588	$ 6,951,969

AG Administrative Audit Request: Number 35
June 24, 2005

Headcount*

	2004	2003	2002	2001	2000
BCBSM	3,779	4,012	4,040	3,519	3,114
First Plan	240	236	238	219	203

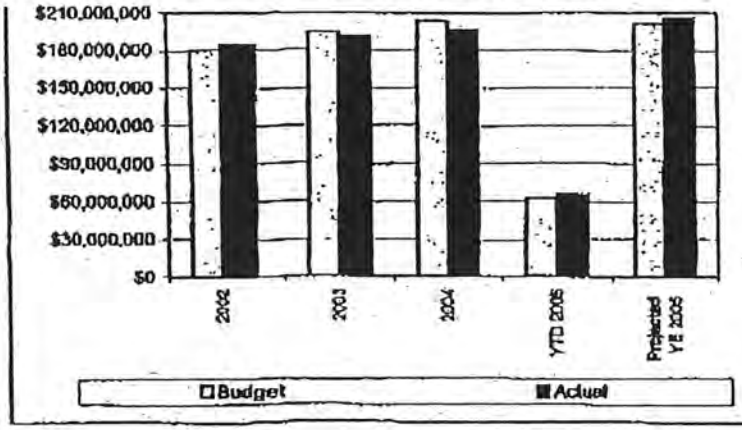
* active employees only

F-717 P003/039 T-433 6516621099 10-10-'05 12:11 FROM-651-662-1099

Operations Dashboard - April 2005

Overall Operations

1 Operations Admin - Actual vs Budget

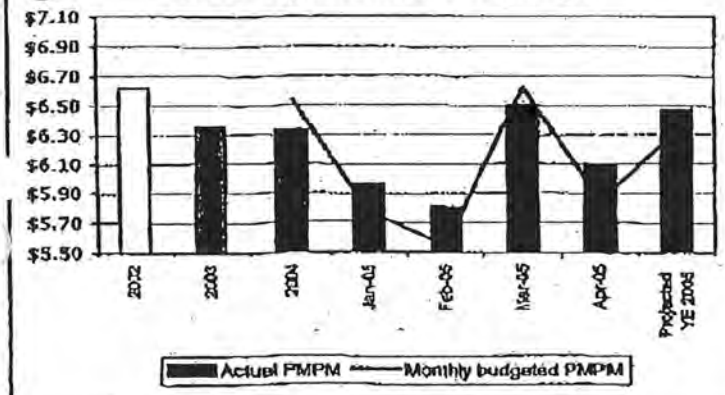


For 2005 YTD, there is a net unfavorable variance to budget of ($2,161,771) due primarily to the inability to charge to projects at a rate that was budgeted and to overspending in printing and postage. Forecast for 2005 is ($5.4M) unfavorable.

For 2004 FY, there was a net favorable variance to budget of $6,490,352 caused primarily by: 1) a reduction in claims volume and the associated subcontracted claims fees, 2) the additional use of IS employees to work on projects approved by the Executive Committee in July 2004, which created a credit to expense in corp. and 3) not filling budgeted requisitions for personnel.

For 2003, there was a net favorable variance to budget of $3,370,083. IS Physical Resources was $2.2M favorable. Membership was $0.9M favorable. Service was $0.4M favorable.

2 PMPM - Operations Actual vs Budget

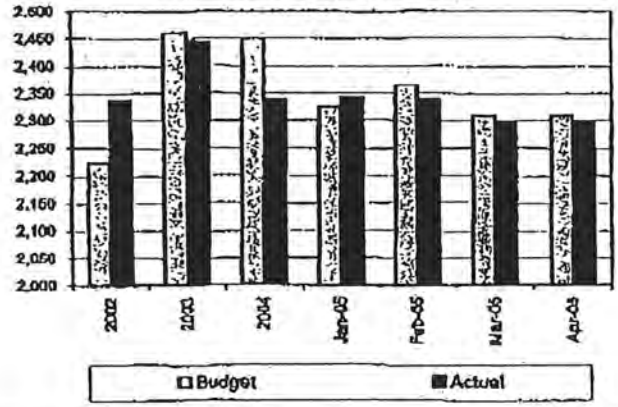


For 2005 YTD, there is a net unfavorable variance to budget of ($2,161,771) or ($.068) pmpm, due primarily to the inability to charge to projects at the rate that was budgeted and to overspending in printing and postage.

The 2005 Operation's YTD average pmpm is $6.09 for April vs $6.33 in 2004, $6.35 in 2003 and $6.62 in 2002. Forecast for 2005 $6.47 pmpm. This is ($0.15) unfavorable to the 2005 budgeted pmpm.

For 2004, there was a net fav variance to budget of $6,490,352, or $0.21 pmpm, caused primarily by: 1) a reduction in claims volume and the associated subcontracted claims fees, 2) the additional use of IS employees to work on projects approved by the Executive Committee in July 2004, which created a credit to expense in corp. and 3) not filling budgeted reqs for personnel.

3 Operations Employee FTEs



	Actual	Budget	Variance
Employee FTE's as of April 2005:			
Membership	186	193	
EPMO	10	11	
Customer Service	679	705	26
Corp Adjudications	884	840	(44)
IS Division	539	558	19
	2,298	2,307	9
2004 Employee FTE's	2,338	2,449	111
2003 Employee FTE's	2,442	2,459	17
2002 Employee FTE's	2,335	2,225	(110)

BCBSM 108967

Comparison of National and Minnesota Health Industry Wages

Occupation Title	Minnesota Median Hourly	Minnesota Mean Hourly	Minnesota Mean Annual	*National Median Hourly*	*National Mean Hourly*	*National Mean Annual*
Healthcare Practitioner and Technical Occupations:						
Anesthesiologists	**$66.22**	**$66.23**	**$137,770**	*Equal to or greater than $70/hour*	*$83.77*	*$174,250*
Athletic Trainers	**N/A**	**N/A**	**$35,010**	*N/A*	*N/A*	*$36,350*
Audiologists	**$24.45**	**$26.99**	**$56,140**	*$24.74*	*$26.47*	*$55,050*
Cardiovascular Technologists and Technicians	**$18.97**	**$19.60**	**$40,770**	*$18.60*	*$19.09*	*$39,710*
Chiropractors	**$34.37**	**$37.38**	**$77,740**	*$33.61*	*$42.01*	*$87,390*
Dental Hygienists	**$29.74**	**$28.31**	**$58,870**	*$28.05*	*$28.58*	*$59,440*
Dentists, General	**$59.16**	**$65.03**	**$135,250**	*$59.16*	*$63.87*	*$132,850*
Diagnostic Medical Sonographers	**$26.85**	**$27.09**	**$56,340**	*$25.24*	*$25.78*	*$53,620*
Dietetic Technicians	**$15.66**	**$15.64**	**$32,520**	*$11.05*	*$11.89*	*$24,730*
Dietitians and Nutritionists	**$21.97**	**$22.28**	**$46,340**	*$20.98*	*$21.46*	*$44,640*
Emergency Medical Technicians and Paramedics	**$12.79**	**$14.13**	**$29,390**	*$12.17*	*$13.30*	*$27,650*
Family and General Practitioners	**$66.77**	**$70.74**	**$147,150**	*$65.91*	*$66.58*	*$138,490*
Health Diagnosing and Treating Practitioners, All Other	**$32.44**	**$50.94**	**$105,960**	*$27.87*	*$44.38*	*$92,300*
Health Technologists and Technicians, All Other	**$19.91**	**$20.93**	**$43,540**	*$16.46*	*$18.10*	*$37,650*
Healthcare Practitioner and Technical Workers, All Other	**$16.40**	**$17.80**	**$37,020**	*$16.04*	*$18.20*	*$37,860*
Internists, General	**$68.86**	**$71.87**	**$149,490**	*Equal to or greater than $70/hour*	*$76.06*	*$158,200*
Licensed Practical and Licensed Vocational Nurses	**$16.26**	**$16.42**	**$34,160**	*$16.33*	*$16.75*	*$34,840*
Medical and Clinical Laboratory Technicians	**$16.72**	**$16.91**	**$35,170**	*$14.83*	*$15.44*	*$32,120*

Medical and Clinical Laboratory Technologists	**$22.81**	**$23.06**	**$47,970**	*$21.99*	*$22.41*	*$46,600*
Medical Records and Health Information Technicians	**$13.24**	**$13.92**	**$28,950**	*$12.30*	*$13.30*	*$27,660*
Nuclear Medicine Technologists	**$29.34**	**$28.97**	**$60,260**	*$27.14*	*$29.43*	*$61,210*
Obstetricians and Gynecologists	**Equal to or greater than $70/hour**	**$85.47**	**$177,780**	*Equal to or greater than $70/hour*	*$84.74*	*$176,270*
Occupational Health and Safety Specialists	**$26.57**	**$26.80**	**$55,740**	*$24.79*	*$25.54*	*$53,110*
Occupational Health and Safety Technicians	**$17.81**	**$18.85**	**$39,200**	*$20.25*	*$21.31*	*$44,320*
Occupational Therapists	**$23.61**	**$23.64**	**$49,170**	*$26.28*	*$27.19*	*$56,550*
Opticians, Dispensing	**$14.43**	**$14.27**	**$29,680**	*$13.44*	*$14.37*	*$29,880*
Optometrists	**$46.54**	**$52.81**	**$109,840**	*$42.51*	*$46.53*	*$96,780*
Oral and Maxillofacial Surgeons	**Equal to or greater than $70/hour**	**$95.84**	**$199,340**	*Equal to or greater than $70/hour*	*$79.69*	*$165,750*
Orthodontists	**Equal to or greater than $70/hour**	**$86.82**	**$180,590**	*Equal to or greater than $70/hour*	*$72.45*	*$150,700*
Orthotists and Prosthetists	**$20.98**	**$21.83**	**$45,410**	*$24.17*	*$27.47*	*$57,130*
Pediatricians, General	**Equal to or greater than $70/hour**	**$76.21**	**$158,520**	*$65.26*	*$68.04*	*$141,520*
Pharmacists	**$42.81**	**$42.42**	**$88,240**	*$40.82*	*$40.56*	*$84,370*
Pharmacy Technicians	**$13.73**	**$13.64**	**$28,360**	*$11.37*	*$11.87*	*$24,700*
Physical Therapists	**$26.64**	**$26.38**	**$54,870**	*$28.93*	*$30.00*	*$62,390*
Physician Assistants	**$33.39**	**$33.98**	**$70,690**	*$33.37*	*$33.07*	*$68,780*
Physicians and Surgeons, All Other	**Equal to or greater than $70/hour**	**$85.52**	**$177,880**	*$67.44*	*$66.16*	*$137,610*
Podiatrists	**$59.25**	**$56.09**	**$116,670**	*$45.38*	*$52.11*	*$108,400*
Psychiatric Technicians	**$13.29**	**$13.26**	**$27,590**	*$12.28*	*$13.43*	*$27,940*
Psychiatrists	**Equal to or greater than $70/hour**	**$82.95**	**$172,550**	*Equal to or greater than $70/hour*	*$72.17*	*$150,110*

Radiation Therapists	$27.15	$27.14	$56,460	$27.74	$29.05	$60,420
Radiologic Technologists and Technicians	$22.51	$22.44	$46,670	$20.84	$21.41	$44,530
Recreational Therapists	$17.87	$18.58	$38,650	$15.82	$16.48	$34,280
Registered Nurses	$27.00	$27.47	$57,130	$25.16	$26.06	$54,210
Respiratory Therapists	$23.73	$23.60	$49,080	$20.74	$21.24	$44,180
Respiratory Therapy Technicians	$18.29	$17.62	$36,660	$17.67	$18.00	$37,440
Speech-Language Pathologists	$23.72	$23.67	$49,240	$25.20	$26.71	$55,550
Surgeons	Equal to or greater than $70/hour	$91.42	$190,160	Equal to or greater than $70/hour	$87.31	$181,610
Surgical Technologists	$19.34	$19.48	$40,520	$16.35	$16.72	$34,770
Therapists, All Other	$22.89	$22.32	$46,430	$19.32	$21.45	$44,620
Veterinarians	$28.04	$32.48	$67,550	$32.01	$36.07	$75,030
Veterinary Technologists and Technicians	$13.16	$13.39	$27,850	$11.99	$12.49	$25,990
Healthcare Support Occupations:						
Dental Assistants	$17.06	$16.85	$35,040	$13.62	$13.97	$29,060
Healthcare Support Workers, All Other	$13.03	$13.16	$27,360	$12.01	$12.62	$26,250
Home Health Aides	$10.16	$10.37	$21,580	$8.81	$9.13	$18,980
Massage Therapists	$23.74	$22.43	$46,640	$15.36	$17.63	$36,670
Medical Assistants	$13.19	$13.24	$27,530	$11.83	$12.21	$25,400
Medical Equipment Preparers	$13.50	$13.48	$28,050	$11.76	$12.14	$25,240
Medical Transcriptionists	$14.43	$14.34	$29,830	$13.64	$14.01	$29,150
Nursing Aides, Orderlies, and Attendants	$11.31	$11.52	$23,960	$10.09	$10.39	$21,610
Occupational Therapist Aides	$11.38	$11.55	$24,020	$11.13	$12.51	$26,030
Occupational Therapist Assistants	$15.66	$15.67	$32,580	$18.48	$18.49	$38,460
Pharmacy Aides	$9.50	$9.79	$20,360	$8.86	$9.52	$19,810
Physical Therapist Aides	$11.83	$12.24	$25,470	$10.28	$11.14	$23,160
Physical Therapist Assistants	$16.30	$16.32	$33,950	$18.22	$18.14	$37,730
Psychiatric Aides	$10.50	$10.79	$22,430	$11.19	$11.70	$24,340
Veterinary Assistants and Laboratory Animal Caretakers	$8.37	$9.16	$19,040	$8.97	$9.44	$19,640

Summary of Current Examination Results

Executive Compensation

The examination review of the Report on Executive Compensation (Form 22-060) for 2002 noted that the company is not reporting all compensation as instructed. The amounts reported on the form excluded the 401(k) company match, accruals for pensions, and health care benefits. It is recommended that the company complete the Report on Executive Compensation (Form 22-060) in accordance with its instructions.

Financial Reporting

Examination review of the Exhibit of Capital Gains and Losses noted that Atrium did not report any gains or losses. In Schedule D part 4 and part 5, Atrium reports the difference between consideration and the book/adjusted carrying value as an adjustment. The difference between the sale price and the consideration at the time of sale is a capital gain/loss not an adjustment to the carrying value. NAIC Annual statement instructions require that gains/losses be included in Column 13 of Schedule D part 4 and Column 15 in Schedule D part 5. The instructions also require gains be included as part of the Statement of Revenues and Expenses on line 24 and the completion of the Exhibit of Capital Gains and Losses. It is recommended the company complete the annual statement exhibits and schedules regarding capital gains/losses in accordance with the NAIC Annual Statement Instructions for Health Insurers.

The company does not allocate a portion of the capitation expense for its Medicaid enrollment under the GHC agreement to administrative expenses. Since some of the capitation paid to the subcontractor, GHC, is used for administrative costs, this should be reported in administrative expenses. Reporting the amount of capitation entirely in medical expenses skews the company's administrative and loss ratios. It is recommended the company allocate a portion of the capitation expense to administrative expenses.

Premiums Receivable

Atrium nets amounts over 90 days on its aging report by the type of plan. For instance, at year-end, the Atrium Standard Plan had a total receivable balance over 90 days due of $(1,492.60). This balance included a receivable of $563.90 that was not nonadmitted since the

total of the Atrium Standard Plan over 90 day balance was negative. This practice does not follow the guidance established by SSAP No. 6, which states all receivables with balances over 90 days should be non-admitted on the balance sheet. Atrium has a policy of only writing off "over 90" receivables if there is a receivable balance for that plan. Atrium should be looking at the over 90 day balance of each individual receivable and making a determination if the amounts are uncollectible. In the instance where the balance is a de minimus balance, only the amount over 90 days should be nonadmitted according to INT 01-01. Due to the fact any amount that would be nonadmitted was immaterial, no adjustment to the annual statement was made. It is recommended the company comply with SSAP No. 6 and INT 01-01 and properly report premium receivables that are over 90 days old.

Agents

The examination compared the company's list of licensed agents to the licensed agents listed by OCI. Testing produced seventeen exceptions. Four of the exceptions were for licensed agents the company had incorrectly listed as terminated agents. The other thirteen exceptions were terminations that were filed electronically, but had not been officially approved. In a sample of these cases the termination was not approved because the company back dated the termination date more than 15 days. It is recommended the company set up a procedure to monitor that filed terminations are accepted and that the company discontinue back dating its agents' termination dates by more than fifteen days. (Note: Subsequent to fieldwork the company sent an appointment action letter dated July 16, 2003, that showed all but one of the agents in question were subsequently terminated with an action date of July 14, 2003).

Affiliated Agreements

The company, in cooperation with MII Life, Inc. (MII), offers a jointly marketed product, effectively creating a point-of-service product. Premiums are divided between the company and MII. Atrium collects the premium on behalf of MII and then allocates a portion of the premium. In addition, Atrium is also billing, on behalf of MII, amounts for AD&D and Life insurance coverage to those groups with Atrium coverage and MII coverage. An administrative agreement to document this arrangement was requested from the company. No agreement

could be provided to the examiners. However, the company stated that it is currently working on the preparation of such an agreement. It is recommended the company submit the administrative agreement to this office within 30 days of adoption of this report.

Reinsurance

Examination testing provided that the company was reporting its reinsurance recoverable amounts on paid claims as on offset to claims payable. The company should be reporting the reinsurance recoverables as an asset in accordance with the NAIC Annual Statement Instructions for Health Insurers. It is recommended the company correctly report any reinsurance recoveries on its balance sheet in accordance with the NAIC Annual Statement Instructions for Health Insurers.

BCBSM - 022872

BlueCross BlueShield of Minnesota

BlueCard Program Financial Review

Resulting from the Financial Review
Conducted May 7 - 11, 2001

BlueCard Alliances
Blue Cross and Blue Shield Association

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BlueCross BlueShield of Minnesota

BlueCard Program Financial Review

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Executive Summary

BlueCard Alliances staff have completed the scheduled on-site evaluation of the BlueCard Program at BlueCross BlueShield of Minnesota. Ken Matuszak and Cheryl Prater conducted the financial review during the week of May 7 - 11, 2001. The evaluation focused on the Plan's compliance with the BlueCard Program financial policies and provisions including compliance with discount extension policies, compliance with the application of approved pricing methods, controls over variance accounting, Host and Home accounting transactions, and reasonableness of cost allocations as reported quarterly to the Association for the BlueCard Host line of business.

Summary and Conclusion

With the exception of the issues discussed in the report, we found the Plan's current policies and procedures for the BlueCard Program to be generally in compliance with BlueCard Program financial policies and provisions. We are working with Plan staff to resolve the variance issue as part of our routine Plan variance monitoring process.

Notable Issues and Recommendations – Financial Review

Host Accounting – Classification of Host Plan Access Fees on the BCBSA Quarterly Financial Report

Plan Accounting staff should change its procedures for reporting data on the Quarterly Financial Report (QFR) it submits to the Association to classify BlueCard Host Plan access fees received as other income (line 20) rather than as administrative expense reimbursement (line 13). QFRs filed for each quarter of 2001 should be revised and resubmitted with the access fees reclassified. It is not necessary for Plan staff to change its internal reporting procedures.

Pricing Methodology / Variance Accounting – Impact of Payment Differences and Provider Settlements on the BlueCard Program

Plan staff should:

a) Research the cause(s) of variances identified on its exception report (NU 39 – Host) and take appropriate corrective action so that the provider will not balance bill subscribers for any payment shortfalls.
b) Complete and submit to BCA staff a pricing proposal with the necessary information and data requirements to justify the use of supplemental pricing factors for BlueCard Host claims.

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BlueCard Program Financial Review Detail

Introduction

BlueCard Alliances staff conducted a BlueCard Program financial review at BlueCross BlueShield of Minnesota on May 7 – 11, 2001. This evaluation included a limited review of the financial administration of the Program for the period January 1, 2000 through December 31, 2000.

Objective

The objective of the review was to ensure that the Host Plan financial and accounting practices comply with the following BlueCard Program policies and procedures:

- To ensure that the Plan passes the levels of discounts or differentials to Home Plans that are at least equal to the levels received from providers on local subscribers' claims;

- To ensure that the Plan, if using other than actual prices, is properly and consistently modifying prices in accordance with the terms of the BlueCard Program Policies and Provisions;

- To ensure that the Host Plan is properly accounting for any variances between the approved to pay amounts received from Home Plans and the amounts it actually paid to providers for Host Plan claims;

- To ensure that charges to and through the BlueCard Program are actual, necessary, proper and consistent with the terms of the BlueCard Program Policies and Provisions and that costs reported on the Quarterly Host Line of Business Cost Summary represent reasonable allocations of costs to the Program;

- To ensure that the Plan, as Host and Home, is properly accounting for the BlueCard Program;

- To ensure that any affiliate participating in the BlueCard program has executed the appropriate agreements, is using a unique alpha-prefix identifier code and is complying with the financial policies and provisions of the BlueCard Program, and

- To advise Plans regarding compliance with policies and procedures established by the Blue Cross and Blue Shield Association.

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Scope

To accomplish this objective, the review included an evaluation and recommendations regarding the following financial administrative segments:

- Pricing
- Variance Accountability
- Access Fees
- Accounting for BlueCard Transactions
- Administrative Expense
- Appropriateness of Affiliates using the BlueCard Program

Issues and Recommendations – Financial Review

The following summarizes the results of the BlueCard Program financial review of BlueCross BlueShield of Minnesota, for the period of January 1, 2000 through December 31, 2000.

1. **Host Accounting – Classification of Host Plan Access Fees on the BCBSA Quarterly Financial Report**

   Issue: When Host Plans process claims for Home Plans' members, they are allowed to charge access fees to the Home Plans for the use of the Hosts' provider networks. Access fees may equal up to 10 percent of the Host Plan's discount/differential savings, but may not exceed $2,000 per claim. The Plan's Accounting department records Host Plan access fees in Account 73002, ITS Access Fees, and classifies them as an administrative expense reimbursement on line 13 of the BCBSA Quarterly Financial Report (QFR).

   The BlueCard Program Manual, Chapter 5, Finance and Accounting Procedures, classifies Host Plan access fees as "other income" for BlueCard Program financial data recording and reporting purposes. The rationale for this classification is that the access fee is a limited fee that Home Plans pay based on the claim savings they receive, and not a recovery of administrative expenses that Host Plans incur in processing BlueCard Host claims. Although Plans may classify financial transactions at their discretion for their internal financial reports, they must abide by BCBSA standards and requirements for reports they send to BCBSA.

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Issues and Recommendations – Financial Review (continued)

1. **Host Accounting – Classification of Host Plan Access Fees on the BCBSA Quarterly Financial Report** (continued)

   Issue: (continued) When Plans use standardized reporting on the QFR, it provides for consistency and uniformity of reported data. Such reporting among Plans allows for the determination of meaningful aggregate Plan underwriting and other results and for comparisons among Plans.

   Effect: For the year ended December 31, 2000, Operating Income (line 15) on the Plan's QFR was overstated by approximately $4.87 million, the amount of access fee income included in administrative expenses reimbursement on line 13 of the QFR. Also, other income (QFR line 20 and Schedule 8) was correspondingly understated by the same amount for the same period.

   Recommendation: Plan Accounting staff should change its procedures for reporting data on the Quarterly Financial Report (QFR) it submits to the Association to classify BlueCard Host Plan access fees received as other income (line 20) rather than as administrative expense reimbursement (line 13). QFRs filed for each quarter of 2001 should be revised and resubmitted with the access fees reclassified. It is not necessary for Plan staff to change its internal reporting procedures.

2. **Pricing Methodology / Variance Accounting – Impact of Payment Differences and Provider Settlements on the BlueCard Program**

   Issue: BlueCard claim variances result when the amount approved for payment by the Home Plan on the Disposition Format (DF) record differs from the amount initially paid to the provider for the same claim. Such variances can be caused by either a) systematic or manual errors or b) the use of BCBSA-approved modified (estimated or average) pricing by the Host Plan. BlueCard Alliances requires Plans to account separately for both types of variances. Since the beginning of the BlueCard Program in 1994, and continuing to the present time, both situations have existed for the Plan as Host. Specifically,

   a) Payment differences or errors that occur when the approved-to-pay (ATP) amount on the DF record cannot be matched back to the local system (STAR) financial record. Plan staff investigated and found that the majority of differences occur when STAR reads the wrong DF field related to Other Insurance, and the final amount results in a provider underpayment. A System Test Plan was completed in 2000 which now flags all claims with payment differences over $50 and generates Reports

Issues and Recommendations – Financial Review (continued)

2. **Pricing Methodology / Variance Accounting – Impact of Payment Differences and Provider Settlements on the BlueCard Program** (continued)

   Issue: (continued)

   a) (continued) – NU39 (Host) and NU40 (Par) - where a manual provider check and remittance are issued.

      Differences under $50 are allowed to continue processing in STAR, where they are reported on the ZG39 (Host) and ZG40 (Par) Reports and journalized for write-off by Accounting staff. In all cases, the Reconciliation Format (RF) record is transmitted based on the correct payment amount per the DF. During year 2000, Accounting staff identified and wrote-off $9,340 of payment differences. However, occurrences were less frequent during the fourth quarter (only 5 in our audit test month of Dec 2000) and amounts written-off were immaterial. Any provider underpayment could result in the provider balance billing the subscriber. Under BlueCard Program Policy 3.6, Plans must have an enforceable hold harmless arrangement with providers when it charges an access fee.

   b) Variances caused by the use of modified pricing in conjunction with the contingent reimbursement provisions of provider contracts may cause the initial amount paid to differ from the ATP on the DF. Historically, the Plan's retrospective settlements have resulted in additional payments to providers. When the Plan implemented the BlueCard Program in 1994, it had received approval from BlueCard Alliances staff to use modified pricing for claims from all but two of its providers, Mayo Clinic and Fairview Hospital. The Plan did not account for variances for these providers until their contractual terms where changed to come into compliance with BlueCard Program requirements. Upon conversion to the STAR system in 1996, the accumulated variances were written-off to claims expense because STAR could not accommodate modified pricing (use of supplemental pricing factors). The variance write-off occurred without prior notification or approval of BlueCard Alliances staff. Subsequently, Plan staff was asked to reconstruct the variance account balance since the inception of the Program so that the data could be validated. Recently, provider contracts were amended to permit supplemental pricing in accordance with BlueCard Policy and state legal requirements. As BlueCard volume has increased, management felt it necessary to apply for approval to use supplemental pricing factors on BlueCard Host claims in order to be reimbursed for the additional payments to its providers resulting from the retrospective settlements.

Issues and Recommendations – Financial Review (continued)

2. **Pricing Methodology / Variance Accounting – Impact of Payment Differences and Provider Settlements on the BlueCard Program** (continued)

   b) (continued) During 2001, work began to determine the appropriate supplemental pricing factors to be used on the Submission Format records issued to Home Plans. A Systems Request (SR) had been initiated for the mechanisms (e.g., settlement factor table, modified reports, etc.) necessary to track and report variances in accordance with BlueCard Policy 3.6.

   At the time of our May 2001 Financial Review, Plan staff was still testing its design, including an analysis of the historical BlueCard variance and the impact of current provider settlements, as requested by BlueCard Finance staff. In addition, management was preparing the necessary pricing proposal documentation for BlueCard Host Traditional / PPO and POS claims to be submitted to BlueCard Finance. Information needed for BlueCard pricing proposals was outlined in our letter of February 21, 2001.

   Effect: Because there were differences between initial payments and final settlements with providers, and the amounts approved by Home Plans based on the Plan's current pricing methodologies, the Plan has accumulated a variance deficit, from underpricing BlueCard claims, that is estimated by Plan staff to range from $9.0 to $10.0 million since the beginning of the BlueCard Program in 1994 to the present.

   Recommendation: Plan staff should:

   a) Research the cause(s) of variances identified on its exception report (NU 39 – Host) and take appropriate corrective action so that the provider will not balance bill subscribers for any payment shortfalls.

   b) Complete and submit to BCA staff a pricing proposal with the necessary information and data requirements to justify the use of supplemental pricing factors for BlueCard Host claims.

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Issues and Recommendations – Financial Review (continued)

3. **Cost Accounting – Cost Center Documentation and Allocation Justification**

   Issue: In general, the Plan's cost center allocation methodologies appear to be consistent with the Association's guidelines. However, Cost Accounting staff does not conduct periodic cost center reviews to confirm that allocation methodologies and statistics are valid or need to be revised. Some cost centers have not been reviewed since 1998. In addition, staff does not maintain adequate cost center documentation (in narrative form) to support the allocation statistics used to allocate administrative expenses to the various Profit Centers including Profit Center 250100, BlueCard Host. Since cost center activities and/or Profit Centers may change over time, it is important to document pertinent information, including reporting structure and responsibilities by Profit Center, of each cost center periodically. Such documentation will help provide justification and support for the methodology and statistics used for cost allocation purposes.

   Effect: Lack of periodic cost center reviews and adequate cost center documentation may result in inaccurate charges to major Profit Centers, including 250100, BlueCard Host. Use of inaccurate cost data by Plan management could result in erroneous decisions based on such costs.

   Recommendation: Cost Accounting staff should review and document the activities of all costs centers at least annually. Cost Accounting staff should periodically conduct interviews with cost center management to determine the Profit Centers benefited by cost center activities and the appropriateness of the assigned allocation methodology and statistics. This documentation will assist internal staff reviewers to identify any systematic changes in cost allocations for variance analyses and provide external reviewers with support for cost allocations in use. In addition, formal procedures should be established requiring cost center management to notify Cost Accounting staff on a timely basis of any cost center reorganizations or changes that could affect the allocation of expenses to benefiting Profit Centers.

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Issues and Recommendations – Financial Review (continued)

4. **Cost Accounting – Costs Reported to the BCBSA on the Quarterly Cost Summary Report for the BlueCard Host Line of Business**

   Issues:

   a) Since August 2000, Cost Accounting staff has used membership statistics to allocate expenses to all Profit Centers from cost center 73200, Provider Network Management. This cost center is responsible for all provider inquiries, including but not limited to, inquiries concerning provider payments and/or contract issues. BlueCard network providers are included in the scope of this cost center's activities. Through July 2000, "dummy" Host membership statistics were used by the Plan's primary cost allocation software (SNAP) to ensure that Profit Center 205100, BlueCard Host, received a share of the total $4.2 million of expenses incurred. However, in August of 2000, after the implementation of SAP, as the new cost allocation software, the use of "dummy" membership statistics was discontinued, and Profit Center 250100, BlueCard Host, did not receive any share of the costs from cost center 73200, Provider Network Management. As a result, for the year 2000, BlueCard Host received only seven, instead of twelve, months worth of allocated expense.

   b) Cost Center 83500, Litigation / Subrogation, allocated $5,000 to Profit Center 250100, BlueCard Host, in year 2000 based on "dummy" membership statistics used through July. Blue Card Policy 1.7, Home Licensee Functions, states that investigating other party liability cases (including subrogation) is a Home Plan responsibility. As a result none of cost center 83500 costs should have been charged to BlueCard Host during 2000.

   Effect: Although the under-allocation to Profit Center 250100, BlueCard Host from cost center 73200, Provider Network Management, and the over-allocation from cost center 83500, Litigation / Subrogation, for the period after July 2000 appears immaterial, other Profit Centers in total, were misstated by comparable amounts.

   Recommendation: Cost Accounting staff should review the results of automated cost allocations on a regular basis to ensure reasonability before completing the Quarterly Cost Summary: BlueCard Program - Host LOB. Questionable allocations should be investigated and adjustments should be made as necessary. In addition, allocations before and after implementation of SAP should be compared to ensure that appropriate Profit Centers are charged in the new cost system.

Issues and Recommendations – Financial Review (continued)

5. **Cost Accounting – Overallocation of ITS Custom Administrative Expenses to BlueCard Host**

   Issue: Since the implementation of SAP in August 2000, Cost Accounting staff updates various statistical tables in the software to ensure that accurate expense allocations are made to the various Profit Centers. In 2000, claims statistics were generated for all Products, and reported on the ITS Claims - SKF #200004 report for use by Cost Accounting staff. The report used the following Nature of Business Codes, during claims processing, to distinguish among the different types of ITS claims, and ensure that claims are classified correctly:

   1 = ITS Home
   2 = ITS Host
   3 = ITS Par (where membership is loaded onto the local system e.g., POS)
   9 = ITS Par Plan (no membership loaded onto the local system, e.g. ITS custom)

   A separate Profit Center 200200, National Par, is included on the report to segregate monthly totals for National Par claims from Host claims, which are shown on the report under Profit Center 250100, BlueCard Host. Our review of the ITS Claims - SKF #200004 report for December 2000, (and its year 2001 successor, E310 Report), showed only 252 National Par claims reported under Profit Center 200200. The monthly average should be 6,000 to 7,000 claims based on our analysis of ITS Performance Tracking Software Reports (ITCP9314-00).

   Further investigation by Plan staff discovered that approximately 111,257 ITS claims, comprised of 104,683 Business Code 2 claims, and 6,574 Business Code 9 claims, were improperly included on the ITS Claims - SKF #200004 report, under Profit Center 250100, BlueCard Host, instead of being segregated and separately reported under Profit Center 200200, National Par.

   The Finance Work Group uses Plans' reported costs to evaluate and set BlueCard Program administrative expense allowances. Consequently, when Plans report their costs accurately, this helps BCBSA evaluate the impact of BlueCard administrative cost allowance changes on Plans' operating costs. In addition, Plans use reported cost data to evaluate their own costs with allowances received through the Program.

Issues and Recommendations – Financial Review (continued)

5. **Cost Accounting – Overallocation of ITS Custom Administrative Expenses to BlueCard Host** (continued)

   Effect: By reporting National Par claims, which represent ITS Custom business, with Blue Card Host claims, on the ITS Claims - SKF #200004 report, under Profit Center 250100, any subsequent allocations of administrative expense from any cost center that used ITS claims in its allocation statistics, would overstate BlueCard Host unit costs.

   Recommendation: Systems staff should rerun the E310 Report (2001 successor to the ITS Claims - SKF #200004 report), for all ITS Claims, using the correct Nature of Business Codes to determine the correct reporting for National Par, Business Code 9 claims (ITS Custom business). Cost Accounting staff should then determine if reallocations of 2001 administrative expenses are necessary for Profit Center 250100, Host or Profit Center 200200, National Par. (**Note:** Subsequent to our review, but prior to the issuance of this report, Plan staff made a change in the programming logic, and reran the E310 report back to January 2001 to segregate the National Par claims and include them in Profit Center 200200, National Par. It is unknown if administrative expenses were reallocated by Cost Accounting staff in accordance with the new claims statistics).

CONFIDENTIAL

MANAGEMENT REPORTS:

Legal Update

Mark Banks, M.D., President and CEO, Aware Integrated, Inc. and BCBSM, and Robert Milis, Vice President and General Counsel, BCBSM, provided a legal summary of the attorney general behavioral health lawsuit and the steps staff is taking as a response to the lawsuit. Greg Weyandt, of Rider Bennett, provided an update on activities his law firm has taken in connection with the litigation. Board members discussed issues related to the litigation, as well as other potential actions the Attorney General may undertake with respect to the organization.

Minnesota Decides Forums

Kathy Mock, Vice President, Policy and Legislative Affairs, and Tim Penny, former legislator, provided an overview of the Minnesota Decides Forums that have been conducted throughout the state. The goal of the forums is to shape the external environment as it relates to public affairs in which Blue Cross conducts its business. The process is to bring stakeholders together to find consensus solutions. Scheduled from January through May 2001, 19 different communities will be visited by staff conducting Minnesota Decides town hall forums. Each forum is preceded by meetings with local service groups, businesses and the media. BCBSM staff is reaching hundreds of people in different communities through taped or live radio interviews, forum events, and daily and weekly newspapers from Fergus Falls to Marshall.

Enrollment Update

Dr. Banks provided an enrollment update summarizing successes and losses since the last board meeting, as well as new accounts and prospect accounts for 2001. Total enrollment is 2,130,946 members through February with a year to date net gain of 87,632 members.

Finance Report

Tim Peterson, Chief Financial Officer and Vice President, Finance, BCBSM, reviewed the February 2001 financial highlights. The administrative expense ratios are favorable at this time. BCBSM is experiencing unfavorable results on fully-insured business and is showing an operating loss at this time. Net income is unfavorable by $(2.4) million. With respect to the gross margins by market segment, small group and rated group continue to balance each other. The total variance is $(5.7) million.

Mr. Peterson reviewed the 2000 financial highlights. He noted that the 2000 audited financials include a $22.5 million operating gain, the first time since 1994.

Minnesota *Decides*SM

BlueCross BlueShield BluePlus of Minnesota

Minnesota Decides℠

Minnesota *Decides*℠

Creating a Community BluePrint for Health Reform

Fall 2001 Report

BlueCross BlueShield BluePlus of Minnesota
An Independent Licensee of the Blue Cross and Blue Shield Association

Table of Contents

Fellow Minnesotans,

Raise an issue with Minnesotans — give them some background, pose some questions — and you can learn a lot. Whenever I have the opportunity to have in-depth discussions with Minnesotans, I come away impressed.

I visited 20 communities this year on Blue Cross' behalf to listen to what people have to say about health care reform. We held a public forum in each community. We also sat down with diverse groups, from the Itasca Area Council of Non-Profits in Grand Rapids to the Rochester Chamber of Commerce to the Urban Coalition in St. Paul.

These discussions started with the acknowledgement that in many ways Minnesota's health care system is the envy of much of the country. For example, Minnesota's uninsured population is only about one-third the national average and the quality of care in the state ranks high. As a result, Minnesota is at or near the top in national surveys of population health.

Still, Gov. Jesse Ventura has challenged health plans and others to engage Minnesotans in building on these strengths and improving the health care system. Blue Cross and Blue Shield of Minnesota is answering the governor's challenge. Through a unique survey, small group discussions and town hall meetings across the state, Blue Cross is making sure the public's voice is heard and heeded, as Minnesota decides how best to improve the health care system.

I thank the people who came and put in the time and effort to be part of this discussion. It's a complex topic. And for many people, it can be emotionally wrenching as well. But at each stop, we kept learning more and more about what people think should be done.

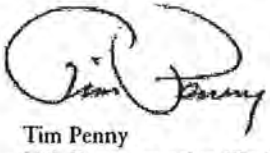
This report lays out the themes that were heard. Along with some background information, it also includes some suggestions about how we all can respond — health plans, providers, employers, government and individuals. I want to mention a few points that stood out for me:

- Minnesotans are beginning to recognize that trade-offs are inherent to health care. For people who want more ability to choose their benefits, they generally see that costs would rise as well. For people who want to control costs, they generally see the need for people to be more careful health care consumers. While no clear consensus emerged on the trade-offs people think our state should pursue, Minnesotans recognize that the health care system is a delicate balance. For every action, there is a reaction.
- If there's one value or attribute that people agree they want to see in the health care system, it's fairness. People don't just want the health system to be cheaper or easier for themselves. They want the system to be fairer for everyone.
- People see the need for management of various aspects of health care, from costs to quality. While this is the role that managed care was created to play, people are certainly not calling for more managed care. (And, interestingly enough, they're also generally not supporting a government-run system.)

More important than any one finding was the readiness Minnesotans showed to engage in this conversation. From the start, this process was dubbed Minnesota *Decides*. But as I said at many of our meetings, a more accurate name for this first stage would have been Minnesota *Thinks Out Loud*. People came with honest opinions, they spoke with great passion and they listened to what others in their communities had to say.

This isn't a report that offers answers to the challenges of health reform. The participants in Minnesota *Decides* made it clear that they don't have the answers...yet. Instead, they have a commitment to share their views and to begin the process of building a better system.

I hope that this report serves as a useful starting point for understanding what Minnesotans are looking for from health reform — as policymakers grapple with decisions about how to improve a system we all depend on so much.



Tim Penny
U.S. Representative (Retired)

2. Summary

"Minnesotans need to decide just what we want from the health care system. Right now these decisions are made piecemeal, as different bills pass the Legislature or as the courts hear different cases. We need to look at the bigger picture and figure out how we want our health care system to operate."

— Blue Cross President and CEO Mark W. Banks, M.D.

Minnesota Decides
Minnesota Decides is an initiative to engage Minnesotans in examining our health care system and identifying solutions.

What was involved?
- Community meetings
- Telephone survey
- Focus groups

There is a lot that is good about Minnesota's health care system. For example, according to a comprehensive survey conducted by the University of Minnesota, the state's uninsured population is one-third the national average.[1] The quality of care also ranks high, contributing to one of the country's healthiest populations.[2] In fact, in every year of the highly regarded State Health Rankings, Minnesota has ranked first, second or third among the states in the health of our population.

Gov. Jesse Ventura and others, though, have challenged Minnesota to do even better. Blue Cross agrees with the need to engage Minnesotans in improving how the health care system works for everyone. The rising cost of health care is a challenge to our health care system; as costs go up, access to care goes down.[3] Driven by increasing utilization, new technology, higher use of more expensive drugs and a graying society, these costs are threatening to erode a system that has provided care for so many.

So Blue Cross has set out to discover what Minnesotans think. Yes, health care is a complex issue. But Blue Cross knows that any reform efforts that aren't based on a solid understanding of what the public really wants will fail. We put our faith in the willingness of Minnesotans to puzzle out difficult issues for the common good. And we haven't been disappointed.

Dubbed Minnesota *Decides*, this effort has included focus groups, a unique survey and perhaps most importantly, a series of public forums and small-group meetings that involved thousands of people from around the state. Each of these elements built upon what came before it. The focus group results guided the formation of the survey. And the public forum discussions were structured around four key principles drawn from the survey.

CORE QUESTIONS

Many different questions have been asked along the way. But all of the discussion and research aimed to explore three core questions that our state needs to address:

1. What kind of health care system do Minnesotans want?
2. How much are we willing to pay?
3. Who should pay?

Minnesota *Decides* hasn't produced clear answers to these questions. But there are principles and general suggestions to help the state's citizens and policymakers reach some conclusions. They're listed below in the "Findings" section.

Blue Cross thanks all the people who've contributed to this effort. We have a lot to learn from each other as we make health care better for all of us. As Margaret Mead is quoted saying, "Never doubt that a small group of thoughtful, committed citizens can change the world. Indeed, it's the only thing that ever has."

[1] Call, K.T. et al., 1999. Minnesota Health Access Survey. Department of Health Services Research and Policy, School of Public Health, University of Minnesota.

[2] UnitedHealth Group State Health Ranking — 2000 Edition

[3] Blumenthal, D. Controlling Health Care Expenditures. New England Journal of Medicine 2001; 344; 766-769

FINDINGS

What have we learned up until this point from this conversation about health care reform? Based on the Minnesota *Decides* focus groups, survey results and community meetings, we've learned that:

Minnesotans want a system that is fair.

For example, participants said if Minnesota is to have a fair system, health care should be available to all residents. As one participant said, we should have a "Triple A model: accessible, affordable and available." Yet some participants expressed views similar to the participant who said, "Life is not fair. Everyone needs a certain standard of care, but some will have nicer care, just like some have a nicer house, a nicer car, or anything else." A number of participants did not think it was fair that some government programs had better benefits than what they could afford to buy. There was often general support for the idea of asking people to pay something for their health care, even if it were only a few dollars on a sliding fee scale.

The connection between employment status and health care coverage was also often seen as unfair. And when employers sponsor coverage, many participants thought health plans should charge the same premiums to all employers, whether large or small. They also generally thought it would be unfair to make care decisions solely based on cost.

Minnesotans want a system where costs are under control — for both the system as a whole and for individuals.

Many participants felt that costs are growing out of control for a variety of reasons. People generally recognized that consumers had a role to play in managing costs. They also said that health plans, employers, physicians and the government need to help control costs.

Minnesotans want a system that is market-driven but they see specific areas where government may play a role.

A minority of participants, however, thought a Canadian-style system is needed. There was general interest in having the government take steps to improve the system and look after consumers' interests in specific areas. For example, many participants thought employers could be encouraged to offer group health insurance or the government could ensure that people have catastrophic coverage. There was even general support for requiring employers to offer group health insurance, even if employees were to pay the full cost.

Minnesotans want a system where choice is preserved and enhanced.

Many participants wanted people with insurance to be able to choose their doctors and other providers and they want employers to offer more than one plan option. While participants generally thought that people have a *responsibility* to not use more health care services than they need, they supported the *right* of people to use as many services as they want.

20 town hall forums were held around the state:

- Albert Lea
- Bemidji
- Bloomington
- Brainerd
- Duluth
- Fergus Falls
- Grand Rapids
- Granite Falls
- Hibbing
- Mankato
- Marshall
- Minneapolis
- Moorhead
- Rochester
- St. Cloud
- St. Paul
- Virginia
- Willmar
- Winona
- Worthington

"I see the costs getting out of hand....And I think it's going to get worse."

— Hibbing participant

"I'd like more information. This is all new to me. So what type of money are we talking?"

— Duluth participant

"There are no incentives for the individual to be healthy."

— Granite Falls participant

'ommunity Meetings
n page 5 summarizes what participants had to say.

Participant Suggestions on page 11 lists what initial ideas were offered at community meetings.

Minnesotans want a better response to the state's diverse populations, in terms of improving health and reducing costs.
Participants said language and cultural barriers and a lack of sensitivity are personal health care issues for consumers and potential public health issues for communities.

Minnesotans want to enhance the importance of public health.
Participants suggested that the public needs to understand the important role public health plays in prevention, detection and treatment of community health problems, which in turn were deemed to be cost savers.

Minnesotans' views about health care mirror the complexity of the system itself.
Participants held some views that appeared to be contradictory at times. For example, most participants were quite tentative about government-run health care, but they also felt that our current reliance on employer-based insurance coverage is unfair. Some participants concluded that there are limited resources for health care while others concluded that the United States has unlimited resources for health care. In addition, participants indicated they dislike regulation but supported price controls on drugs.

Minnesotans are concerned about the situation and they have a desire to get involved in creating solutions.
Many participants feared that health care costs are spinning out of control and that nothing is being done to stop them. This environment left many of them feeling vulnerable and worried. This backdrop of concern appeared to create a desire to participate in figuring out how to improve the health care system. Participants were acutely aware of how the system affects them.

Minnesotans believe all stakeholders are part of the problem and all need to be part of the solution.
If the public sees all the elements and players coming together in good faith, identifying problems, considering options and each making sacrifices, participants indicated they would be likely to respect the changes, even if they don't necessarily like them all.

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SUMMARY

About 1,000 people participated in Minnesota *Decides* community meetings. They came to 20 town hall forums and more than 50 small-group discussions. Public input was extensive, diverse and sometimes conflicted. An independent research analyst was retained to review the transcripts and notes of all forums and small group discussions. Her assessment forms the basis of the themes detailed below.

"We all — as the users, as the providers, as the insurers and the government — we all have a share in correcting the situation. And it has to be corrected."

— Winona participant

From all the comments, two areas repeatedly triggered significant discussion on their own and then often resurfaced in the context of other topics: cost and fairness.

"What can we do? We have no recourse. ... I don't know what to do."

— Virginia participant

Cost-related comments were varied. Generally, participants were concerned about the growth of costs and their impact on the system and their own personal financial situation. Comments included acknowledgement that costs are growing out of control and that costs are often invisible to consumers with traditional employer-based coverage. There also was extensive discussion about how best to control costs and how consumers, insurers, physicians and other providers all can play a part.

Comments regarding fairness were diverse as well. Participants wanted the health care system to be even-handed. Comments regarding fairness included the difficulty people with pre-existing conditions have securing insurance, the difficulty people who pay for their own coverage have paying for their coverage and how we balance personal responsibility with "responsibility for my neighbor," as a Bloomington participant stated. Fairness on its own wasn't as clearly as dominant a topic as cost in the results of the analyses included below. But it continued to appear and be discussed in most parts of the conversations.

Some of the most illuminating portions of the meetings were spent talking about areas where cost and fairness concerns overlap. These were areas where participants seemed to be weighing difficult choices and beginning to recognize the trade-offs they were faced with. Here are two examples:

- One area where cost and fairness came together was when the participants discussed the wisdom of trying to encourage people to take better care of their health by raising the costs for people who smoke or engage in other behaviors that hurt their health. "There are no incentives for the individual to be healthy," a Granite Falls participant said. But the details of how such approaches would be put in place and would be fair to people became a concern for many others. If someone couldn't control his weight, he shouldn't be financially penalized, a Minneapolis participant said. "You don't know what's going on in that person until you've walked in his shoes."

"I find it offensive that drug companies advertise a product on television and every place else."

— Fergus Falls participant

"I'm a dentist. I get patients every day that say, 'How much is this going to cost?'... There's nothing like having to answer that question to watch your costs."

— Albert Lea participant

- There was general support for the idea of asking people to pay *something* for their health care, even if it is only a few dollars, regardless of their financial situation. There was some discussion about whether it is fair that people on government programs generally have better benefits than those with private coverage, even though people on government programs typically don't pay for those benefits. One participant in Willmar discussed, for example, how people on medical assistance can go to the doctor for any little thing while "here I am just down in bed and I'll say, 'Well, gee, I can't afford to go.' And still we're the ones paying the money for them to go." Other participants, though, felt it was important to make good health coverage available regardless of economic status.

Looking ahead, Minnesotans agreed that all the parts of the health care system need to be accountable and play a role in fixing what ails the system. And there was considerable acknowledgement of the role that individuals need to play, whether it is by helping shape health care policy or by being informed, prudent consumers.

PUBLIC MEETING THEMES:
Answering our three core questions

The three questions that triggered this process sound so simple: What kind of health care system do Minnesotans want? How much are we willing to pay? Who should pay?

Yet the topic is extremely complicated and the questions are too new. We heard very few clear answers. But we did gain some valuable insights into the directions Minnesotans are heading and the information they want to refine these answers. Minnesota *Decides* participants at the forums and in small-group meetings generally indicated they need more information if they're going to be able to offer more concrete or specific suggestions.

QUESTION ONE:
What kind of health care system do Minnesotans want?

Minnesotans want to see a variety of characteristics sustained and enhanced in the health care system. In summary, Minnesotans generally want:

- A system that is fair
- A system where costs are contained — for both the system as a whole and for individuals
- A system that is market-driven but that offers some government role
- A system where choice is preserved and enhanced

Discussion at the community meetings touched on several themes that collectively begin to answer the question of what kind of system Minnesotans want:

Prevention and early detection were deemed cost savers.
Participants understood the potential for cost savings when illnesses are prevented or detected early, and strongly recommended greater emphasis on preventive and detection efforts. Some participants were aware that costs to fund prevention programs would be significant on the front end, but savings could be great on the back end. Because they did not know how much this recommendation would cost, however, they were unable to predict their willingness to pay for it.

"We have a responsibility, at least partly, to pay for services we use. I think most people would agree with that."

— St. Cloud participant

The importance of public health needs to be acknowledged, participants observed.
It was suggested that the public needs to understand the important role public health plays in the prevention, detection, and treatment of community health problems (all deemed cost savers). If savings resulting from public health programs were better known, some surmised that Minnesotans would value public health more and view it more favorably.

"Whatever happened to calling Mom or asking your next-door neighbor about how to treat a cold? It costs a lot more for a doctor to tell you to rest, drink fluids and eat chicken soup."

— Fergus Falls participant

Participants thought it was important to have choices for insurance coverages, insurance premiums, doctors/ clinics and treatments.
Concern about choice was particularly high in rural areas, where participants said they had only one insurance carrier writing policies, one clinic to attend or one hospital to use. While participants expressed their opposition to having insurance companies dictating treatment options, they also understood that choice can be costly and compromises might be required.

"Health care should look like a triple-A model: accessible, regardless of circumstance; affordable and available. There are too many exclusions and exceptions."

— Minneapolis participant

Many participants were proponents of a market-driven system.
These participants did not believe the federal or state government could run a cost-effective system that would provide Minnesotans with the level of care and the choice of care they want and expect. A market-driven, competitive system, which builds on what is working well today, was deemed preferable. Participants said the benefits would be: lower provider and hospital fees; more insurance carriers writing policies in Minnesota; greater number of insurance options; lower premiums; and control placed back into the hands of the consumer. These participants said Canada's health care system is a model to be avoided.

Those who favored a single-payer system thought it would be fair.
They believed a state-run health care system would reduce disparities between the rich and poor and make health care affordable for everyone. A statewide pool could combine young and old, healthy and unhealthy. Risk could be shared by all. Costs could drop because there would be no "middlemen to be fed." They also thought that the state could bargain for low prices with key players (for example, pharmaceutical companies, health care providers, hospitals) and that the system could become more efficient. These participants cited Medicare and Canada's health care system as models to be emulated.

"Keep the government out of it. The key to lower health care costs is patient responsibility, not government interaction."

— Mankato participant

Disparities between those with state-sponsored coverage and private coverage should be reduced.
Participants did not object to helping those in Minnesota who cannot afford health care, but many thought it unfair that Minnesotans on state-sponsored programs can receive full coverage at little or no expense, while many insured Minnesotans are paying "sky-high premiums" for just catastrophic coverage. The gap between the two is too wide, participants said, and health care reformers should close it.

"Government-administered health care is the only way to guarantee fairness."

— Granite Falls participant

QUESTION TWO:
How much are we willing to pay?
Participants gave few clues to how they would answer this question. When asked at some of the forums how much of their personal income should go to health care, participants did not have ready answers. In the survey, for example, they were sharply divided on the question of whether the United States has "only limited resources to spend on health care."

Generally, participants indicated that they need more information before they can weigh in on this issue. In particular, they wanted a clearer understanding of the real cost of health care, who is responsible for which costs, who holds whom accountable and what factors are pushing costs higher.

Again, some of the themes from the community meetings bring some focus to the question of how much Minnesotans are willing to pay:

The system must be streamlined if costs are to be lowered.
Health care reformers must identify and eliminate the policies and/or procedures that waste financial and human resources, advised the participants. For example, they said there should be fewer forms, since people at all levels are "buried in paperwork"; hospital billing systems must be improved so they generate clear, concise, accurate bills; and insurance companies must become more adept at finding errors, solving problems, answering questions, and making decisions.

Personal responsibility and accountability were seen as key to lowering health care costs.
If everyone, at every level, felt personally responsible for lowering health care costs, and if they were held accountable for their actions, participants predicted health care costs would drop. They emphasized, however, that everyone in the system — pharmaceutical companies, insurance companies, hospitals, health care providers, state government, and consumers — must feel responsible and be held accountable, or costs will not be contained.

Fear and a sense of helplessness existed among participants.
They said they fear that health care costs are spinning out of control and there is nothing being done to stop them. Participants said they feel extremely vulnerable to pharmaceutical companies, they question whether the actions and business decisions of insurance companies are made in consumers' interest, and they question the decisions and motives of health care providers and hospital management. Participants' comments suggest the belief that various elements of the health care system enjoy unbridled spending at their expense.

QUESTION THREE:
Who should pay?

This question was often hard for participants to answer directly. They generally supported the idea of consumers paying for some portion of their health care costs, even if it is a small amount. The benefits, many people said, could include raising consumer awareness of the real costs, discourage over-utilization of the most expensive services and lighten the financial burden for others.

"So if someone's thin and in shape they would pay less than someone who is overweight and not in shape. ... Who's going to determine that?"

— Hibbing participant

But participants wanted the contribution amounts to be fair to those who need to use more services. Mostly, they did not think that people who are more likely to use care, such as those with small children or those with chronic conditions, should have to pay more. In addition, the survey respondents were more uncomfortable with financial penalties based on individual choices, such as tobacco use. Meanwhile, the idea was generally accepted at the Minnesota *Decides* meetings. The meeting participants who were supportive were concerned about who would decide which health issues are really beyond an individual's control.

"Blue Cross should do some consumer education and illustrate the effect of people's actions on health care costs."

— Brainerd participant

While there was some support for a government role in covering catastrophic and preventive care, most people didn't want to move to a completely government-led system. They instead generally wanted to keep employers involved in paying for health care. There was an interest in making the employer-based system fairer: Minnesotans generally did ask for more consistency in premiums between small and large employers and between group and individual insurance offerings.

Some of the themes from the community meetings began to address the question of who should pay:

Everyone involved with the health care system was deemed a cost driver.
All people involved with pharmaceutical drugs and health insurance, all people responsible for patient care and hospital stays, and every person who uses any part of Minnesota's health care system were identified at different times as cost drivers. Government mandates requiring health plans to cover certain treatments and health-related lawsuits were also cited. Participants held a strong belief that *everyone* plays a role in rising health care costs; therefore, *everyone* must be a part of the solution.

Cost-shifting should be held to a minimum.
Although they dislike cost-shifting, participants were unable to figure out how to eliminate it from the system, especially after claiming that every Minnesotan should have access to health care. Realizing that some people will not be able to pay, participants' comments suggest they want health care for the uninsured *altered*, to more fairly distribute the financial burden, but not *eliminated*.

Healthy lifestyles should be encouraged and rewarded, but participants discovered that might be easier said than done.
If Minnesotans were encouraged to lead healthier lives, and understood the benefits and drawbacks as it relates to their health care costs, participants predicted better health and lower costs. To accomplish this goal, they suggested wellness programs and incentives for healthy lifestyles. A popular incentive was lower insurance premiums for those who do not smoke, those who exercise regularly, and/or those who maintain an appropriate weight for their age, gender, and stature. (Similar to car insurance, where a good driving record means a lower premium.) Participants suggested, however, that only lifestyle choices should be rewarded. They did not want to inadvertently punish people who have no control over their health issues (for example, hereditary disease, genetic defect, broken ankle while running, etc.), and therein lies the problem: who decides which health issues are lifestyle-related and which ones are beyond the individual's control? There was no person or entity within the present health care system that participants said they would trust enough to make such judgments.

Each health care consumer should pay what he or she can, even if it is only a small amount.
This, participants said, would accomplish three important things: raise consumer awareness of the real cost of health care; discourage over-utilization of emergency rooms and other services; and lighten the financial burden currently absorbed by others.

ADDITIONAL THEMES

The participants in the Minnesota *Decides* community meetings also frequently made comments regarding the broader health care context that don't address the three core questions. These additional themes were:

Participants wanted Minnesota's health care system reformed and they were thankful for the opportunity to participate.
They were acutely aware of how rising costs in the health care system has affected them and their families, but wanted more information to make informed suggestions for improvement. Participants asked questions, listened to responses, and attempted to resolve problems. They gave thoughtful consideration to the issues, respectfully debated options and struggled with possible conflicts and compromises. They felt they need a much better understanding of the health care system if they are to be effective agents of change.

Minnesota's health care system should be examined from top to bottom.
Participants said all cost drivers should be identified and then policies, procedures, and/or laws should be put in place to hold all players responsible for their decisions and accountable for their actions. A complete review and rethinking of Minnesota's health care system is necessary, they said, or changes will be nothing more than another "Band-Aid solution" for a systemic problem.

Many people came to the Minnesota *Decides* meetings and forums with strong feelings on different issues. As participants put their ideas out for discussion, they lead to other comments. Here are the suggestions we heard. Many are in preliminary form and some raise other questions and challenges. Still, they provide a useful starting point.

- Offer **public education** about health care and costs; it is particularly important to make the real costs of health care visible. Topics to address include what are the actual costs, what drives them up, what is being done to contain costs and what can consumers do to contain costs. Participants said citizens need more information to be effective agents of change.

- Support **personal responsibility and accountability** with information and resources. Examples include toll-free nurse lines, insurance ombudsmen and explanations of generic vs. brand-name drug decisions. Use clear, concise language to make information as understandable as possible. Help all parties — physicians, hospitals, insurers, pharmaceutical companies, State government and consumers — feel personally responsible for managing health care costs and accountable for their actions. Raise end-of-life decision making early on, including advance directives. It's a point Minnesotans raised in Minnesota *Decides* focus groups as well: "We should be more responsible for our own health," one participant said.

- Explore the **role of the federal and state government.** For example, the federal government could regulate drug prices by setting caps on their costs or limiting drug companies' ability to charge more for drugs here than they do in other countries. The state could assure health care coverage for all residents. Options include the state setting up a pool that includes all residents, who would be sharing risk. The state could also take the lead in negotiating drug prices, hospital fees and health care provider fees.

  In contrast, many participants offered suggestions to reduce the role of government. Examples include cutting government mandates that drive up costs and avoiding one-size-fits-all government programs.

- Explore ways to **provide the uninsured with health care.** Minnesotans realize that some people cannot pay for health care and they want them to have access. They think it is unfair, however, that Minnesotans on public programs have access to the system with limited costs to them while many insured Minnesotans are scaling back due to rising costs.

- Expand **preventive care** coverage for more people. Include preventive services for everyone (for example, mammograms, Pap tests and immunizations) and some early detection screenings (e.g., diabetes, cancer and heart disease). As a Hibbing participant said, "Maybe if we had the preventive paid in full, but the rest was going to cost us a little something, we'd be a little more careful about how we took care of ourselves."

"The government, the individual, the communities and the companies have to work together if they want to change the system."

— Minneapolis participant

"We need to take some responsibility individually ourselves."

— Moorhead participant

"Life is not fair. Everyone needs a certain standard of care, but some will have nicer care..."

— Worthington participant

Participant Suggestions (continued)

- Raise the importance of **public health** efforts to meet community health needs. This suggestion built on the prevention idea within public health. As one Minneapolis participant said, "We have built our system on illness, not prevention."

- Address **drug issues**. Set up pharmaceutical coverage that favors generic drugs (for example, pay for 100 days of a generic drug or 34 days of a name brand drug). But have an easy appeals process if a generic drug doesn't work. Use a sliding scale copay arrangement based on family income and drug price. In addition, insurers could consider covering herbal or alternative remedies.

- Use **sliding scale copays and premiums** based on a person's annual income. The adjustable copay could apply to a variety of services, from pharmaceuticals to emergency room use to clinic services.

- Investigate ways to offer **new options to consumers**. Offer consumers a choice of benefit levels, with those willing to pay more having more freedom to seek care from the doctors of their choosing. Include nursing home and other long-term care within the health insurance system. And consider how new supplemental insurance products could be created and sold directly to interested consumers. Focus areas could include better prescription coverage, preventive care or mental health. Consumers were interested in new insurance models, such as medical savings accounts.

- Allow small businesses and individuals to band together in **purchasing pools**. This could allow more people to share risk and smooth out premium rates. Also consider community rating.

- Look for ways to **simplify**. Health care has become so complex. Re-examine each step in the process and see what makes sense, what improves health and what saves money.

The Minnesota *Decides* forums to date have demonstrated the value of a grassroots discussion on the future of our health care system. Informed consensus-building can lay the foundation for building a better health care system and can help answer the questions of how much health care should cost and how we should pay for it. Blue Cross is committed to pursuing three next steps:

1. **Broadly distribute information about what's occurred to date.**
   A report on what has been learned so far through Minnesota *Decides* will be sent to people who participated in the community meetings. Blue Cross will also share a summary of this report with a diverse set of stakeholders, including physicians and other health care providers, employers, consumer and other groups and Gov. Ventura's administration.

2. **Continue to facilitate the collection of information and ideas on how best to improve the health care system.**
   The community discussions have generated a wealth of information and have identified areas for possible action steps by health plans, health providers, employers, consumers, policy makers and others. It now is appropriate to take this information and these suggestions to other stakeholders — especially employers and health care providers — to gain their insight and ideas to the discussion. This process will help translate the concepts that are coming forward into appropriate action steps. We will ask new audiences to explore and evaluate the suggestions collected to date. The goal will be to refine and prioritize what participants have contributed. Blue Cross' role is to facilitate this process, collecting the advice, direction and suggestions that can help inform specific action steps to improve the health care system in Minnesota.

3. **Engage community members around the complex questions of who pays for health care and how much.**
   Minnesota *Decides* participants told us they needed more information to answer two critical questions — who should pay for health care and how much? Blue Cross will sponsor consumer education on cost issues and impacts, arming Minnesotans with the tools they'll need to further grapple with how they want the system to address costs. We hope that education also expands the number of Minnesotans involved in Minnesota *Decides*, bringing more people to the discussion.

Blue Cross will be working in the fall of 2001 and throughout 2002 to carry through on these steps. If you haven't been part of Minnesota *Decides* and you want to get involved, contact us at the number and addresses listed below.

"I'm sorry we didn't have any answers for you tonight. But no one has ever asked these questions before. ...Will you come back again and let's talk some more?"

— Moorhead participant

FOR MORE INFORMATION:

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SUMMARY

The consumers who participated in four focus groups at the start of the work on the Minnesota *Decides* process were most concerned about **health care costs and coverage.**

The topics raised were used to develop the survey and the community meetings.

- They said they worried about **high prices** and a system that seemed to have an **inappropriate for-profit focus,** even in the Minnesota setting of nonprofit hospitals and health plans.

  "I have a high deductible so I wait until the last minute to go. I'm discouraged from going to the doctor because of the cost."

  "I don't think anyone knows what they should be paying."

  "The root charge is the desire of the insurance company and the doctor to make money."

- They also worried about **lacking the coverage** they needed.

  "To have this whole family without insurance was the scariest six months of my life, never mind that we had no income and not enough money for food."

  "People are living much longer now and they may not have the family that is going to take us in when we're old."

- Changes that have **compromised medical care** and factors that **prevent people from obtaining the care they need** were other concerns.

  "You don't get to know your doctor. They don't know you ..."

  "A lot of times you have to change doctors when your company changes insurance."

  "All decisions are money-based."

  "Insurance companies have too much control over what the doctors do."

- In addition, **inequities in health care** were discussed regularly.

  "Why can some people get group rates and others can't? Why can't self-insured people get group rates?"

  "My nephew has MinnesotaCare and it pays for everything. He gets better coverage and doesn't have to pay for it. That's not right. Everyone should have health care."

  "They should lower the cost of the premiums so that even poor people could afford insurance."

While few participants supported the idea of a government-run system, others wanted the government to do more to help manage costs and regulate the current system.

BACKGROUND

Four focus groups with about 10 to 12 participants each were held in the summer of 2000. Two were held in the Twin Cities and two in Hutchinson. Two groups were made up of 30- to 54-year-olds and two groups were made up of 55- to 75-year-olds. All participants were health plan decision-makers within their families. No more than half of the participants in any one group were covered by a Blue Cross plan. Qualitative research like this uses small sample sizes, meaning the results cannot be projected to represent the total population. The major themes detailed below were drawn from the results reported by the focus group consultant. The focus groups helped lay the groundwork for developing the quantitative telephone survey.

MAJOR THEMES

What's working?

While participants found it easier to talk about what's not working, they tended to agree that:

- Medical care is generally good, as long as access and coverage aren't restricted
- Paperwork burdens have shrunk for consumers
- Research has offered new treatments and drugs

Identifying health care issues

Cost was one of two top concerns. Topics included high prices as well as a system that discouraged people from seeking care. Participants saw the system contributing to the problem, with fraud, billing inaccuracies, unchecked pricing and a for-profit orientation that seemed inappropriately greedy to some.

Coverage was the other principal concern. They worried about the consequences of lacking sufficient coverage.

Factors that would prevent people from obtaining good care were another cause for concern. These included HMO network restrictions, insurance company changes that necessitate a change in physicians and delays in getting in to see a doctor.

Changes that have compromised medical care were another worry.

- Problems involving physicians included a lack of involvement or caring manner, an over-specialization and limitations imposed on physicians
- Problems involving hospitals included insufficient staffing and the isolation of rural hospitals that are "dying on the vine"
- Problems involving health insurance companies included having too much control over medical care, making decisions based on money alone and preventing individuals from getting the best possible care

Health care inequities

Inequities of health care came up at various points during the sessions. When directly asked, most respondents agreed that "health care isn't fair." Inequities include:

- Limits on coverage for mental health, chiropractic care, physical therapy, holistic treatments, certain prescriptions and pre-existing conditions
- Lack of ability to buy group-rate coverage
- The quality of care that people on government-sponsored plans receive and the low price they pay, compared to what people with private insurance get for what they pay
- Drug companies are profiting from research supported by public dollars
- Quality of care varies around the state and nation

Funding health care

While a few participants suggested the government should pick up the tab for health care, most disagreed.

Participants generally supported distributing health care costs between employers and individuals, with more efforts to manage or "regulate" costs and more attention to being evenhanded about how costs are dealt with.

Health care roles

Government and politicians should ensure that people are treated fairly, but not manage health care.

Lobbyists should be watchdogs but they shouldn't be too pushy.

Doctors should be given more say in patient care and have their loads lightened.

Insurance companies should control their costs, pay the bills, help with prevention, be efficient and play an oversight role with providers.

Drug companies should develop and sell drugs.

Employers should pay the majority of the bill or give employees the money to do so. They should also sponsor wellness programs. Individuals should be informed, make open enrollment decisions and use insurance wisely.

The media should educate but not over-sensationalize.

Impact of societal changes

Participants in the Twin Cities were asked about societal changes and the impact on health care. They thought that an increase in education levels means that more people will be interested in pursuing preventive care. They also thought that greater mobility of patients reduces the stability of the patient-physician relationship.

SUMMARY

The Minnesota *Decides* survey took a unique approach at gauging public attitudes about health care. It measured public agreement on a range of themes or value statements about what policies should be pursued by government, employers, physicians and individual consumers.

The analysis derived four key principles for health care reform: fairness, compassion, market-driven structure and choice. These results were used at the community meetings.

Fairness

Fairness was a dominant principle as survey respondents thought about health care. It was stated and reinforced in numerous ways, but always to the same point — make the system fair for all people. For example, more than three-quarters (79 percent) of survey respondents believed that government plans should not be better than coverage through employer-based or private health insurance.

The link between employment and coverage also is a source of perceived unfairness — 58 percent thought it was fundamentally unfair that most people's coverage depends on who they work for and whether or not they are employed. Survey respondents supported a variety of means to close this perceived fairness gap. About two-thirds (69 percent) agreed that health plans should charge the same premiums to all employers, large or small. And nearly three-quarters (73 percent) thought plans should offer coverage for individuals at the same premiums charged to big employers.

Minnesotans also believed that pharmaceutical companies treat their customers in the United States unfairly; 85 percent agreed (37 percent strongly agreed) that drug companies should not be allowed to charge more for a drug in the United States than in other countries.

Compassion

Survey respondents wanted a system that is compassionate. For example, 59 percent did not support sanctions for groups that are likely to use more health care benefits, such as families with children and people with chronic conditions. In addition, 80 percent were supportive of adding coverage for long-term care for seniors to the health care system. Also, respondents wanted rewards for positive choices but there is strong division on the question of applying sanctions for choices that are within a person's control.

Market-driven structure

Minnesotans believed the system should be market-driven, building on what has worked in Minnesota. Despite concerns about the soundness of the current system, fewer than one-third agreed that a Canadian-style system of government-run insurance is needed to ensure fair health care. We also found that half (50 percent) agreed that private health insurance is better than a government-run system, with 26 percent uncertain and 23 percent in disagreement. Respondents were evenly divided on whether a health insurance "safety net" should be provided by the government. And while 42 percent agreed that the government should pay for catastrophic care for everyone, a virtually identical portion (41 percent) disagreed with that principle.

Choice

Survey respondents said that the health system should place a priority on the choices that individuals make for themselves and their families. Yet many recognized that there are limits to what the system can afford to provide. This is one of the most complex contradictions revealed by this research. Nearly all Minnesotans agreed that, if people are willing to pay higher premiums, they should have the right to see any doctor they wish as part of their plan. But people also endorsed the principle of limiting their utilization to services they really need — nearly three-quarters (72 percent) thought that setting these limits for themselves is a "moral responsibility."

People also were reluctant to limit the benefits of new technology to those who can afford it. Forty-one percent thought that everyone in the country should be able to get expensive new treatments, even if it makes taxes go up, with 27 percent saying anyone with insurance should have access, even if their premiums would increase.

BACKGROUND

The questions for the survey were developed from the comments and questions raised at the focus groups. The survey involved 1,200 Minnesota adults who were interviewed by phone in the summer of 2000. A pilot test survey was conducted beforehand to refine the survey. After an initial set of questions, each respondent was asked one of four sets of questions related to specific roles for government, employers, health plan and individuals. The results were used to engage people in the discussion at the public forums and small group meetings.

Theme Rankings

Multiple themes were presented to survey respondents. Respondents were asked to say how much they agreed using a five-point scale (1-strongly disagree, 2-disagree, 3-not sure, 4-agree, 5-strongly agree).

The themes which had the highest agreement among those surveyed were the following:

- If they are willing to pay higher premiums for their health insurance, people should have the right to see any doctor they wish under their insurance.
- The fees charged by doctors, hospitals and other health providers should be available to the public.
- Pharmaceutical companies should not be allowed to charge more for a prescription drug in the United States than in other countries.
- Employers should be given additional tax incentives to provide group health insurance for employees.
- Nursing home and other long-term care for the aged should be a standard part of our health insurance system.

Agreement was mixed for some other themes. For example:

- Opinions were almost equally divided over whether employers should work with health plans to charge higher premiums for workers who don't take care of their health by smoking or not exercising.
- There was no agreement over whether we as a nation had limited or unlimited resources to spend on health care.
- People were divided over whether the government should pay for catastrophic medical care for everyone as well as whether the government should pay for preventive medical care for everyone.
- The majority of people felt that they had a "moral responsibility to use health care services no more than we absolutely need in order to control spending on health care, even if we have full insurance." Yet a majority also thought that "if you have health insurance, there is nothing wrong with demanding all the treatment, tests or medications you want."

The themes which had the highest levels of disagreement among the Minnesotans surveyed included:

- The government should be able to limit the premiums charged by health insurance companies, even if they have to limit the benefits they offer to cover their costs.
- Health insurers should be able to review all new medical treatments, devices and drugs and decide which ones they will cover.
- Employees and their dependents who are likely to use more health care, such as families with children or people with chronic conditions, should be expected to pay higher premiums than others.
- The government should regulate the salaries paid to doctors and other health care providers.
- Employers who pay for their employees' health insurance should be able to review all new medical treatments, devices and drugs and decide which ones they will cover.

Blue Cross organized 20 **town hall forums** in the following communities:

Albert Lea	Marshall
Bemidji	Minneapolis
Bloomington	Moorhead
Brainerd	Rochester
Duluth	St. Cloud
Fergus Falls	St. Paul
Grand Rapids	Virginia
Granite Falls	Willmar
Hibbing	Winona
Mankato	Worthington

Participants were either invited to attend through mailings to Blue Cross members or they responded to publicity in the local media or radio or newspaper ads alerting the public and inviting citizen participation. Town hall forums lasted about 90 minutes.

The participants at the forums were generally covered by health insurance that they either acquired through their employers or by purchasing themselves or they were covered by Medicare. Based on participant comments, it appears that only a few were covered by state-supported programs.

Blue Cross also coordinated more than 50 **small-group discussions** with existing organizations, such as the Centre for Asians and Pacific Islanders in Minneapolis and the Duluth Chamber of Commerce. These discussions generally ran about 60 minutes.

Worthington/Albert Lea:

Southwestern Minnesota Private Industry Council, Worthington
Noon Kiwanis Club, Worthington
Chamber of Commerce, Worthington
Client Community Services Inc., Worthington
Nobles County Department of Public Health, Worthington
Chamber of Commerce, Albert Lea
Freeborn County, Albert Lea
Albert Lea Medical Center, Albert Lea
Independent School District #241, Albert Lea

St. Cloud:

Stearns County
Stearns County Department of Public Health

Twin Cities:

Centre for Asian and Pacific Islanders, Minneapolis
Indian Family Services, Minneapolis
Minnesota Women's Consortium, St. Paul
Model Cities Health Center, St. Paul
Urban League of Minneapolis, Minneapolis
Urban Coalition, St. Paul
Insight News/KMOJ Public Policy Forum, Minneapolis
Blue Cross and Blue Shield of Minnesota, Eagan

Vinona:
Winona County
Winona Clinic

Bemidji/Brainerd:
Business and Professional Women, Bemidji
Veterans of Foreign Wars Post #1647, Brainerd
Sertoma Club, Brainerd
Lakes Area Chamber of Commerce, Brainerd
Independent School District #181, Brainerd

Duluth/Grand Rapids:
Minnesota Power, Duluth
Chamber of Commerce, Duluth
Itasca Medical Center, Grand Rapids
Itasca County, Grand Rapids
Itasca Area Council of Non-Profits, Grand Rapids

Virginia/Hibbing:
Noon Kiwanis Club, Virginia
Arrowhead Economic Opportunity Agency, Virginia
Elder Services Network, Mountain Iron
United Way of Hibbing, Hibbing
Independent School District #701, Hibbing Moorhead/Fergus Falls:
Women's Network of the Red River Valley, Moorhead
American Crystal Sugar, Moorhead
Early Risers Kiwanis Club, Fergus Falls
Chamber of Commerce, Fergus Falls
Lake Region Hospital, Fergus Falls
Otter Tail County, Fergus Falls

Granite Falls/Marshall:
Fagen, Inc., Granite Falls
Lincoln Lyon Murray Pipestone Public Health Services, Marshall
Wiener Memorial Medical Center, Marshall
Independent School District #413, Marshall
Chamber of Commerce, Marshall

Mankato/Rochester:
Mankato Clinic, Mankato
Midwest Wireless Inc., Mankato
Chamber of Commerce, Rochester

Willmar:
Affiliated Community Medical Center
Family Practice Medical Center
Bethesda Health and Housing Network
Rice Hospital

The town hall forums were moderated by Tim Penny, former U.S. representative, advisor to Gov. Ventura, and co-chair of the Humphrey Institute Forum at the University of Minnesota. Blue Cross representatives were also in attendance and participated in the discussions, including Sanne Magnan, M.D., Ph.D., a Blue Cross medical director and Kathy Mock, J.D., vice president for policy and legislative affairs. The small-group discussions were moderated by Sanne Magnan, Kathy Mock or other Blue Cross representatives.

The stated objectives of the community forums and small group meetings were to:

- Identify challenges and opportunities
- Listen to solutions
- Begin building consensus
- Develop suggestions for action

The discussions were focused around four principles: fairness, compassion, market-driven structure and choice. These principles had been developed from the results of the Minnesota *Decides* engagement survey, which in turn had built on the results of the Minnesota *Decides* focus groups. (The survey and focus groups are detailed in attachments A and B.)

Conducted during the first eight months of 2001, the community forums were audio-taped and the tapes were professionally transcribed. The small-group discussions were summarized by Blue Cross representatives. An independent research analyst was retained to review the transcripts and tapes of all forums and identify the key themes. Her assessment forms the basis of the 15 themes detailed in the "Community Meeting" section of the Minnesota *Decides* Fall 2001 Report.

Category Analysis

In addition to the research analyst's review of the forums, a separate analysis tabulated the number of comments that were made, based on 14 topical areas. This analysis was performed on the town hall forums alone. The top nine categories are listed below in the order in which they were ranked, along with a brief description of the kinds of comments included in each category. (The numbers in parentheses are the numbers of comments that were counted for that category.)

First:	General Cost Concerns (221)	Comments about premium increases as well as concerns about the overall rise in costs
Second:	Consumer Accountability (141)	Comments about need for education and remarks advocating consumers taking a more active role
Third:	Insurer Accountability (134)	Comments about insurers' responsibility to properly manage resources
Fourth:	Provider Accountability (128)	Comments about the responsibility of hospitals, doctors and clinics, in particular in regards to costs
Fifth:	Systemic Disparities / Fairness (113)	Comments outlining disparities among different groups or that raised fairness concerns
Sixth:	Pharmaceuticals (91)	Comments about drugs, in particular about high costs, overuse or advertising practices
Seventh:	Government Role (88)	Comments advocating more government regulation of the health care industry or a national system
Eighth:	Prevention (86)	Comments touting benefits of preventive care or encouraging insurance coverage
Ninth:	Choice (84)	Comments expressing a desire for options, in particular regarding providers or health plans

The remaining categories with significantly lower numbers of comments included Coverage Gaps (41), Compassion (38), Mental Health (36), Less Government (33) and Community Coordination (23).

A Healthier You, A Healthier Minnesota

Community Forums on Prevention

A Minnesota *Decides* SM Initiative

BlueCross BlueShield of Minnesota

An Independent licensee of the Blue Cross and Blue Shield Association

Dear Fellow Minnesotan:

January 2005

Minnesota takes great pride in our state of health. According to the State Health Rankings, Minnesota is the healthiest state in the country, a distinction it has held in nine of the 15 years the rankings have been published.

But look a bit deeper at the data behind the rankings and a more mixed picture emerges. The State Health Rankings, published by United Health Foundation, is a compilation of 18 factors. When looked at as a whole, the Rankings are like the anecdote about the person standing with one foot in a bucket of ice water and one foot in a bucket of boiling water. On average, that person is comfortable. The same holds true for Minnesota's standing in the rankings. On average, we do well. But on some specific points tied to health we fall short. For example, we rank only 17th on the prevalence of smoking (in other words, 16 states have a lower smoking rate than Minnesota). On obesity, we are in the bottom half of states, ranking 26th. Our rate of cancer deaths per 100,000 population places us at 14th.

In short, while there is much to celebrate about the state of our health, there is much work to do. And a great deal rides on our success – the health of our population, the enormous public and private resources devoted to health and our ability to invest in other public priorities like education and transportation.

It is against this backdrop that Blue Cross and Blue Shield of Minnesota hosted forums with diverse groups of leaders in six cities to talk about prevention and the role of individuals and communities in creating a healthier Minnesota. Invariably, our conversations followed the same path regardless of the community. They started with most participants focusing on individual action – encouraging Minnesotans to eat better, promoting more physical activity programs for students at school or developing cessation programs to help smokers quit.

But bit by bit as our discussions probed deeper, participants in the forums looked at the policies and decisions that affect prevention in their communities. They started to explore how individual actions are strongly influenced – sometimes promoted, sometimes undermined – by our surroundings. The community, through good policies and wise public investments, can make a difference. If tobacco is taxed at higher rate, cigarettes will be more expensive and fewer children will start smoking. If a community has safe, pleasant sidewalks and paths, more people will walk.

As a participant in the Rochester forum said, "We're at a point where we really need to make personal choices, but we can help people do that by creating community environments, work environments and school environments that help with that. The evidence is there; what we really need to do now is make the commitment to create sustainable change."

In a nutshell, that's the purpose of "A Healthier You, A Healthier Minnesota," the Blue Cross Minnesota *Decides* initiative that served as the foundation for the forums during 2004. Our purpose is to engage community leaders in discussing what can we do together about prevention and health care costs, how we can better manage health care costs by focusing on preventable diseases and how allies can be engaged in supporting the policies that will make prevention a cornerstone of Minnesota's health system.

Enclosed is a report that describes the "A Healthier You, A Healthier Minnesota" process and findings. As this report conveys, the community leaders who attended the forums are ready to act. They are ready to promote prevention as an individual commitment and a community priority. And ultimately, that is what it will take to make Minnesota the healthiest state not just on average, but across every measure of health and cost.

Sincerely,

S. Magnan

Sanne J. Magnan, M.D., Ph.D.
Medical Director
Ctr. for Tobacco Reduction & Health Improvement

Kathleen A. Mock, J.D.
Vice President
Policy & Legislative Affairs

I. Introduction

Minnesota *Decides*, a public engagement and education initiative of Blue Cross and Blue Shield of Minnesota begun in 2000, has reached thousands of citizens in all walks of life and from communities throughout the state. Minnesotans have weighed in on health reform, including the challenge of rising health care costs (an overview of Minnesota *Decides* is included in Appendix A).

LEADING PREVENTABLE CAUSES OF DEATH

1. Tobacco
2. Poor diet/physical inactivity
3. Alcohol consumption
4. Microbial agents
5. Toxic agents
6. Motor vehicle
7. Firearms
8. Sexual behavior
9. Illicit drug use

Source: JAMA, 2004

The ideas that citizens have shared through Minnesota *Decides* over the past few years have been as diverse as the people participating. Yet, one theme has been consistent throughout Minnesota *Decides*: prevention is essential to improving our health and managing health costs. Minnesotans recognize the need to "get upstream" and move toward a system that not only treats the sick but prevents the illnesses from occurring.

"A Healthier You, A Healthier Minnesota"

To further explore prevention and its role in reforming our health care system, "A Healthier You, A Healthier Minnesota" was launched in 2004 as a new Minnesota *Decides* initiative. The campaign was designed to promote prevention as both an individual commitment and a community priority. The goal was to inform people about prevention and prevention policies, then engage them in creating the best solutions for their families, their workplaces and their communities. Specifically, "A Healthier You, A Healthier Minnesota" is engaging people as allies in promoting the policies and investments that create healthier communities.

The emphasis of "A Healthier You, A Healthier Minnesota" is on the three leading causes of preventable death and illnesses: tobacco use, physical inactivity and poor nutrition.

As "A Healthier You, A Healthier Minnesota" was developed, close attention was paid to three points on prevention that Minnesotans emphasized throughout the earlier Minnesota *Decides* work:

First, prevention and early detection were deemed cost savers. People often said, "Can't we get upstream from some of these problems? There has to be a better way through prevention."

Second, most people said that Minnesotans should not be denied health care because of their lifestyle or behaviors. There were, however, strong opinions that consumers should be held accountable for the results of their decisions and that health care should focus as much on preventing disease as it does on curing illnesses. Yet, people recognized that positive changes in individual health behavior are more easily achieved and sustained when communities provide a supportive environment.

Many Minnesota *Decides* participants recognized that solutions require citizens to work together to find consensus, then act together on good public policies. "The government, the individual, the communities and [employers] have to work together if they want to change the system," said a participant in Minneapolis. A commitment to the public health approach addressing the health concerns of entire populations was deemed a very effective and efficient strategy.

Third, Minnesota *Decides* participants recognized that good actions will be driven by good information. In particular, the connection between rising health costs and prevention must be better understood. Many of those who attended Minnesota *Decides* town hall meetings and small group forums stated that Blue Cross could play an important role by informing the public and making the issue "real." More information about the connection between prevention and costs was desired.

Minnesotans' concern and interest in prevention are supported by facts. Tobacco use, physical inactivity and poor nutrition are the three leading causes of preventable deaths in Minnesota and contribute to the rising cost of health care. And unless changes are made, the future promises an acceleration of these costs. More than 60 percent of adults are overweight; 22 percent are considered obese. One-in-five adults use tobacco. Among 18-to-24-year-olds, the rate of smoking is twice that of their older adult counterparts.

Introduction

The first stage of "A Healthier You, A Healthier Minnesota" took place between June and October 2004 when Blue Cross hosted forums to talk about prevention and possible roles for individuals and communities. The forums were held in six Minnesota cities:

- Minneapolis, June 24
- Rochester, Sept. 21
- Duluth, Oct. 5
- Red Wing, Oct. 12
- St. Cloud, Oct. 28
- Willmar, Oct. 29

The forums were designed to bring together a broad cross-section of leaders from the six communities. Participants came from local government, health care, education, business, non-profit organizations, the faith community and other local institutions and organizations (a breakdown of attendance is included in Appendix B). Overall, more than 170 community leaders attended the forums.

Most of the time spent in each of the meetings was in discussion: sharing ideas on how communities can better promote prevention, especially in the priority areas of tobacco use, physical activity and nutrition; the barriers that stand in the way of effective programs; and the opportunities for communities to make progress.

About This Report

The discussions at the six "A Healthier You, A Healthier Minnesota" forums were audio-recorded with the participants' permission and transcribed. An independent qualitative research analyst reviewed the transcripts and identified the key themes that emerged from the forums. The analyst has reviewed this report for consistency with her findings. As a summary of the feedback heard from leaders roughout the state, we believe this report continues to add to the Minnesota foundation for building effective prevention strategies.

For More Information

For copies of the presentation provided to forum participants or more information about "A Healthier You, A Healthier Minnesota" and what individuals and communities can do to promote prevention, contact:

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II. Executive Summary

More than 170 people attended the six forums in communities throughout Minnesota. The forum participants were invited by Blue Cross because of their leadership roles in their communities. Attendees represented local government, health, education, business, the faith community, and other community sectors. Racial and ethnic diversity also were a priority in developing the invitation lists for the forums.

The forums began with an overview of prevention and its impact on health and costs. However, most of the time was spent in far-ranging discussions among participants.

Key Findings

Although the communities participating in "A Healthier You, A Healthier Minnesota" forums are very different, six key themes emerged:

1. People understand that prevention requires both individual actions and community actions.

Although people often were drawn to individual actions and public awareness to promote prevention, the greater strength and importance of environmental factors always surfaced. Kids and future generations were frequent topics, but the importance of adult role models and the community's values and priorities were seen as key determinants. Participants understood that we are each responsible for making good decisions, but recognized the positive role community-wide actions can play in supporting good individual health decisions.

2. Communities should have a plan for what is most important to address. There is an urgent need for action.

Many communities already are promoting prevention initiatives focusing on tobacco, physical activity, and nutrition. However, there was strong agreement that more needs to be done, plans need to be more comprehensive, and efforts must address, be accessible to, and influence citizens of all ages and walks of life. There also was a strong sense that the need for action is urgent.

3. People need to be engaged at the grassroots level in individual and community prevention initiatives.

Community-wide efforts will succeed to the extent that individual citizens are partners in taking action. Efforts that are "top-down" – one agency or organization lecturing the public – won't work. Citizens have to be part of designing the plan based on what works and implementing the action steps. The approach must focus on helping individuals change their own behaviors, creating an environment that supports this new behavior, establishing adult role-models for children, and working together to improve the public's health through community-based programs. Further, the approach needs to reflect Minnesota's growing cultural and racial diversity.

4. Collaboration and new partnerships are critical.

The keys to success will be collaboration and partnerships, according to participants in every forum. Individuals making better health decisions for themselves and their families always will be important, said forum attendees, but the entire community has to support good decisions being made by some and encourage better decisions to be made by others. In this collaborative model, government has an important role to play. Public policies ranging from smoke-free ordinances to community design that allows for biking and walking are essential to prevention. Additionally, public-private partnerships and efforts entirely independent of the public sector are critical to ensuring that all audiences are participants in prevention efforts.

5. More resources are needed.

Prevention efforts – especially sustained approaches aimed at achieving long-term change – often seem to be low on the list of urgent needs. In a time of tight budgets in the private, public and non-profit sectors, prevention programs are among the first to be cut, said many of the participants. Health plans and insurance companies need to evaluate how they could use resources (including premium dollars) to more effectively promote prevention. For example, many participants urged health plans to pay for more prevention-related activities, such as nutrition counseling for weight loss. In addition, participants recognized the role health plans can play in supporting community-based policies.

..Executive Summary

6. Barriers are present but not insurmountable.

Attendees cited several barriers to elevating the importance of prevention and healthy behaviors. Marketing that promotes poor nutrition, sometimes even disguising unhealthy foods as healthy choices, was among the barriers frequently mentioned. Moreover, poverty was one of the most persistent challenges named. It is difficult for people to make good health decisions when they don't have money for enough food, when they are unemployed and when they are in unstable home environments.

Conclusions

The "A Healthier You, A Healthier Minnesota" forums were designed to engage community leaders and build allies for prevention. Based on the discussions in the six forums, there are three conclusions that can be drawn:

1. Many leaders participating in the forums are ready to promote prevention policies and investments for their communities.

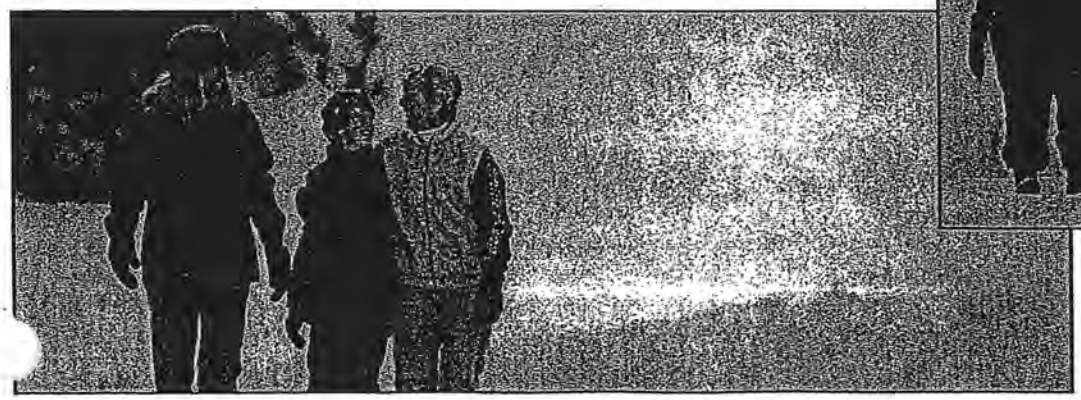
People attending the prevention forums came away from the discussions with increased commitment to promoting the policies and community investments needed to make prevention a community priority. While participants often started the discussions with a focus on prevention actions by individuals, they soon were exploring how individual behavior is strongly influenced – sometimes promoted, sometimes undermined – by community surroundings.

2. Community leaders see public support for prevention policies and investments.

The community leaders, who have a sense of public opinion in their communities, see growing public understanding of prevention as a strategy for both health improvement and cost control. They believe there is an emerging recognition among the public that community-wide initiatives, public policies and individual commitments are important to improving health and managing the cost of health care. The public should be engaged through education, then engaged as allies in promoting prevention policies. If the connection between public policy and health – whether it's about protecting workers and consumers from secondhand smoke or designing communities with safe walking paths – is understood, citizens will support the actions, said forum participants.

3. Focusing on tobacco cessation, physical activity and nutrition makes sense.

Based on disease trends, claims experience and the best science on prevention, Blue Cross is focusing its prevention efforts on tobacco cessation, physical activity and nutrition. This focus was part of the invitation to the forums and was included in the introductory presentation that Blue Cross provided at each session. Importantly, these three areas of emphasis clearly resonated with participants.



III. "A Healthier You, A Healthier Minnesota"

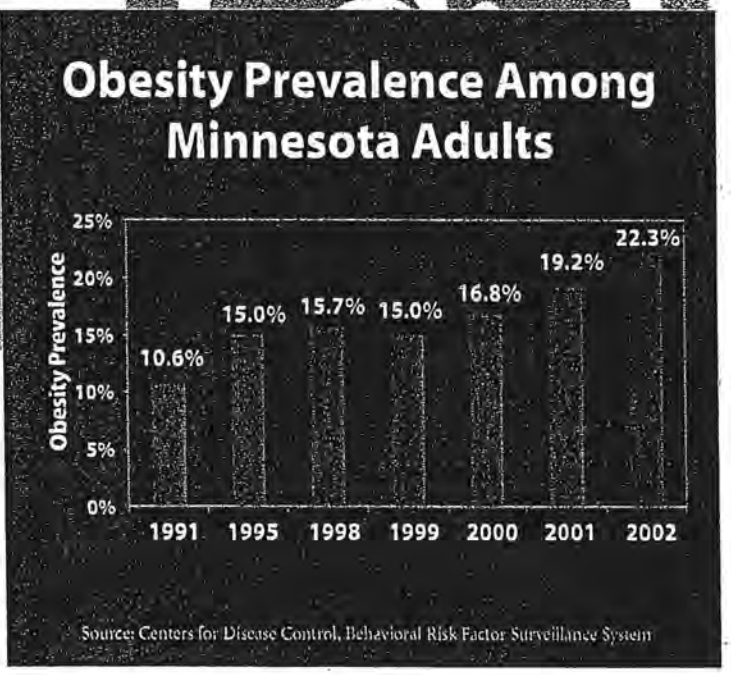
"A Healthier You, A Healthier Minnesota" is a public education and engagement campaign sponsored by Blue Cross. Its purpose is to increase awareness of how individual prevention choices can be influenced – positively or negatively – by community decisions. The campaign includes outreach to community leaders to build partners for prevention and engage them in creating a public environment that supports and promotes prevention.

"A Healthier You, A Healthier Minnesota" has two primary objectives:

- **To discuss with community leaders the relationship between health care costs and prevention.**
- **To engage allies – business and civic leaders and public policy makers – in advocating for prevention policies.**

While there are many contributors to rising health costs, tobacco use, physical inactivity and poor nutrition are major cost drivers and thus the emphasis of the "A Healthier You, A Healthier Minnesota" campaign (information on the economic costs of tobacco and physical inactivity is included in Appendix C).

By focusing on tobacco use, physical inactivity and poor nutrition, "A Healthier You, A Healthier Minnesota" is exploring the most significant root causes of preventable deaths and diseases. The toll taken by these three health challenges is hard to ignore. Tobacco use is responsible for about one in every six deaths. Approximately 22,000 Minnesotans are diagnosed with cancer every year, about 30 percent of all cancers are directly related to tobacco use. There is a high price tag Minnesotans pay for tobacco use – $2.6 billion a year in everything from higher rates of workplace absenteeism to health costs associated with treatment of various respiratory and cardiovascular diseases.



Minnesota spends $495 million a year treating health conditions due to physical inactivity and obesity. Physical inactivity and poor diet often result in obesity. While there is some debate whether studies have overstated the impact of obesity on preventable deaths, there is little argument in the scientific community that physical inactivity and poor diet are now the country's second leading killer. In 2001, Blue Cross paid more than $85 million in claims that were a direct result of physical inactivity and obesity. With the rate of obesity in Minnesota already at 22 percent and rising, the cost of poor diet and physical inactivity is growing.

These challenges are within our power to change, both through what individuals do and the actions taken by communities. For example, studies have shown that:

- Walking is an easy, affordable and effective prevention activity. But if communities develop without safe, pleasant sidewalks and paths, people are less likely to walk.
- Tobacco use continues to be the leading cause of preventable death and disease, yet approximately 20 percent of adults continue to smoke. If the price of cigarettes is raised through taxes, fewer kids and adults will smoke.
- Poor diet is contributing to Minnesota's obesity crisis. Healthier food choices in restaurants, grocery stores, employee cafeterias and schools will encourage people's positive diet choices.

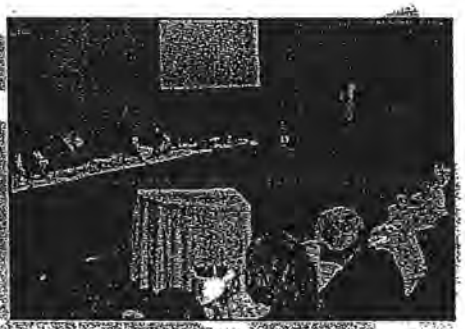
V. Findings

These issues and the individual and community responses to the challenge and opportunity of prevention formed the basis for the six "A Healthier You, A Healthier Minnesota" forums.

Although the people attending the six "A Healthier You, A Healthier Minnesota" forums and the communities represented are very different, there were six major points of agreement that emerged:

1. People understand that prevention requires both individual actions and community actions.

While people believe that we each are responsible for making good health decisions, there was common recognition that community-wide actions are an important part of supporting a person's decisions about their health. Participants pointed to several ways in which communities can help promote healthy behavior among their residents, from making stairways more inviting to supporting smoke-free workplace policies.



Fall 2004 Community Forums

In the area of physical activity, a Duluth participant talked about recent improvements to the sidewalks. "I live in Duluth, in the city. And just recently, they redid the sidewalks ... and I'll tell you ... it's much easier to walk. I can now look up instead of down. I think that makes a big difference."

A participant in Willmar emphasized the importance of community support, particularly with regard to kids and smoking. "We're doing a great job educating the kids in the schools about tobacco cessation and not starting smoking ... but as parents we need to have establishments standing behind us and reinforcing the fact that it's [smoking] not cool."

So, while the "buck stops" with each of us, participants would like to see communities play a role in supporting healthy behavior.

2. Communities should have a plan for what is most important to address. There is an urgent need for action.

Organizations within communities already are taking actions to improve the health of residents. Participants cited several initiatives underway, many of them sponsored by schools, the faith community, local government (especially public health agencies) or others. (Examples of some of the creative approaches discussed at the forums are included in Section V of this report.)

However, forum participants consistently called on their communities to support community-wide, comprehensive approaches to prevention that would address, be accessible to, and influence citizens of all ages and walks of life.

"Part of what needs to happen for the whole community is that we get the idea that we are a healthy community ... Red Wing needs to be 'the healthy town.' Goodhue County needs to be 'the healthy county.' So everything that is done has some focus about what is best for the health of the people. So if that [were] to be the motto ... it would put a lot of other things in focus ... whether it was kids in school or teachers or the executives at Red Wing [Shoe Company], or whatever it is, that now gets to be the focus," said a Red Wing participant.

Participants also were in agreement that community-wide interventions need to begin now. "I feel like we're doing quite a bit, yet I see more obese kids. I see more kids dealing with things like asthma and chronic health programs," said a Willmar participant. "And we do more than ever with tobacco and drug education, yet I still cringe every time I see a 14-year-old at the mall, and I know they're smoking."

Participants, though, agreed that programs would suffer if they tried to take on too much. Most participants agreed that tobacco use, physical activity and diet were the right challenges to emphasize. "I like the idea that we look at just three real focus areas and do what we can in those three areas," said a Red Wing participant. "And I like the idea of really narrowing that down even more with our collective group, and just figuring out what we can realistically do."

At the same time, the community participants agreed that plans must be tailored to each community. Some community participants urged their community to implement things known to work ("evidence-based" approaches) versus doing what seems easiest.

..Findings

3. People need to be engaged at the grassroots level in individual and community prevention initiatives.

Individuals need to be engaged in the community-wide effort. Efforts that are "top-down" – one agency or organization lecturing the public – won't work. Citizens have to be part of designing the plan and implementing the action steps.


Forum Attendees

Efforts also have to be broad-based. People need help changing their own behaviors and in serving as examples for others in the community, especially children. "We're going to try to get everybody walking more and eating a little less in this community, and we're working at it as we did with tobacco, from a lot of different angles," said a Rochester forum attendee. "We're working at it through the schools, and through businesses, and through churches, all of the community ... because what parents do the kid will do [and vice versa]."

Role-modeling is important. Getting adults involved in making better health choices for themselves is essential, chorused participants, not just for their own benefit but for the examples they set. "There's a direct correlation between kids' activity and what their parents do. So, as much as we can get parents involved ... that's really going to ... rub off on the children," said a Willmar attendee.

Participants identified two specific areas that require attention for school-age children: better nutrition in schools (i.e., healthier lunches and vending machine alternatives) and support for physical education curriculum. These pieces stand out as achievable and important areas for youth focus. However, many participants noted that schools already are challenged to deliver basic education and a variety of social services, all while school costs are rising and budgets are tightening.

Many of the people attending the forums, especially those representing public health and health providers, urged community-wide efforts that were simple, affordable and accessible. Break the effort into small, manageable pieces, said many. A community-wide initiative must be incorporated into where people spend their time – school, work, where they recreate, and places of worship. And good health behaviors must be reinforced through consistent and frequent messages and in public places, including restaurants, grocery stores and other public buildings.

For other audiences, messages must reflect Minnesota's growing cultural and ethnic diversity to be effective. Chicanos Latinos Unidos En Servicio (CLUES) is a provider of social services for the Latino community in Minnesota. A CLUES representative at the Minneapolis forum said, "When you provide services, it is very important it is done in a cultural framework ... At CLUES, we've worked with groups ... to do cooking classes that are culturally appropriate for diabetics. I mean, if you are eating tortillas and rice and beans, you can't go to cottage cheese and lettuce."

The challenge and need for diversity also is important outside the Twin Cities metro area. "One of the things [the West Central Integration Collaborative is] doing is reaching minority communities ... our Latino youth and Somali youth. ... We're really working on prevention ... and going back to their original way of life. So, if in Somalia there was a lot of walking, or in Mexico, or wherever you come from ... is there a safe place to do that [here]?" asked a Willmar participant.

For all audiences, people believed that the messages have to go beyond lecturing or nagging. The goal is to change people's behaviors; the challenge is to determine how to capture people's hearts and minds. Only with an emotional buy-in will people make the commitment to participate in making their community healthier, to alter their lifestyles, and ultimately to lead healthier lives, said many participants.

4. Collaboration and new partnerships are critical.

The keys to success will be collaboration and partnerships, according to participants in every forum. Individuals making better health choices for themselves and their families always will be important, said forum attendees. But the entire community has to support good decisions being made by some. They can also encourage better decisions to be made by others.

"I think what is vital to any kind of sustained effort is partnering," said a Duluth participant. "Partnering among the many entities, private and public, and I think that's going to be our biggest challenge, to figure out how to get energy and then work with people to work towards a united goal. No easy answers, but partnering is where it's at."

Findings

A Rochester participant sounded a similar theme, adding, "We're at a point where we really need to make personal choices, but we can help people do that by creating community environments, work environments, and school environments that help with that. The evidence is there ... what we really need to do now is make the commitment to create a sustainable change."

One of the key partnerships should be with government, both in public policy and in providing resources. Many participants noted the importance of engaging the community in good public policy choices, including smoke-free spaces, accessible and safe sidewalks and walking paths, and more nutritional food choices in schools.

Recent successes in providing assistance for those trying to quit smoking and in reducing exposure to secondhand smoke offer good examples of how and why to engage the public on other prevention issues, according to many of those at the forums. For example, cooperation among the state's health plans and the Minnesota Partnership for Action Against Tobacco (MPAAT) now assures that every Minnesota adult who is trying to quit smoking has cessation assistance available free of charge via phone counseling (information on cessation phone services in Minnesota is included in Appendix D).

Grassroots efforts to reduce secondhand smoke exposure in public places have had success in northeast Minnesota, Olmsted County, and the Twin Cities. These actions are effective not just in protecting workers and the public from secondhand smoke, but as a community initiative in reducing smoking. "Duluth was a real leader in tackling tobacco, and I think is still showing leadership. What made that work?" emerged as a question in Duluth. The challenge was to pinpoint the type of collaborative work and community leadership that leads to successful prevention policies.

Government alone isn't the entire answer. A St. Cloud business person urged partnerships with chambers of commerce to create programs for employers. "... if there was something available, a community-based approach through employers that chambers would buy into ... I think it would be a great service the chambers could offer. And chambers all across the state. We have a huge, successful network of chambers."

Partnering doesn't occur simply through the creation of programs. Some of the most important partnering outreach must come through information-sharing and providing support. "We need some sort of integrating capability or knowledge so that the needs of families are completely supported, not just one or the other in isolation," said a Minneapolis participant.

In addition, partnering must exist at the grassroots level, providing the means and opportunities for broad involvement. Said a Red Wing attendee, "Often in our community, it's the same leaders that take charge – and we need them. But we also need new people. Like an underlying force of people that are just the normal citizens who can come out and speak, rather than always seeing the same faces."

5. More resources are needed.

Prevention efforts – especially sustained programs aimed at making long-term change – often seem to be low on the list of urgent needs. In a time of tight budgets in the private, public and non-profit sectors, prevention programs are among the first to be cut, said many of the participants.

A common frustration was the one sounded by a Rochester participant: "We have a lot of problems with getting programs started and seeing results and then having to stop them because when the resources are gone, the programs can't continue. So that is a big issue."

Health plans and insurance companies have an important role to play in making sure the resources of premiums are used wisely – a task at which they sometimes fail, according to some participants.

Others urged insurers to look at how they set premiums. "I think we have to start charging people different rates for health insurance" based on their healthy or unhealthy behaviors, said a St. Cloud attendee. "I would really challenge the insurance folks here to say, 'Don't help me have surgery to staple my stomach. Help me get some programs [to promote better diet and more activity] that we share in the cost of the programs.' I'd happily share the cost," added a Rochester participant.

...Findings

However, increased investment won't come until the public decides that prevention is important and engages in actions to promote funding, according to many participants. "I know from work with the Minnesota Center for Health [Care] Ethics that there's an ethical framework to have the conversation about how we make decisions, about how we distribute our dollars. And it seems to me that until there's political advocacy around having that conversation, that everybody here is going to continue to struggle with models that they know would work and would work better if they had more resources," said a Red Wing participant.

6. Barriers are present but not insurmountable.

Participants in the forums cited several barriers to elevating the importance of prevention and healthy decisions. Marketing that promotes poor nutrition, sometimes even disguising unhealthy foods as healthy choices, was among the barriers often mentioned. "If you're struggling with a weight problem and you run the gauntlet [of ads]; when I come home from work, I pass ... all the fast food restaurants all the way along and I'm hungry," said a Rochester participant.

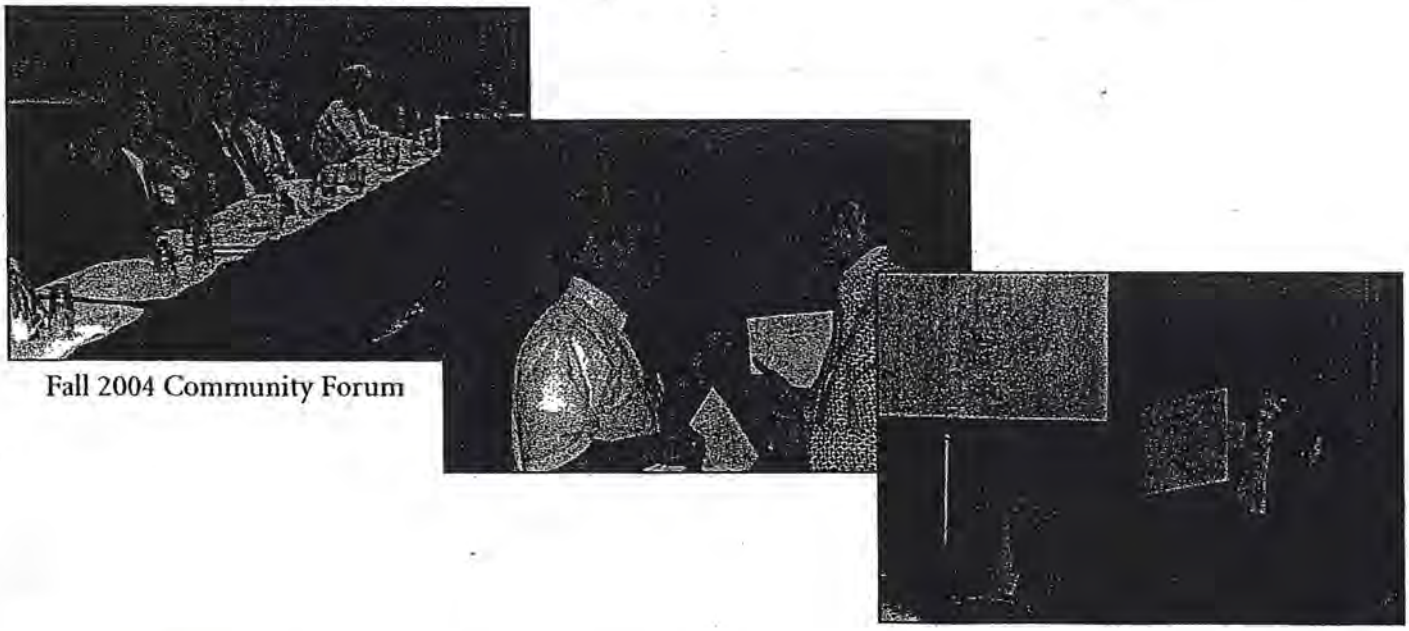
A Duluth forum attendee was more blunt. "Whether it's tobacco or food choices, portion sizes, activity, there are very large commercial interests that have a stake in people not changing."

One of the most persistent challenges named was poverty. It is difficult for people to make good health decisions when they don't have money for enough food, when they are unemployed and when they are in unstable home environments. A Minneapolis participant said that if we are "educating people that activity and diet are critical, but they don't have the economic tools and a good diet isn't within their economic reach ... then ... no one's reaching the maximum benefit" from the prevention outreach efforts.

A Duluth participant echoed the theme. "It's good to provide things for people who have money to join a gym or to learn how to eat healthy and that sort of thing. But we also need to think of ways that we can integrate this into programs that deal with those who don't have very much."

Summary of Findings

Overall, participants in the six forums identified clear opportunities for promoting prevention in their communities. While each community identified challenges, participants were eager to move from ideas to actions that could succeed in their communities through collaborative work among all sectors and leaders.



Fall 2004 Community Forum

V. Success Stories: What's happening in Minnesota communities?

During the forum discussions, many participants offered examples of prevention policies and programs being initiated in their communities. The following stories are just a sampling of the ideas highlighted during the forums.

Policy Initiatives

In general, policy initiatives are efforts that are designed to alter a system to promote prevention through public, community collective action.

Smoke-Free Workplace Ordinance - Minneapolis

Many of the participants in the Minneapolis forum raised the issue of the ordinance that was being considered by the Minneapolis City Council at that time to make workplaces, including bars and restaurants, smoke-free. Participants saw the ordinance effort as an important prevention contribution in their community that would protect people from the dangers of secondhand smoke. The smoke-free ordinance was passed by the City Council just weeks after the forum and will go into effect on March 31, 2005.

For more information about the ordinance, contact Patty Bowler at 612-673-3009.

The Walking School Bus – Superior, Wis. and Duluth, Minn.

During 2004, the Duluth-Superior Metropolitan Interstate Council (MIC) conducted a Safe Routes to School (SR2S) Plan for urban Superior, Wis. schools. This plan involved working with the city, school district, police department, principals, parents, teachers, children and elected officials to identify obstacles along primary routes to school and to propose recommendations to improve safety. The plan also was designed to promote public and student safety education regarding bicycle and pedestrian laws.

"Walk to School Week" offered a way for organizers to spur interest in the campaign. During the week, staff coordinated safety presentations at the schools by local law enforcement and initiated a public awareness effort that included posting billboards along major roadways and a public open house to learn about this planning effort.

During 2005, MIC staff will begin working with the Duluth School District staff in hopes of conducting a similar assessment.

For more information, contact Holly Butcher at Arrowhead Regional District Council at 218-529-7548.

City-County Trail System – Willmar and Kandiyohi County

Creating a safe and quality network of trails has been on ongoing priority for the city of Willmar for years. Recognizing the importance of building community infrastructure that encourages activity, city leaders wanted to improve access to the number of recreation areas by creating an easy-to-use trail system throughout and around the city. Willmar has been working with Kandiyohi County to design a trail system, which has the support of residents behind it. In November 2004, residents approved a half-cent sales tax, of which a portion will be dedicated to improving the trail system.

For more information, contact Steve Brisendine at 320-231-8490.

Healthier Vending Machine Alternatives – New London-Spicer and Willmar Schools

Kennedy became an elementary school 10 years ago and since that time school administrators and staff have held strong to the policy of no access to vending machines because they believe it's important to support healthy decisions among young children.

Led by school board members who were concerned about students' nutrition and dental health and the growing problem of obesity, New London-Spicer High School started restricting the amount and availability of soda pop available in its vending machines and lunch lines. Only water and juice are available during school hours. And the middle school store started offering healthy snack alternatives and smaller portion servings to students.

For more information about New London-Spicer schools, contact Peggy Dykema at 320-354-2252. For more information on Kennedy Elementary in Willmar, contact Maria Erlandson at 320-214-6684.

..Success Stories: What's happening in Minnesota communities?

Creating the "Healthy Town" – The Red Wing Health Task Force

Community leaders' initial goal was to find ways to encourage Red Wing citizens to be more active. But when they convened a group to talk about it, they discovered that there were many other issues that people wanted to address in order to make Red Wing a healthier town. The idea is to build a community identity around the idea of community decisions geared toward creating healthier choices for the population. They believe this should be encouraged among all sectors – health, education, business – and among all ages and backgrounds.

"Citizens for a Healthier Red Wing" are working to create a council that will serve as a clearinghouse of information and resources related to health and wellness in the community. By convening interested community leaders, they hope to implement policies to make Red Wing "the healthy town."

For more information, contact Pam Horlitz, Community Outreach Coordinator at Fairview Red Wing at 651-385-3302.

Healthy Concession Stands – Duluth Youth Softball

As the youth softball coordinator for a Duluth neighborhood, Joanne Fay started noticing that over the years there were a growing number of overweight players in her program. She was concerned about the impact poor nutrition was having on the kids, so six years ago she decided to make a change. No longer would the team's concession stands offer sugary junk food but instead would sell healthy snacks. They offered fruit, sunflower seeds, crackers and most recently, the hot-selling pickle-on-a-stick. And the kids still come to put their money down. In an effort to broaden the practice of "healthy food sales," Fay now is thinking about opportunities for organizational partnerships and sponsorships of the healthy concession stands.

For more information, contact Joanne Fay at 218-728-5980.

Minnesota Living Well Community Project – Meeker-McLeod-Sibley Community Health Services Board

Several years ago, organizations and people concerned about a fast-growing older adult population and changes to long-term care in the immediate future started talking about what it means to have a "senior-friendly" community. The idea was that if seniors had more community support, they could remain in their homes longer. Building on the Seniors Agenda for Independent Living (created by the Minnesota Legislature), the Southwest Minnesota Foundation awarded a grant to the Meeker-McLeod-Sibley Community Health Services Board to work with city councils throughout the 18-county southwest region.

They developed a checklist to review the environment of cities with more than 1,000 residents: curbs, gutters, lighting, signage and transportation options – all of the things seniors need for safe walking. Several assessments have been completed and many more will be conducted over the next year in several southwestern Minnesota counties. While the goal of the program is to improve conditions for older adults, the effort is being embraced by cities because of the overall benefit to the entire community.

For more information, contact Amy Wilde, Meeker County Commissioner and Chair of the Meeker-McLeod-Sibley Community Health Services Board at 320-275-3684.

Prevention Programs

In general, prevention programs are educational efforts that also offer resources or services to help change individual choices.

C.A.T.C.H. Program – Church of New Life, Minneapolis

Amidst growing concern about the health of the community as a whole and the risks among certain populations, the Church of New Life started the C.A.T.C.H (Congregation Advocating Their Community Health) program, developed by the Minneapolis Council of Churches. The program's goal is for the faith community to play a strong role in mentoring and educating their members on the importance of regular check-ups and making healthy choices for their families.

..Success Stories: What's happening in Minnesota communities?

Since the program began, the Church of New Life has strongly embraced its role in promoting good health – initiating a six-week program from the pulpit on healthy diet and conducting a health fair with blood pressure and cholesterol screenings and informational booths on specific health topics including obesity, asthma and heart disease.

For more information on the Church of New Life's programming, contact Carolyn Gilbreath at 612-823-6822.

Improving Your Bottom Line on Rising Health Care Costs – Rochester Area Chamber of Commerce

Over the last several years, the Rochester business community has become increasingly concerned about rising health care costs. In the face of double-digit cost increases, employers came to the Rochester Area Chamber of Commerce looking for education and guidance. For the past three years, the Chamber has sponsored a forum to discuss the issue. Along with presentations from experts in the health and health care field, members are offered examples and ideas on ways to improve employee health within their own companies.

While providing the right tools to employees continues to be a challenge, particularly for small employers, the forums have created a culture among the business community that promotes employer driven programming to make employees healthier and better consumers. One of the strongest efforts to come out of the forums is employer participation in a walking program, creating a competitive environment between businesses and their employees as a way to engage people in physical activity.

For more information on the Rochester Chamber of Commerce efforts, contact John Eckerman at 507-288-1122.

Olmsted County Health Summit

After completing a community assessment about a year ago, staff at Olmsted County Public Health started discussing the growing problem of obesity and its impact on the community. At the same time, the Mayo Clinic was pulling together a national summit called Action on Obesity (held in May 2004). Not wanting to let the momentum fade, Olmsted County convened a local summit in October 2004 to engage key opinion leaders in the community including education leaders, public health, health care providers, city planners, parks and recreation interests and local elected officials. Through panel presentations and small group breakout sessions, these leaders discussed specific strategies to address obesity among the various population groups throughout the community.

The first major initiative to come out of the summit is promotion of America on the Move, a Web-based program that encourages people to be more active. The effort is being promoted through schools, businesses and churches, with some key employers already signed-on. The group meets on a monthly basis and sub-groups were created to address specific concerns. They are in regular communication to continue finding ways to make health choices available at a community level.

For more information on the Olmsted summit and the ongoing work of the group, contact Judy Voss at Olmsted County Public Health at 507-285-8370.

Gardens Galore Program – University of Minnesota Extension Service in Duluth

The allure and ease of access to processed foods was becoming a barrier to better nutrition among kids. Most children eat their snacks and meals without giving much thought to how they were created or grown. Commissioner Joanne Fay changed that through a program with the University of Minnesota Extension Service. Fourth graders in the Duluth area are becoming experts on food growth and nutritional value of foods they eat.

The Gardens Galore curriculum was developed to help students see the entire cycle of growth. These students are learning the science behind good nutrition – where does a tomato come from, what is its nutritional value? The students plant their own tomatoes in fourth grade, harvest the plants in fifth grade and have a feast to celebrate the process.

.Success Stories: What's happening in Minnesota communities?

Students who have gone through the program have developed an appreciation for "home-grown" food, pride in their role in the process and a new-found knowledge about the foods they're eating. The program has become so popular that it will be expanded to other age groups and classrooms.

For more information on the Gardens Galore program, contact Joanne Fay at 218-728-5980.

Giving employers tools for wellness – St. Cloud Area Chamber of Commerce

Employers in the St. Cloud area are interested in conducting wellness efforts on a community basis and bringing them into the workplace because they recognize the value to their own businesses as a way of addressing rising health care costs. The challenge is that the large majority of employers are small businesses and lack the resources and staff to focus solely on health promotion. The St. Cloud Area Chamber of Commerce wants to be proactive on the issue and help their members with wellness and prevention efforts by serving as a central clearinghouse for resources, information, coordination with experts/physicians, etc. Ideally, the St. Cloud Area Chamber could buy into a program and have staff assist with implementation.

For more information or ideas, contact Teresa Bohnen, President, St. Cloud Area Chamber of Commerce at 320-251-2940.

Willmar Area Youth Programs

The Willmar area community is serious about creating and promoting healthy behavior among its youth with the hope of building a healthy sensibility that will carry on throughout their lives. Driven by programs funded and supported by multiple sources, schools have implemented tobacco awareness, prevention and cessation programs, and efforts to encourage physical activity from elementary through high school. Select programs include:

- SWAT teams – Adult-supervised program that works with youth in the schools on tobacco prevention.
- TEG (Tobacco Education Group) and TAP (Tobacco Awareness Program) – Youth tobacco cessation program averaging about 120 students annually going through the program.
- Fitness Center/wellness curriculum – A free fitness center in the school that is available to all Willmar high school students, alternative learning center, and others (not open to athletes). It was started as a two-year demonstration project and now is proceeding due to a local grant fund. The school also is incorporating professional instructors into health and physical education curriculum to teach about lifelong fitness and wellness.
- "TV Turnoff Challenge" – Elementary school program initiated by two school nurses that encourages kids to take the challenge home to their parents to be more active. Because of its success and positive reaction from students and parents, it will be expanded to all elementary schools in Willmar.

For more information, contact Andrea Carruthers at 320-214-6840.

Smoking Cessation for Hispanic Population – United Migrant Opportunity Services (UMOS)

UMOS organizers were concerned about the higher rates of smoking among the Hispanic population, the lack of Spanish information available on tobacco issues and the fact that Hispanics are often unable to afford health care costs associated with smoking related illnesses and treatments. To address these issues, they applied for and received a grant from MPAAT (Minnesota Partnership for Action Against Tobacco). The city of Willmar was designated as a priority area due to the high concentration of Hispanics in the community.

The grant will be used to educate thousands of Hispanics in Greater Minnesota about tobacco use and to provide cessation services to the Hispanic population. The effort will involve a media campaign; partnering with employers to educate peers and establish smoke-free workplaces; a resource center with access to cessation services and organizing community support groups within Hispanic communities.

For more information, contact Jaime Villalaz at United Migrant Opportunity Services at 320-251-4961.

I. Conclusions

Blue Cross hosted the "A Healthier You, A Healthier Minnesota" forums to engage leaders from six communities in a conversation about prevention. In particular, Blue Cross focused the discussion on three challenges: tobacco use, physical inactivity and poor nutrition.

The purpose of the forums was to build allies and engage them in creating policy changes that will work for their families, workplaces and communities. It was not to directly promote specific policy agendas or action plans. What Blue Cross found in all the communities is a growing awareness of the need to make prevention a more integral part of health reform, especially as health costs continue to increase. Some communities already have been successful in tobacco reduction efforts. Many of the communities are pursuing their own plans of action to continue to reduce tobacco use and to promote physical activity and better nutrition.

Blue Cross also found consensus on three conclusions:

1. Many leaders participating in the forums are ready to promote prevention policies and investments for their communities.

The "A Healthier You, A Healthier Minnesota" forums weren't aimed at the general public the way the previous Minnesota Decides meetings were. However, the people who attended the prevention gatherings are among those most involved in their communities. These leaders came away from the discussions with an increased commitment to promoting the policies and community investments needed to make prevention a community priority. While participants often started the discussions with a focus on prevention actions by individuals, they soon were exploring how individual behavior is strongly influenced – sometimes promoted, sometimes undermined – by community surroundings. As the forums progressed, the conversation in the forums began to focus more and more on the policies and community action needed to promote prevention.

Community leaders see public support for prevention policies and investments.

The community leaders, who have a sense of public opinion in their communities, see growing public understanding of prevention as a strategy for both health improvement and cost control. They believe there is an emerging recognition among the public that community-wide actions, public policies and individual commitments are important to improving health and managing the cost of health care. The public should be engaged through education, then engaged as allies in promoting prevention policies. If the connection to public policy – whether it's about protecting workers and consumers from secondhand smoke or designing communities with safe walking paths – is understood, citizens will support the actions, said forum participants.

The opinion, according to the participants, is that the public is ready for information on prevention that will lead to action, and some communities are ready now to initiate prevention policies. As evidence of this sentiment, forum participants point to the success of grassroots efforts to pass smoke-free ordinances and community-based programs to encourage more physical activity and better diets. Many also see a growing sentiment among the public that unwise individual decisions and poor community response are leading to poor health, and poor health is a driver of rising health costs.

As a St. Cloud participant said, "There is no way to pay for what's coming up if we stay on the track we're on and I think everybody knows that."

Changing behaviors and lifestyles will take time and resources. The public should be engaged through education, then focused on the needs of their communities and the opportunities for themselves and their families. But forum participants recognized that resources will continue to be scarce. Consequently, developing and implementing supportive private and public policies are especially important. Programs that draw attention to prevention are helpful, but changing private and public policies in ways that support healthy choices over the long-term is key to making prevention part of people's everyday thinking.

...Conclusions

3. Focusing on tobacco cessation, physical activity and nutrition makes sense.

Based on disease trends, claims data and the best science on prevention, Blue Cross focused on tobacco cessation, physical activity and nutrition. This focus was part of the invitation to the forums and was included in the introduction Blue Cross provided at each session. These three areas of emphasis resonated with participants: "I like the idea that we look at just three real focus areas and do what we can in those three areas," said a Red Wing forum attendee.

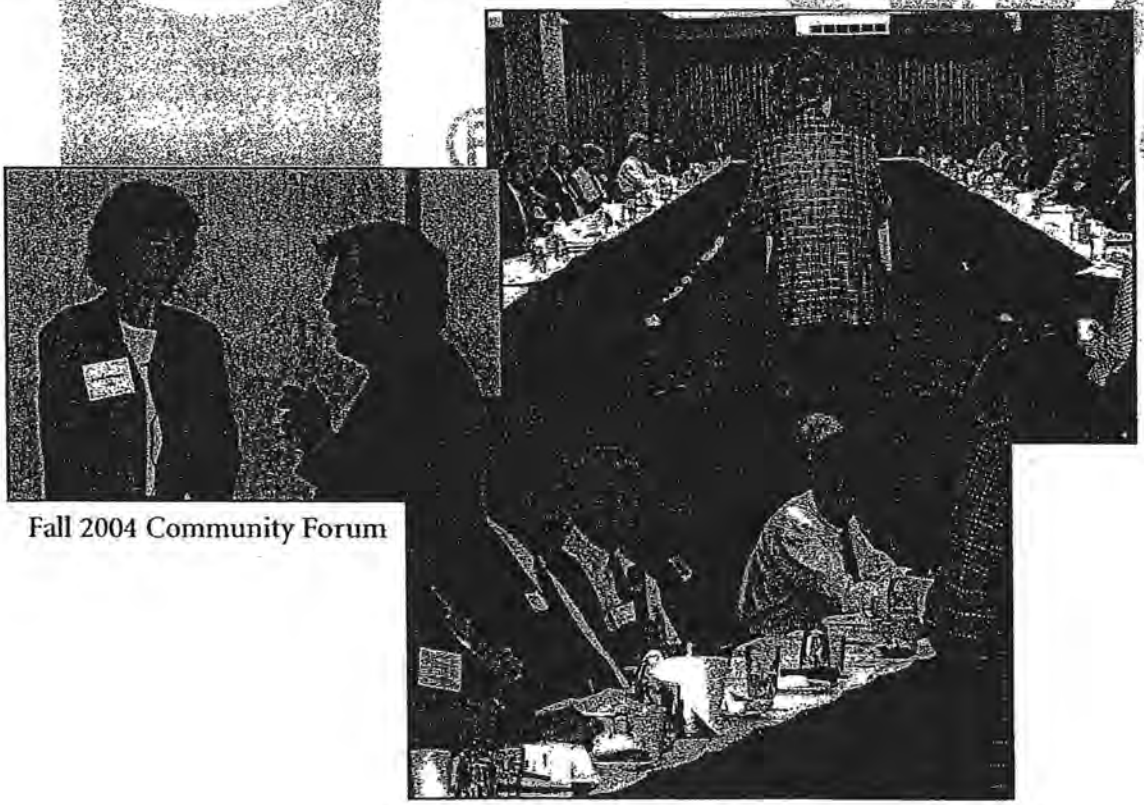
Those attending the forum generally agreed that these three areas of focus would be understood by the public, would be credible and would have the greatest payback in terms of improved health and cost control.

What's Next?

The "A Healthier You, A Healthier Minnesota" forums demonstrated a genuine interest among community leaders throughout Minnesota in embracing the community's role in improving health. There is a clear understanding that the most effective strategies and programs will be community-driven. And for one obvious reason: each of us knows best our own community, neighbors, facilities, resources and leaders.

The information outlined in this report reflects the first stage of the "A Healthier You, A Healthier Minnesota" initiative. The next step is to turn theory into practice: to build on the ideas and recommendations from the forums by having community leaders move forward with achievable prevention planning and implementation within their own communities.

While the challenges are substantial, the ideas and leadership exist to begin implementing prevention initiatives within communities, helping to make Minnesota a healthier place in which to live and work. Blue Cross looks forward to working with leaders throughout the state to reach that goal in tobacco cessation, physical activity and nutrition.



Fall 2004 Community Forum

Appendix A Overview of Minnesota *Decides* – Fall 2004

Minnesota *Decides* is a long-term initiative of Blue Cross and Blue Shield of Minnesota to listen to Minnesotans, to share information on health policy and improvement and to engage people in building a better health system. Through Minnesota *Decides*, people are able to learn more about the opportunities and challenges in our health system, to discuss ideas for improvement and to act where there is consensus for change.

Minnesota *Decides* began in 2000 with research to identify the core values Minnesotans want reflected in our health system. The research included focus groups and an extensive survey of 1,200 adults.

In Phase II of Minnesota *Decides*, the research findings were brought to the public through town hall meetings in 20 communities around the state in 2001. Employers, advocacy groups and others were engaged through smaller meetings. The research findings helped frame the three critical questions of health reform: what kind of health care system do we want?; how much are we willing to pay?; and who should pay? From the research and the forums, key attributes of fairness, affordability, choice and simplicity emerged as dominant themes for the desired health care system

The questions and the themes provoked lively discussion and generated a deeper understanding among participants of the health system's complexity. While the Minnesota *Decides* town hall meetings didn't produce a road map to reform, they did identify some action areas. In fact, the Minnesota *Decides* forums made it clear that the public is ready for reform. This strong sentiment led to Phase III of Minnesota *Decides*, a series of "dialogues" co-sponsored with the National Institute of Health Policy. These intense, two-day programs brought together stakeholders (including care providers, policy makers, employers, consumers, health plans and others) and resulted in specific proposals built around four themes and 14 recommendations. (The report is available at www.bluecrossmn.com/public/news/pdfdocs/MnDecidesReport.pdf.)

The recommendations that emerged from the Minnesota *Decides*-NIHP dialogues have been shared with policy makers and others engaged in changing the health system. They also formed an important foundation for reform proposals submitted in February 2004 to the Minnesota Legislature by the Minnesota Citizens Forum on Health Care Costs, an initiative commissioned by Governor Tim Pawlenty and led by former U.S. Senator Dave Durenberger.

One of the themes that has carried through the four years of Minnesota *Decides*, from the research to the town hall meetings to the dialogues with stakeholders, is the importance Minnesotans place on prevention as a tool to improve health and control costs. Prevention is viewed by many Minnesotans as not just an individual responsibility, but a community priority. Many people at the town hall meetings, for example, cited the importance of investing in public health to improve the health of the community.

Minnesota *Decides* now is acting on that recommendation for reform, focusing Phase IV of Minnesota *Decides* on prevention, especially the role the community plays in improving health and controlling costs. A new Minnesota *Decides* initiative, "A Healthier You, A Healthier Minnesota," is engaging Minnesotans in forums, through education and calls to action to enlist our communities as partners in promoting good health through private and public policies.

Appendix B 2004 Forum Attendees

Total number of attendees: 173							
	Mpls	Rochester	Duluth	RedWing	St Cloud	Willmar	Total
Education	6	2	3	2	4	5	22
Business	2	2	5	3	8	7	27
Faith	5	0	0	1	1	1	8
Local Govt	4	3	3	1	7	3	21
State Govt	2	2	2	0	0	0	6
Health	16	7	11	5	9	10	58
Social Service	5	2	2	1	1	9	20
Labor	0	1	1	0	1	0	3
Other	2	2	1	0	0	3	8
Total	42	21	28	13	31	38	173

Appendix C Economic Costs

Background Information

Minnesota Department of Health December 2002

Toll of Tobacco Use in Minnesota

Tobacco kills

Death and disease related to tobacco use

- 5,600 Minnesotans die every year from tobacco related diseases.
- Cigarette smoking is the single most preventable cause of death in the United States.
- One in every seven deaths in Minnesota is smoking related.
- Minnesota smokers shorten their lives by an average of 12.7 years.

Secondhand smoke

- Secondhand smoke is known to cause cancer in humans.
- Annually, exposure to secondhand smoke causes death to nonsmokers from lung cancers and coronary disease.
- An estimated 280,000 Minnesota children are exposed to secondhand smoke in the home.

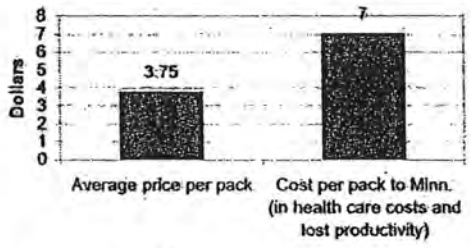
Exposure to secondhand smoke increases the risk in children of middle ear infections, asthma, bronchitis and sudden infant deaths syndrome (SIDS).

Tobacco use contributes to Minnesota's budget deficit

***Every year* smoking-related costs total $2.64 billion in Minnesota:**

- $1.6 billion in direct health care costs
- $1 billion in lost productivity
- $341 burden per capita

The Cost of Smoking in Minnesota



Prevention saves lives and dollars

This toll will be significantly reduced by maintaining the comprehensive youth health initiatives currently funded by the tobacco endowment. *By achieving and maintaining the legislatively mandated goal of reducing youth tobacco use by 30 percent by 2005, Minnesota's long-term return on investment is estimated at:*

- *1,700 Minnesotans who will be saved every year from premature death*
- *$480 million in health care costs that will be saved every year*

Reducing the state's commitment to its youth health initiatives will not save money in the long run. It will cost the state far more in the future to reduce this commitment to prevention.

Tobacco use begins in adolescence

- Over one-third (34 percent) of high school students and one in ten (11 percent) middle school students are current tobacco users.
- Use of tobacco increases steadily throughout adolescence. Current use of any tobacco product rises from 6 percent in 6th grade to 44 percent in 12th grade.
- Nearly half of current smokers in high school started smoking at the age of 12 or younger.
- 13,000 Minnesota kids under age 18 become new daily smokers each year.

But the trend is changing

Following a decade of increasing youth smoking rates, youth smoking started to drop between 2000 and 2002. These are the first two program years of the Minnesota Youth Tobacco Prevention Initiative, funded by the tobacco prevention endowment.

MINNESOTA MDH DEPARTMENT OF HEALTH
Commissioner's Office
85 East Seventh Place, Suite 400
P.O. Box 64882
St. Paul, MN 55164-0882
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Appendix C Economic Costs

Minnesota Department of Health Fact Sheet May 15, 2002

Health Care Costs of Physical Inactivity in Minnesota

How active are Minnesotans?

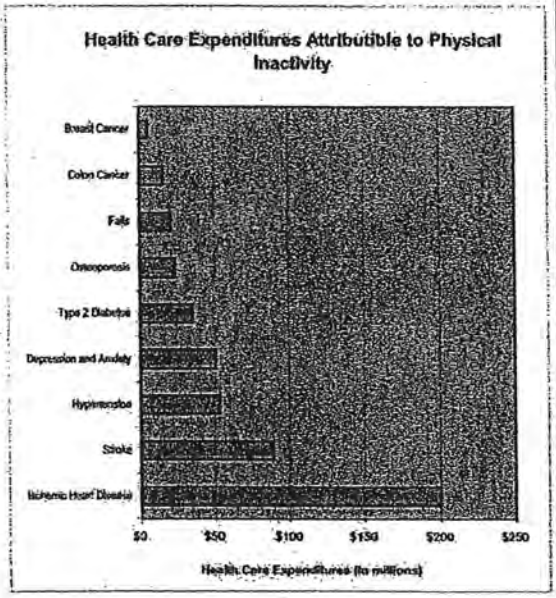
- The consensus recommendation from the Centers for Disease Control and Prevention and the American College of Sports Medicine states "Every US adult should accumulate 30 minutes or more of moderate-intensity physical activity on most, preferably all, days of the week." Brisk walking is an example of a moderate-intensity activity.
- In 2001, only a third of Minnesota adults knew the physical activity recommendation for general health.
- In 2000, only 27 percent of Minnesota adults achieved the recommended level of physical activity per week; 48 percent engaged in some form of physical activity, but not enough to meet the recommendation; and 25 percent engaged in no physical activity at all.
- In 1998, more than half of all 6th and 12th graders were 'insufficiently active'.
- Disparities exist in the proportions of adults and children achieving the recommended levels of physical activity between subpopulations. The subpopulations that are less likely to achieve the recommended amounts of activity include females, older adults, less educated, lower income, obese, ethnic and racial minorities, and people with disabilities.

Health Consequences of Physical Inactivity

- Physical inactivity and diet combined are the second leading cause of preventable death and disease in the United States and a huge economic burden on the state.
- Nearly 60 percent of Minnesota adults are overweight and nearly 17 percent are obese.
- The proportion of overweight or obese children in the United States has doubled in the last 20 years, to 13 percent.
- Mortality, morbidity, and cancer rates are higher among sedentary populations.
- Research has shown that many cases of heart disease, hypertension, type 2 diabetes, colon cancer, stroke, osteoporosis, depression and anxiety, breast cancer, and falls among the elderly are attributable to inactive lifestyles.

Direct Costs of Physical Inactivity

- **An estimated $495 million were spent during 2000 treating diseases and conditions that would be avoided if all Minnesotans were physically active.**
  - $383 million for hospital, outpatient, and professional expenses
  - $112 million for outpatient prescription drugs.
  - This amount represents over 100 dollars annually for every man, woman, and child living in Minnesota.



MINNESOTA MDH DEPARTMENT OF HEALTH
Family Health Division
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..Appendix C Economic Costs

Health Care Costs of Physical Inactivity in Minnesota - page 2

Other Costs of Physical Inactivity

- The total estimated amount spent treating conditions preventable with moderate physical activity, $495 million, is likely an underestimate of the true costs attributable to physical inactivity for several reasons:
  - The analysis was limited to diseases with a strong link to physical inactivity established in the literature.
  - These costs represent only a portion of the total direct costs related to these diseases. Examples of other direct expenditures that are not included in this analysis include those incurred for long-term care treatment and those for which the condition was not listed as the primary diagnosis.
  - The indirect costs of productivity losses from illness and early death from these diseases are expected to add several hundred million dollars to this total.
  - Research linking physical inactivity to disease is relatively new. The number of diseases attributable to physical inactivity will likely increase as new studies are completed and published.

Sedentary Behavior is a Natural Response to our Environment

- Our culture increasingly values cars, television, computers, and convenience, making physical activity less a natural part of our lives.
- Newer communities are often designed without sidewalks or streetlights, decreasing walkability.
- Communities are designed with housing far from schools, shopping, or other activities, making walking or biking for transportation infeasible.
- Increasing traffic congestion and aggressive driving hampers the walkability of neighborhoods.
- More and more employees have sedentary jobs decreasing the amount of activity incurred during daily routines.
- Children are taking fewer physical education classes in school.

Activity can be Easy

- Achieving the recommended amount of physical activity is as simple as taking three ten-minute walks per day.
- Health benefits occur even with very modest increases in activity, even if the recommendation is not met.
- The largest benefits occur to those who were previously completely sedentary.
- Any incremental physical activity is beneficial to health.
- Vigorous exercise is very beneficial to health, but a brisk walk is beneficial as well.
- Little changes, such as parking farther away from the store or opting for the stairs instead of the elevator, go a long way toward promoting health and preventing disease.

Physical Activity Improves Lives

- Physical activity can help people live longer, healthier lives.
- A physically active Minnesota population would expect to see:
  - 30 percent fewer cases of heart disease, stroke, colon cancer, and osteoporosis
  - 18 percent fewer cases of type 2 diabetes and hypertension
  - 16 percent fewer injuries from falls in the elderly
  - 12 percent fewer cases of depression and anxiety
  - 5 percent fewer cases of breast cancer
- Physical activity can help the elderly maintain their independence longer.
- Physical activity improves mental health and well-being.
- Physical activity is beneficial in managing many chronic conditions.
- Physical activity results in more productive employees by decreasing illness and absenteeism.

..Appendix C Economic Costs

Health Care Costs of Physical Inactivity in Minnesota - page 3

- Physical activity can help to reverse the trend of childhood obesity and type 2 diabetes.

Combating the Physical Inactivity Epidemic

- Environmental changes may result in more permanent lifestyle change than behavior modification.
- Active Community Environments, places where people of all ages and abilities can easily enjoy walking, bicycling, and other forms of recreation, should be promoted.
- Communities, schools, workplaces, and health care settings should be used to promote more active lifestyles.

The Reality of Physical Inactivity's Impact on Minnesota

Unless significant measures are taken, the deaths, diseases, and health care expenditures attributable to physically inactive lifestyles will only increase.

Acknowledgements

The report summarizes a study which was collaboratively conducted by researchers at the Minnesota Department of Health, BlueCross and BlueShield of Minnesota, and the University of Minnesota School of Public Health. Hospital discharge data was obtained from the Minnesota Hospital and Healthcare Partnership and claims data was provided by BlueCross and HealthPartners.

A full report of this study will be completed by August 1, 2002 and can be obtained at www.health.state.mn.us

Calculating the Direct Costs of Physical Inactivity

- The prevalence of physical inactivity among Minnesota adults and the relative risk for diseases with compelling relationships to physical inactivity are used to estimate the population attributable risk (PAR) for each disease.
- Hospital discharge data, medical claims data, and pharmaceutical data for all patients with a primary diagnoses of heart disease, hypertension, type 2 diabetes, colon cancer, stroke, osteoporosis, depression or anxiety, breast cancer, or a source of injury code of falls (if the patient was over age 64) were obtained, aggregated to the disease category level, extrapolated to the state population, and discounted to reflect amounts actually paid within each disease category.
- Using the PAR, the expenditure amount associated with physical inactivity is calculated from the total medical expenditure amount for each disease category.

Appendix D
Phone Services

Fax to: (651) 662-1657

Or mail to: Fulfillment Center (S210)
Blue Cross and Blue Shield of Minnesota
P.O. Box 64560
St. Paul, Minnesota 55164-0560

Contact information:

Quantity desired:_____

Clinic name: _____

Contact: _____

Address (no P.O. #s):_____

City, State, ZIP _____

Phone:_____

T1753R01 (12/04)

Mr. Murphy noted that Mark Banks, M.D., is featured in an article by the University of Minnesota Medical Bulletin on doctors who have transferred their skills to the world of business. In addition, Emmett Carson, Ph.D., was selected to the Non-Profit Times Power and Influence Top 50. Both articles were made available to the full board.

PRESIDENT'S REPORT:

Mark Banks, M.D., President and CEO, BCBSM, reported on a local and national advertising campaign by the Alliance for Advancing Non-Profit Health Care, which is a group of 20 non-profit plans, representing 24 states including Minnesota, committed to the support of non-profit health care. Howard Berman, President and CEO of Excellus Health Plan in New York, is Chair of the Alliance.

Meetings are taking place with Attorney General Mike Hatch and other health plan executives to discuss a proposal to create a mental health trust fund that would pay for 30–50 transitional beds for adult or adolescent patients easing the shortages of psychiatric beds in the metro area. Each hospital group and health plan would place $250,000 - $1,000,000 toward the trust fund and would be operated by community nonprofit organizations. The Anna Westin House, a residential treatment center for women with eating disorders, held an open house and dedication which Blue Cross staff attended. Blue Cross provided $1 million as settlement with the Westin family in mental health litigation which has been used to help fund the facility.

An update was provided on progress being made with provider contract negotiations. The focus has been on negotiating the most cost-effective agreements possible, ensuring contracts are structured in a way that they can be administered efficiently, and negotiating multi-year agreements where possible.

Dr. Banks reported on class action litigation initiated by providers against health plans in other states challenging the methods health plans use in processing provider claims.

Blue Cross is sponsoring "meet the candidates" sessions featuring candidates nominated by Minnesota's major political parties through the use of Citizen Blue, Blue Cross' non-partisan grassroots employee organization promoting good citizenship and political education.

Total enrollment as of August 2002 is 2,416,463 members, a gain of approximately 230,000 members year to date. Doctor Banks reviewed the new accounts and existing account successes. Losses continue in the small group market, as well with Comprehensive Care Services, Inc. (CCS) business.

Minn. Health Plan Spending $6.7 Million to Combat Inactivity

The winters are long and cold in Minnesota, driving most residents indoors to pursue warmer and unfortunately more sedentary past-times. It is estimated that nearly three-quarters of the state's residents do not get enough physical activity. That lifestyle comes with a hefty price tag, as $495 million was spent during 2000 in Minnesota to treat illnesses and conditions related to physical inactivity.

To combat this trend, Blue Cross and Blue Shield of Minnesota has decided to spend $6.7 million to wage an unconventional campaign to convince residents that they can be more physically active without having to visit their local fitness center.

In the cities of Minneapolis-St. Paul and Duluth, the health plan is running mass media advertising, including billboards, television, newspaper, and city busses. In the Twin Cities, a new light rail system will also carry ads.

The message the health plan is sending is that every bit of physical activity helps, says Amy Lyons Sayers, cardiovascular initiatives project manager at the insurer. The campaign encourages people to use the stairs rather than an elevator or escalator. It also suggests that people park their cars farther away from buildings and walk the remaining distance. Homeowners are encouraged to use manual tools like a lawn rake over power tools.

"We as a society have forgotten that we have opportunities to be physically active every day, all around us. We need to take advantage of those opportunities."

The point of the campaign, which has been dubbed 'do,' is that doing small amounts of physical activity spread throughout the day can add up to big improvements in health, says Lyons Sayers. People may feel that only strenuous workouts count as physical activity, she says, but that's not true. "We as a society have forgotten that we have opportunities to be physically active every day, all around us. We need to take advantage of those opportunities," she says.

The campaign is being run with the assistance of the American Heart Association. It suggests that grabbing 10-minute bits of physical activity three times a day can be beneficial.

Employers cooperate

Blue Cross and Blue Shield of Minnesota is working with a number of employers in the state, says Lyons Sayers. Those include the Target department store chain, which is headquartered in Minneapolis, state government, a computer software company, and a medical device manufacturer.

Employers are supplied with signs that they can post next to their elevators and escalators, suggesting that workers take the stairs. There are also signs to exhort workers to skip looking for a parking spot close to the building's entrance, and park on the outer fringes of the lot.

The signs make these suggestions by using clever and humorous phrases. For example, a sign posted at an elevator says, "Don't let the machines win. Take the stairs." A sign that hangs inside an elevator cautions people to, "Avoid awkward silences. Next time, take the stairs."

The signs fit with the campaign's approach, which is to motivate people to change their routines without being harsh or nagging them, says Lyons Sayers. "The approach we take with the campaign is a very fun, non-nagging approach," she says.

There is evidence that this approach does work. The insurer pilot tested the campaign in Duluth earlier in 2004, and residents said they liked the way the messages reinforce each other. "It's not just a message at their worksite, it's not just a message at home, it's not just a message here or there, but it's the continual reinforcing messages that really encourage people to become more active," she says.

Success stories

From the pilot test, the insurer received anecdotal evidence that the campaign does work. One of the suggestions was that people carry their groceries in from their car one bag at a time, in order to add a few more steps to the chore. "A

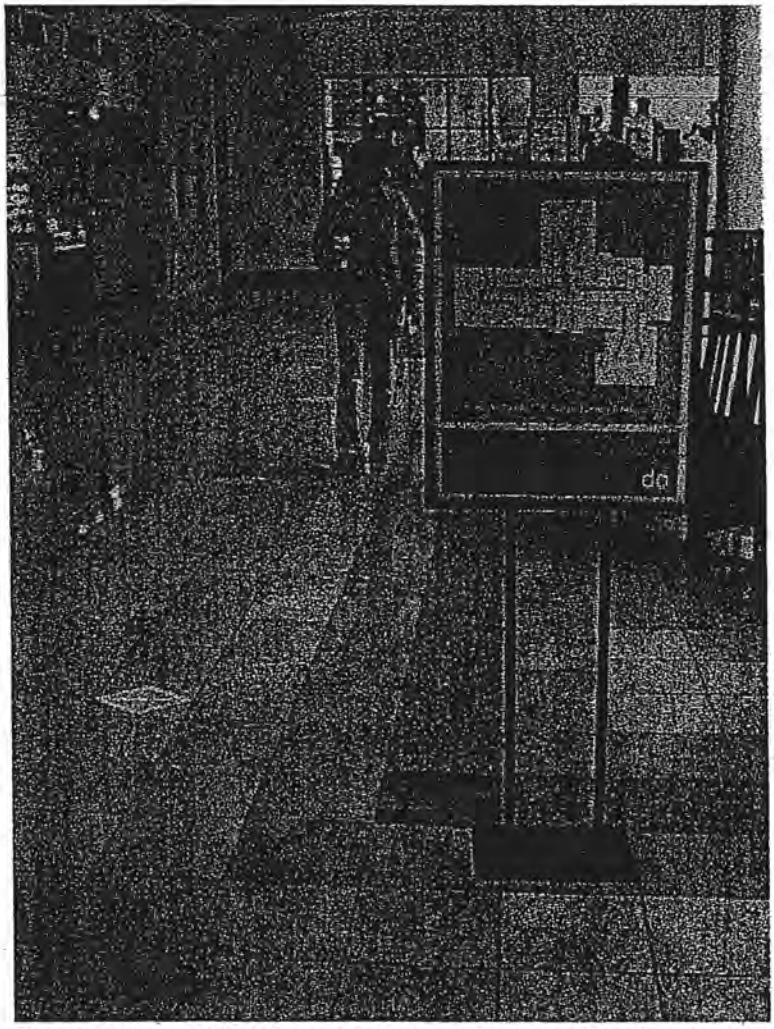
(See Campaign... page 9)

Campaign ... (from p. 3)

woman told us that's where she felt like she could start. She started bagging her groceries lighter so she had more bags to carry in, and started carrying them in from her car one bag at a time," says Lyons Sayers.

After that small start, the woman began taking more and more steps and eventually graduated to walking 45 minutes a day, she adds.

A man heeded the campaign's advice of taking 10-minute breaks at work to stroll around the company's offices. Soon the man was taking longer walks and was able to shed 60 pounds. With the weight loss, he was able to discontinue two blood pressure medications.



Blue Cross Blue Shield of Minnesota is working with owners of large buildings to develop walking lanes. In the photo above, a mall has put the diamond shaped decals on the floor to mark a loop around the complex. The sign at the right shows a diagram of the mall and the indoor walking path. The sign also reminds people to "groove your body 10 minutes, three times a day."

To give people convenient places to walk inside buildings, Blue Cross Blue Shield of Minnesota is working with public and private property owners to establish "walking lanes." These are circuit routes marked by diamond-shaped decals placed on the floor, about five feet apart (see photo).

The idea is to take advantage of long hallways in a building to give people a place where they can walk for 10 minutes or more without having to battle the weather outside, says Lyons Sayers. "It takes away the 'it's too cold out excuse,'" she says. The walking lanes also diminish the excuse that someone is too busy to visit the gym to get in some physical activity.

One of the walking lanes is being planned for a tunnel network connecting buildings in the state capital, to form a 1-mile loop.

Guerilla marketing

Much of the do campaign's marketing is through conventional channels, but the insurer has set aside some money for what is known as guerrilla marketing. That is a form of marketing aimed at reaching people when they least expect it, and thus the message has a better chance of cutting through the clutter and making an impression.

With the blessing of city governments and employers, the campaign has been putting down chalk drawings on walkways in busy locations. The attention-getting art includes hopscotch lanes, and slogans such as "free treadmill" on sidewalks and "free step climber" at the base of a stairway.

"It's low budget ideas, 67-cent ideas, that people can do to encourage their employees or the public or whoever is accessing their building's grounds, to become more physically active," says Lyons Sayers.

In keeping with this on-the-street flavor, the insurer has hired a group of people to scout neighborhoods

(continued on next page)

looking for residents who are being physically active, doing manual activities such as shoveling snow or raking their lawns. They also look for people doing fun activities, such as building a family of snow people or a snow fort.

When such a person is spotted, the "do crew" hands out rewards such as T-shirts, water bottles, and ice scrapers. With their permission, a photo of the resident undertaking their activity is snapped and the picture is placed in a newspaper advertisement. The caption thanks the person for taking time to "groove their body" and making the city more beautiful.

The nine-member crew goes out three to a team, Lyons Sayers explains. The crew members are contractors who work part-time, about 15-20 hours a week during the campaign, which will run until December 2005. The monthly cost of the crew is approximately $15,000.

Financial returns

The money that Blue Cross and Blue Shield of Minnesota is spending on the campaign is actually quite small, compared to the $83.6 million a year that the company spends on claims for diseases associated with physical inactivity, Lyons Sayers says.

The campaign is being funded out of the proceeds of a lawsuit settlement reached with tobacco companies, she explains. The money is still tied up in litigation, so the insurer is funding the campaign from its own budget, with the expectation of being paid back once the litigation has been resolved.

If the tobacco money doesn't come through, Lyons Sayers says the insurer still believes the money it is spending on the campaign is a good investment in improving the health of its members.

To prove that signs suggesting taking the stairs do work, Lyons Sayers says the insurer installed infrared sensors in a stairwell at an employer in Duluth to measure foot traffic on the stairs. Each time a person walked up or down the stairs, the infrared beam was broken and that person was counted.

The data from the test confirmed what the literature said would happen, Lyons Sayers reports. "As long as the sign is up, more people use the stairs. As soon as the sign comes down, people revert back to their usual behavior of using the escalator," she says.

The research predicted that 5 percent to 8 percent more people would use the stairs with a reminder sign in place. The test data showed similar increases.

A 5 percent increase may not sound like much, but to Lyons Sayers it is something worth doing. "If we can get 5 percent of our society moving, we can see a reduction in health care costs of $9 million," she says. "So 5 percent is actually a big number." ■

Contact: Lyons Sayers at 651/662-3378. The campaign's web site is located at www.do-groove.com.

Health Benefit Cost Increased 7.5 Percent in 2004, Lowest Hike in Five Years According to Employer Survey

Average per-employee cost in 2004 rose 7.5 percent — still outpacing general inflation, but the lowest increase since 1999 and well down from last year's 10.1 percent increase, according to a survey conducted by Mercer Human Resource Consulting.

According to the National Survey of Employer-Sponsored Health Plans 2004, the average total cost of health benefits for active employees (for all medical and dental plans offered) rose from $6,215 per employee in 2003 to $6,679 in 2004. This amount includes both employer and employee premium contributions, but does not include employee out-of-pocket expenses.

The survey is conducted using scientific methodology and, with 3,020 employer participants, is the largest annual survey on the topic. All employers, public and private, with at least 10 employees were sampled. The survey was conducted during late summer, when most employers have a firm fix on their costs for the current year. Results have an error range of plus or minus 3 percent.

and dental services to children and teens from ethnic and minority communities throughout the state.

Dr. Owen reported on Wilder Research Center's evaluation efforts of Growing Up Healthy. Dr. Owen stated that a final evaluation report would be completed by the end of 2004. This final report will use cluster analysis to identify findings and lessons learned based on results and data reported by grantees as well as interviews with clients, project staff and partners. Dr. Owen remarked on the outcomes of the Growing Up Healthy initiative that are emerging from the analysis. He reported that during the first year of Growing Up Healthy, 1,199 children received a preventive medical or dental exam through Growing Up Healthy grantees. These children were served in Greater Minnesota, where access to medical and dental care is limited. Grantees report that virtually no dental care providers accept new low-income patients on Medical Assistance. Discussion ensued and the Foundation Board had time for several questions. Dr. Banks thanked Wilder Research for the presentation.

MANAGEMENT REPORT

Mr. Johnson provided an update on the Foundation's new strategic program direction. Staff attention has turned to planning and preparing for the announcement and launch of the Foundation's new initiatives. Mr. Johnson reviewed that on August 11th the Audit and Investment Committee approved a revised 2004 budget. The committee approved an additional $135,000 for staff salaries and related administrative expenses and $101,277 for new program initiatives. This budget honors the board's requirement that the year-end fund balance is no less than that approved last December. This is possible due to the larger than anticipated contribution from BCBSM, Inc. resulting in an increased principle balance. The last phase of the program development work is geared toward three areas: 1. Strengthening capabilities to undertake new program directions; 2. Designing and implementing the new initiatives; and, 3. Grantmaking, monitoring, convening and program communications.

Mr. Johnson reported on two Employee Community Involvement Programs. Dollars for Doers is a program launched last year with funding from the Foundation. $200 is awarded to eligible nonprofits when an employee volunteers 40 hours or more of their personal time. Year to date, 42 employees have received the award. In addition, 6,000 hours of volunteer paid time off has been contributed, compared to 3,700 hours last year. Blue Cross recognizes that such participation provides employees with valuable leadership training, work experience and a sense of personal fulfillment. In turn, Minnesota communities benefit from the time and energy of Blue Cross volunteers. Mr. Johnson highlighted one employee that volunteers and works on the web page for CaringBridges, a not-for-profit organization, a free online service connecting patients to friends and families.

Mr. Johnson also reported on the Community Giving Campaign that is starting this week. The Foundation provides a 50 percent match of employee pledges as an incentive. Last year the Foundation contributed $207,400, based on 47 percent

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Part XV, Line 3a - Grants and Contributions Paid During the Year:

Name and Address	Foundation Status of Recipient	Purpose of Grant or Contribution	Amount
Affiliated Community Health Foundation 101 Willmar Avenue Southwest Willmar, MN 56201	Public Charity	Integrate the school-based teen health and wellness center into the school curriculum	$36,500
Aitkin Community Hospital, Inc. dba Riverwood Health Care Center 200 Bunker Hill Drive Aitkin, MN 56431	Public Charity	Conduct market analysis to help define the future vision for Riverwood Healthcare Center	$10,000
Anishinaabe Center 921 8th Street SE Detroit Lakes, MN 56501	Public Charity	Young Warrior Society Youth Program	$5,000
Appalachia Service Project, Inc. 4523 Bristol Highway Johnson City, TN 37601	Public Charity	Support of ongoing programs	$200
Apple Tree Dental 8960 Springbrook Drive, Suite 150 Minneapolis, MN 55433	Public Charity	Head Start Smiles project in southwest Minnesota	$39,000
ARC Great Rivers 1201 89th Avenue Northeast, Suite 305 Blaine, MN 55434-3373	Public Charity	Pilot mentoring program for Latino parents of developmentally disabled children	$30,000
ARC Hennepin-Carver 4301 Highway 7, Suite 140 Minneapolis, MN 55421	Public Charity	Multicultural Inclusion Program to assess and integrate cultural competence in ARC programs and operations	$80,000
ARC Retreat Center 1680 373rd Avenue NE Stanchfield, MN 55080	Public Charity	Support of ongoing programs	$200
Boy Scouts of America 393 Marshall Avenue St. Paul, MN 55102	Public Charity	Support of ongoing programs	$600
Bridging Incorporated 201 West 87th Street Bloomington, MN 55420	Public Charity	Support of ongoing programs	$200
Bundles of Love 7975 166th St W Lakeville, MN 55044	Public Charity	Support of ongoing programs	$400
Cannon Valley Girl Scout Council, Inc. P.O. Box 61 Northfield, MN 55057	Public Charity	Support of ongoing programs	$200
Caring Bridge Corporation 4607 Beacon Hill Court Eagan, MN 55122	Public Charity	Support of ongoing programs	$200
Cass Lake Indian Hospital and Clinic 217 Seventh Street Northwest Cass Lake, MN 56633	Public Charity	Partnership with Bemidji State University to improve the hospital's operational effectiveness	$10,000
CentraCare Health System P.O. Box 548 110 Sixth Avenue South St. Cloud, MN 56302-0548	Public Charity	Strategic planning process for Long Prairie Memorial Hospital including employment and health services for the growing Hispanic community	$10,000
Charities Funds Transfer 701 N. Fairfax Street, Suite 300 Alexandria, VA 22314	Public Charity	Support of ongoing programs	$22,159

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Charities Review Council 46 East Fourth Street St. Paul, MN 55101-1112	Public Charity	Support ongoing programs and feasibility study	$5,000
Chicanos Latinos Unidos En Servicio 220 South Robert Street, Suite 103 St. Paul, MN 55107	Public Charity	Pilot project for insured Latinos	$44,450
Children's Defense Fund Minnesota Office 200 University Avenue West, Suite 210 St. Paul, MN 55103	Public Charity	Third year funding for Covering Kids and Families project	$48,000
Children's Home Society & Family Services 2230 Como Avenue St. Paul, MN 55108	Public Charity	Support of ongoing programs	$200
Cokato Ambulance Service P.O. Box 1030 Cokato, MN 55321	Public Charity	Recruitment of additional EMTs and training of personnel	$8,000
Community Action Council 20730 Holyoke Avenue P.O. Box 1256 Lakeville, MN 55044-1256	Public Charity	Partners for the Promotion of Preventitive Health Care for Under-Served Populations	$51,200
Cook Area Health Services 20 Fifth Street Southeast Cook, MN 55723	Public Charity	Expansion of the diabetes collaborative chronic care model to all CAHS clinic sites	$10,000
Courage Center 3915 Golden Valley Road Minneapolis, MN 55422	Public Charity	Support of ongoing programs	$200
Dakota Area Resources and Transportation for Seniors 1645 Mathaler Lane West St. Paul, MN 55118	Public Charity	Support of ongoing programs	$200
Deaf Minnesotans Charitable Fund 2055 Rice Street St. Paul, MN 55113	Public Charity	Increase access to information for deaf people and increase cultural competency for practitioners in the field of end-of-life care	$5,000
Divine Providence Health Center 312 East George Street P.O. Box 136 Ivanhoe, MN 56142-0136	Public Charity	Implementation of a holistic training initiative that will address leadership skills, IT skills, and compliance and quality education	$10,000
East YMCA 1075 Arcade Street St. Paul, MN 55106	Public Charity	Development of a children weight program	$65,000
Faith in Action: Todd-Wadena Interfaith Caregiver Service P.O. Box L, 109 South Walker New York Mills, MN 56567	Public Charity	Recruitment, training and recognition of 50 new volunteers for Faith In Action: Todd - Wadena Interfaith caregiver services	$9,388
Fremont Community Health Services, Inc. 3300 Fremont Avenue North Minneapolis, MN 55412	Public Charity	Support for sliding fee dental clinic for north and northeast Minneapolis	$5,000
Friends of Animal Adoptions, Inc. 809 East 7th Street St. Paul, MN 55109	Public Charity	Support of ongoing programs	$400
Glencoe Regional Health Services 1805 Hennepin Avenue North Glencoe, MN 55336-1416	Public Charity	Conduct a study to improve services and outreach to the area's growing Hispanic community	$10,000

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Grant County Health Center 930 First Street Northeast Elbow Lake, MN 56531	Public Charity	Recruitment and training of high school students to become EMTs	$10,000
Grantmakers in Health 1100 Connecticut Avenue NW, Suite 1200 Washington, DC 20036	Public Charity	Funding of the Grantmakers in Health Association	$2,650
Greater Mankato Area United Way 101 North Second Street, Suite 202 Mankato, MN 56001-3566	Public Charity	Support of ongoing programs	$358
Greater Northwest Emergency Medical Services, Inc. 2301 Johanneson Avenue NW, Suite 103 Bemidji, MN 56601	Public Charity	Organization of management activities for ambulance managers in northwest and west central Minnesota	$7,500
Greater Twin Cities United Way 404 South Eighth Street Minneapolis, MN 55404-1084	Public Charity	Support of ongoing programs	$207,824
Groveland Park Elementary School 2045 St. Clair Avenue St. Paul, MN 55105	Public Charity	Support of ongoing programs	$200
Harriet Bishop Elementary School 14000 O'Connell Road Savage, MN 55378	Public Charity	Support of ongoing programs	$200
Hayfield Community Ambulance Service 10 1st Street Northwest Box 471 Hayfield, MN 55940	Public Charity	Volunteer recruitment and training and office systems improvements	$9,000
Helping Hands Outreach to Elders, Inc. 511 Main Street P.O. Box 293 Holdingford, MN 56340	Public Charity	Building organizational capacity in partnership with Rural Stearns Faith in Action and improving quality assurance	$10,000
Highland Catholic School 2017 Bohland Avenue St. Paul, MN 55116	Public Charity	Support of ongoing programs	$200
Hmong American Partnership 1075 Arcade Street St. Paul, MN 55106	Public Charity	Partnership with Minnesota Department of Health to ensure culturally appropriate and timely coordination of health screening for new Hmong refugees	$50,000
Hmong National Development, Inc. 1112 16th Street Northwest, Suite 110 Washington, DC 20036	Public Charity	Hmong Refugee Wellness Planning Project	$5,000
Horizon Health, Inc. 93 Edward Street South P.O. Box 220 Pierz, MN 56364	Public Charity	Increase organizational capacity of the Faith in Action program through focused training for staff and volunteers	$10,000
Hospice Minnesota 1600 University Avenue West, Suite 301 St. Paul, MN 55104-3800	Public Charity	New Directions program	$10,000
Humane Society for Companion Animals 1115 Beulah Lane St. Paul, MN 55108	Public Charity	Support of ongoing programs	$200
International Health Service of Minnesota P.O. Box 16149 St. Louis Park, MN 55416	Public Charity	Support of ongoing programs	$200

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Jewish Community Action 2375 University Avenue, Suite 150 St. Paul, MN 55114	Public Charity	Support of ongoing programs	$200
Kids 'N Kinship, Inc. 14870 Granada Avenue #127 Apple Valley, MN 55124	Public Charity	Support of ongoing programs	$200
La Escuelita 4137 Bloomington Avenue South Minneapolis, MN 55407	Public Charity	Develop a comprehensive evaluation for the Juventud Viva Youth-Led Health program	$5,000
La Escuelita 4137 Bloomington Avenue South Minneapolis, MN 55407	Public Charity	Juventud Viva program	$15,000
Lake Superior Community Health Center 2 East 5th Street Duluth, MN 55805	Public Charity	Creation of a coordinated volunteer recruitment and management system for clinical and support staff	$10,000
Lakeshore Lutheran Home 4002 London Road Duluth, MN 55804	Public Charity	Expand Arrowhead Parish Nurses and increasing screening activities under the Arrowhead 'Know Your Numbers' campaign	$10,000
Lao Assistance Center of Minnesota, Inc. 503 Irving Avenue North, Suite 100 Minneapolis, MN 55405	Public Charity	Strengthen capacity and continue health care education and patient advocacy to Hmong and Lao residents of North Minneapolis	$30,000
League of Women Voters Education Fund 550 Rice Street St. Paul, MN 55103	Public Charity	Support of ongoing programs	$200
Linus Project 1660 Edmund Avenue St. Paul, MN 55104	Public Charity	Support of ongoing programs	$600
Mesabi Family YMCA 8367 Unity Drive Virginia, MN 55792	Public Charity	Support of ongoing programs	$400
Metropolitan Area Agency on Aging, Inc. 1600 University Avenue West, Suite 300 St. Paul, MN 55104-3825	Public Charity	Sustaining Minority Elders in Their Communities project	$60,000
Midwest Avian Adoption & Resource Services, Inc. P.O. Box 821 Stillwater, MN 55082	Public Charity	Support of ongoing programs	$200
Migrant Health Service, Inc. 810 4th Avenue South, Suite 120 Moorhead, MN 56560	Public Charity	Strategic planning by the staff and board of directors	$10,000
Mille Lacs Health System 200 North Elm Street P.O. Box A Onamia, MN 56359-0800	Public Charity	To support market research and analysis for stategic planning	$10,000
Minneapolis Medical Research Foundation Office of Grants and Contracts 914 South 8th Street 600 HFA Building Minneapolis, MN 55404-1249	Public Charity	Una Sonrisa Saludable project	$49,000
Minneapolis Urban League 2100 Plymouth Avenue North Minneapolis, MN 55411	Public Charity	Expansion of the Mental Health Advocacy Program	$25,000

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Minnesota Association for Children's Mental Health 165 Western Avenue, Suite 2 St. Paul, MN 55102	Public Charity	Support for Parent-to-Parent program	$52,038
Minnesota Community Foundation P.O. Box 16341 St. Louis Park, MN	Public Charity	Support of ongoing programs	$200
Minnesota International Health Volunteers 122 West Franklin Avenue, Suite 210 Minneapolis, MN 55404	Public Charity	Planning grant to conduct additional research with Community Health Worker Program	$5,000
Minnesota Medical Foundation University of Minnesota Gateway 200 Oak Street SE, Suite 300 Minneapolis, MN 55455	Public Charity	Somali Diabetes and Depression Project	$23,481
Minnesota Star, Inc. 416 Cedar Avenue South Minneapolis, MN 55454	Public Charity	Support of ongoing programs	$200
National Hemophilia Foundation Minnesota Chapter 750 South Plaza Drive, Suite 207 Mendota Heights, MN 55120	Public Charity	Support of ongoing programs	$200
Neighborhood Health Care Network 2610 University Avenue W, Suite 400 St. Paul, MN 55114-1904	Public Charity	Expand the Community Health Worker (CHW) Program	$125,000
Neighborhood House 179 Robie Street East St. Paul, MN 55107	Public Charity	Phase 2 of Plain Talk in St. Paul and replication of the Comadres Program in Rice County	$25,200
New Americans Community Services 1821 University Avenue, Suite S-281 St. Paul, MN 55104	Public Charity	Partnership to provide a 'Community Health Outreach Program' directed to African immigrants and refugees	$49,100
Northern California Grantmakers 625 Market Street, 15th Floor San Francisco, CA 94105	Public Charity	Support for national convening 'Immigrant Integration in New and Non-Traditional Immigrant Destinations'	$5,000
Northfield Starlets, Inc. P.O. Box 148 Northfield, MN 55057	Public Charity	Support of ongoing programs	$200
Northwestern College 1101 East Central Entrance Duluth, MN 55811	Public Charity	Support of ongoing programs	$200
Open Arms of Minnesota, Inc. 1414 Franklin Avenue East Minneapolis, MN 55404	Public Charity	Support of ongoing programs	$200
Open Door Health Center 309 Holly Lane Mankato, MN 55416	Public Charity	Project to secure financial future of regional safety net clinic	$39,900
Our Savior's Lutheran Church 2315 Chicago Avenue South Minneapolis, MN 55404	Public Charity	Support of ongoing programs	$200
Payne-Phalen Living at Home/Block Nurse Program 1280 Arcade Street St. Paul, MN 55106	Public Charity	Develop a culturally diverse community based faculty nursing practice in St. Paul's Payne/Phalen planning district	$25,000

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Peta Wakan Tipi 459 North Wheeler Street St. Paul, MN 55104	Public Charity	Dream of Wild health	$25,000
Pine Medical Center 109 Court Avenue South Sandstone, MN 55072	Public Charity	Support of community-based strategic planning and related feasibility analysis	$10,000
Portico Healthnet 2610 University Avenue, #550 St. Paul, MN 55114-2007	Public Charity	Expand program into new markets	$115,000
Rice Health Foundation 301 Becker Avenue SW Willmar, MN 56201	Public Charity	Development of a music therapy program at Rice Hospice	$5,000
Roseau Area Hospital and Homes, Inc. 715 Delmore Drive Roseau, MN 56751	Public Charity	Expanding the Health Occupations curriculum at the area high school, developing grief support groups and creating a health library for the community	$10,000
Rushford Community Ambulance Service P.O. Box 603 Rushford, MN 55971	Public Charity	Training activities to enhance the community's emergency care system	$9,000
SADD-Students Against Driving Drunk, Inc. 16750 49th R. St. SE Kindred, ND 58051	Public Charity	Support of ongoing programs	$200
Saint Elizabeth's Medical Center 1200 Grant Boulevard West Wabasha, MN 55981	Public Charity	Expanding the Commitment to Leadership Excellence initiative	$9,650
Scott-Carver-Dakota CAP Agency, Inc. 712 Canterbury Road Shakopee, MN 55379	Public Charity	Support of ongoing programs	$400
Shakopee Public Schools 505 South Holmes Shakopee, MN 55379	Public Charity	Support of ongoing programs	$200
Simpson Housing Services, Inc. 2740 1st Avenue South Minneapolis, MN 55408	Public Charity	Support of ongoing programs	$200
Somali Community Resettlement Services, Inc. 1421 Third Avenue Southeast, Suite 205 Rochester, MN 55904	Public Charity	Project to continue to build long-term organizational viability needed to continue health education and access efforts for Somali families	$49,800
Southeastern Minnesota Emergency Medical Services, Inc. 1903 South Broadway Rochester, MN 55904	Public Charity	Regional consortium to train members on the use of Automatic External Defibrillators	$9,350
Southwest Minnesota Foundation 1390 Highway 15 South P.O. Box 428 Hutchinson, MN 55350	Public Charity	Development of an infrastructure that will help build and sustain parish nursing in southwestern Minnesota	$10,000
Spare Key 820 Southview Blvd South St. Paul, MN 55414	Public Charity	Support of ongoing programs	$200
Special School District #1 415 4th Avenue Southeast Minneapolis, MN 55414	Public Charity	Support of ongoing programs	$200

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Springfield Medical Center-Mayo Health System 625 North Jackson Sreet Springfield, MN 56001	Public Charity	Implementation of the Emergency Skills Instructor Training Project	$10,000
St. Francis Medical Center 415 Oak Street Breckenridge, MN 56520	Public Charity	Leadership development training for the hospital's middle management team	$10,000
St. Gabriel's Hospital 815 Southeast 2nd Street Little Falls, MN 56345	Public Charity	Support focus group research and an action plan on the issues of local health care access and continuity of care	$7,500
St. Louis Park Emergency Program, Inc. 4100 Vernon Avenue South St. Louis Park, MN 55416	Public Charity	Support of ongoing programs	$200
St. Mary's Duluth Clinic Health System 407 East Third Street Duluth, MN 55805	Public Charity	Establishing a hospital-based palliative care program	$10,000
Stairstep Foundation 1404 14th Avenue North Minneapolis, MN 55411	Public Charity	There is A Balm program	$53,362
The Aliveness Project 730 East 38th Street Minneapolis, MN 55407	Public Charity	Support for health programs for low-income, HIV-infected members	$5,000
The Center for Cross-Culture Health 1313 Fifth Street Southeast, Suite 100B Minneapolis, MN 55414	Public Charity	Launch a sustainable collaborative partnership to improve healthcare cultural competence within a local community	$27,550
The College of St. Catherine 2004 Randolph Avenue St. Paul, MN 55105	Public Charity	Project to increase access to medical interpreters for the deaf/blind community	$39,500
The Eagan Heights Figure Skating Club 7215 121st Street West Apple Valley, MN 55124	Public Charity	Support of ongoing programs	$200
The Hope Heart Institute 1710 East Jefferson Seattle, WA 98122	Public Charity	Feasibility study of health literacy as a potential funding interest under the foundation's new program direction	$10,000
The Minneapolis Foundation 800 IDS Center 80 South Eighth Street Minneapolis, MN 55402	Public Charity	Partnership for Peds project	$75,000
Tides Center 1112 16th Street, Suite 110 Washington, DC 20036	Public Charity	Support of ongoing programs	$200
Tracy Area Medical Services Foundation 251 Fifth Street East Tracy, MN 56175	Public Charity	Improve mental health services for immigrant population and surrounding communities in general	$45,000
Trust Church Group 9 West Rustic Lodge Avenue South Minneapolis, MN 55409	Public Charity	Support of ongoing programs	$400
Twin Cities Habitat for Humanity, Inc. 3001 4th Street SE Minneapolis, MN 55414	Public Charity	Support of ongoing programs	$200

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Twin Cities Public Television, Inc. 172 East 4th Street St. Paul, MN 55101	Public Charity	Support of ongoing programs	$200
United Way of Cass-Clay P.O. Box 1609 Fargo, ND 58107-1609	Public Charity	Support of ongoing programs	$260
United Way of Central Minnesota 2700 First Avenue North, Suite 300 St. Cloud, MN 56303-4587	Public Charity	Support of ongoing programs	$606
United Way of Greater Duluth 402 Ordean Building 424 West Superior Street Duluth, MN 55802-1532	Public Charity	Support of ongoing programs	$931
United Way of Northeastern Minnesota P.O. Box 66 Chisholm, MN 55719-0066	Public Charity	Support of ongoing programs	$13,361
United Way of Olmsted County 903 West Center Street, Suite 100 Rochester, MN 55902	Public Charity	Support of ongoing programs	$255
United Way of St. Croix County 911 Fourth Street, Room 207 Hudson, WI 54016-1681	Public Charity	Support of ongoing programs	$275
University of Minnesota Division of General Pediatrics and Adolescent Health 200 Oak Street Southeast, Suite 200 Minneapolis, MN 55455-2002	Public Charity	Preventive Care for Adolescents project	$23,139
University of Minnesota 1300 South 2nd Street Minneapolis, MN 55454-1015	Public Charity	Social Capital Conference	$5,000
University of Minnesota Mayo Mail Code 85 420 Delaware Street Southeast Minneapolis, MN 55455	Public Charity	2004 Minnesota Health Care Access Survery	$200,000
Vietnamese Social Services of Minnesota 1159 University Avenue, Suite 100 St. Paul, MN 55104	Public Charity	Vietnamese Open Door to Health Care Project	$25,000
West Central Minnesota Communities Action, Inc. 411 Industrial Blvd Elbow Lake, MN 56531	Public Charity	Support of ongoing programs	$200
West St. Paul Youth Athletic Association, Inc. P.O. Box 18097 West St. Paul, MN 55118-0097	Public Charity	Support of ongoing programs	$200
Western Mental Health Center, Inc. 1212 East College Drive Marshall, MN 56258	Public Charity	Community needs assessment and survey for a proposed telehealth network project	$10,000
White Earth Land Recovery Project 32033 East Round Lake Road Ponsford, MN 56575-9250	Public Charity	Initiative to combat type 2 diabetes	$5,000
Young Dance, Inc. 3326 15th Avenue South Minneapolis, MN 55407	Public Charity	Support of ongoing programs	$200

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Youthlink 41 North 12th Street Minneapolis, MN 55403	Public Charity	Health and wellness clinic	$5,000
YWCA Minneapolis 1130 Nicollet Mall Minneapolis, MN 55403	Public Charity	Women's Wellness Program for low-income women in North Minneapolis	$20,664
Zumbro Valley Mental Health Center 315 Elton Hills Drive Northwest Rochester, MN 55901	Public Charity	Improving management and leadership practices to increase organizational capacity	$10,000
Total			$2,285,551

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Part XV, Line 3b - Grants and Contributions Approved for Future Payment:

Name and Address	Foundation Status of Recipient	Purpose of Grant or Contribution	Amount
Blue Earth County Community Mental Health Center 410 South Fifth Street Mankato, MN 56001	Public Charity	Develop a telemedicine communication system that will link area providers	$10,000
Falls Memorial Hospital 1400 Hwy 71 International Falls, MN 56649	Public Charity	Provide comprehensive leadership training to senior, midlevel and supervisory staff members	$10,000
Family Health Care Center 306 North 4th Street Fargo, ND 58102	Public Charity	Implementation of an annual training program for medical interpreters	$9,845
Glacial Ridge Health System 10 Fourth Avenue Glenwood, MN 56334	Public Charity	Joint health service planning for Glacial Ridge Health System and Minnewaska Regional Health System	$10,000
Hmong American Partnership 1075 Arcade Street St. Paul, MN 55106	Public Charity	Partnership with Minnnesota Department of Health to ensure culturally appropriate and timely coordination of health screening for new Hmong refugees	$50,000
Lakeland Mental Health Center, Inc. 1000 Western Avenue Fergus Falls, MN 56537	Public Charity	Improve leadership and management practices	$10,000
Minnesota International Health Volunteers 122 West Franklin Avenue, Suite 522 Minneapolis, MN 55404	Public Charity	Create and pilot a peer mentoring network for active Community Health Workers in Minnesota	$74,668
Minnesota State University, Mankato Healthcare Education - Industry Partnership 102 Wiecking Center Mankato, MN 56001	Public Charity	Community Health Workers project	$89,865
Minnewaska Regional Health System P.O. Box 234 Starbuck, MN 56381	Public Charity	Joint health service planning for Minnewaska Regional Health System and Glacial Ridge Health System	$10,000
Neighborhood Health Care Network 2610 University Avenue W, Suite 400 St. Paul, MN 55114-1904	Public Charity	Expand the Community Health Worker (CHW) Program	$125,000
New Americans Community Services 1821 University Avenue, Suite S-281 St. Paul, MN 55104	Public Charity	Partnership to provide a Community Health Outreach Program directed to African immigrants and refugees	$48,000
North Central Region Health Ministries Network 101 East Grant Street, Suite A Minneapolis, MN 55403	Public Charity	Development of a plan to identify and network parish nurses and local congregations	$10,000
Northern Pines Mental Health Center, Inc. 1906 SE 5th Avenue Little Falls, MN 56345	Public Charity	Board development activities	$9,500
Range Regional Health Services dba North Star Hospice 750 East 34th Street Hibbing, MN 55746	Public Charity	Expanding a hospice volunteer recruitment, retention and recognition program	$3,500
South Central Human Relations Owatonna, MN 55060	Public Charity	Design a mental health telecommunication system across the ten southeast county region	$10,000
Southside Community Health Services 4730 Chicago Avenue South Minneapolis, MN 55407	Public Charity	Establish a Teen Health Defense Squad	$5,000

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St. James Health Services 1207 6th Avenue South St. James, MN 56081	Public Charity	Improvement of health care services and outreach to the Hispanic community	$10,000
Wellspring Faith in Action Program P.O. Box 365 St. James, MN 56081	Public Charity	Expansion of organizational capacity for community outreach and coordination	$2,700
West Side Community Health Services 1544 Timberlake Road, Suite 235 St. Paul, MN 55117	Public Charity	Increase the capacity at La Clinicia En Lake to provide culturally competent health care services	$34,280
Total			$532,358

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PART XV, LINE 3a - Grants and contributions paid during the year:

Name and Address	Foundation Status of Recipient	Purpose of Grant or Contribution	Amount
Affiliated Community Health Foundation 101 Willmar Avenue Southwest Willmar, MN 56201	Public Charity	School-based wellness centers in Willmar middle and high schools	$ 67,722
American Cancer Society 3316 W. 66th Street Minneapolis, MN 55435	Public Charity	Support of ongoing programs	$ 200
American Lung Association of Minnesota State Headquarters 490 Concordia Avenue St. Paul, MN 55103-2441	Public Charity	Implement a statewide train-the trainer model of PACE (Physician Asthma Care Education Seminar), a research-tested educational approach to improve asthma treatment practices	$ 35,150
American Red Cross 176 South Robert Street St. Paul, MN 55107	Public Charity	Support of ongoing programs	$ 200
American Red Cross St. Paul Area 176 South Robert Street St. Paul, MN 55107	Public Charity	Emergency grant for mental health services related to 2001 flooding and other potential disasters	$ 35,000
Apple Tree Dental 8960 Springbrook Drive, Suite 150 Minneapolis, MN 55433	Public Charity	On-site dental care and education at Head Start centers in southwest Minnesota	$ 13,000
Arc Hennepin-Carver 4301 Highway 7 Suite 140 Minneapolis, MN 55416	Public Charity	Connecting families of color experiencing mental retardation to community-based services	$ 59,800
Be Active Minnesota 920 East 28th Street, Suite 160 Minneapolis, MN 55407	Public Charity	retrospecitve review and analysis - Phase II	$ 10,000
Bosnian Women's Network 4111 Central Avenue Northeast Suite 202C, PO Box 11 Columbia Heights, MN 55421	Public Charity	Improve access to health care for the Bosnian community	$ 10,000
Boy Scouts of America 1124 11-1/2 Street SE Rochester, MN 55904	Public Charity	Support of ongoing programs	$ 200
Boy Scouts of America 393 Marshall Avenue Saint Paul, MN 55102	Public Charity	Support of ongoing programs	$ 400
B-Team Beltrami Tobacco Education Awareness Movement 4320 Elliot Road North East Bemidji, MN 56601	Public Charity	Hiring school coordinators	$ 25,000

FORM 990-PF - RETURN OF PRIVATE FOUNDATION
BCBSM FOUNDATION, INC.
36-3525653
December 31, 2003

PART XV, LINE 3a - Grants and contributions paid during the year:

Name and Address	Foundation Status of Recipient	Purpose of Grant or Contribution	Amount
Bundles of Love 7975 166th St W Lakeville, MN 55044	Public Charity	Support of ongoing programs	$ 400
Burroughs Community School 1501 West 50th Street Minneapolis, MN 55419	Public Charity	Support of ongoing programs	$ 200
Camphor Foundation 585 Fuller Avenue St. Paul, MN 55103	Public Charity	February 22, 2003 Save the Infants conference	$ 2,300
CaringBridge 4607 Beacon Hill Court Eagan, MN 55122	Public Charity	Support of ongoing programs	$ 200
The Center for Cross-Cultural Health 1313 Fifth Street Southeast Suite 100B Minneapolis, MN 55414	Public Charity	Launch a sustainable collaborative partnership to improve healthcare cultural competence within a local community	$ 33,450
Center for Rural Policy and Development Minnesota State University, Mankato 120 Alumni Foundation Center Mankato, MN 56001	Public Charity	Refuge and immigrant conference 2003	$ 5,000
The Center for Victims of Torture 717 East River Road Minneapolis, MN 55455	Public Charity	Minnesota Mainstream Project	$ 50,000
CentraCare Health Foundation P.O. Box 2206 Saint Cloud, MN 56302	Public Charity	Project H.E.A.L. (Health, Education, Access, Link)	$ 65,000
Centro Campesino 104 1/2 Broadway Street West, Suite 206 Owatonna, MN 55060	Public Charity	Promotores de Salud (Health Promoters) Project	$ 25,000
The Chameleon Theatre Circle 8398 - 139th Court Apple Valley, MN 55124	Public Charity	Support of ongoing programs	$ 200
Charities Review Council 46 East Fourth Street St. Paul, MN 55101-1112	Public Charity	Support of ongoing programs	$ 3,000
Community Design Center of Minnesota 731 East 7th Street, Suite 100 St. Paul, MN 55106	Public Charity	Implement a new leadership development program for high school youth (14-18 yrs old) that incorporates physical activity, nutritional education, and community services	$ 20,000

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PART XV, LINE 3a - Grants and contributions paid during the year:

Name and Address	Foundation Status of Recipient	Purpose of Grant or Contribution	Amount
Community Fitness Today 310 East 38th Street, Suite 215 Minneapolis, MN 55409	Public Charity	African American Church HIV/AIDS Prevention Program	$ 30,000
Cottage Grove Athletic Association PO Box 2068 Cottage Grove, MN 55016	Public Charity	Support of ongoing programs	$ 200
DARTS 1645 Marthaler Lane West St. Paul, MN 55118	Public Charity	Support of ongoing programs	$ 400
East YMCA 1075 Arcade Street St. Paul, MN 55106	Public Charity	Development of a children weight program	$ 45,400
Grand Rapids Area Community Foundation 201 NW Fourth Street, Suite 111 Grand Rapids, MN 55744-2724	Public Charity	Baby Steps Boutique	$ 5,000
Grantmakers In Health 1100 Connecticut Avenue NW, Suite 1200 Washington, DC 20036	Public Charity	GIH funding partner	$ 2,650
Greater Twin Cities United Way 404 South Eighth Street Minneapolis, MN 55404-1084	Public Charity	Support of ongoing programs	$ 396,609
Harriet Bishop Elementary School 14000 O'Connell Road Savage, MN 55378	Public Charity	Support of ongoing programs	$ 200
HOPE Foundation 3214 North Victoria Street Shoreview, MN 55126	Public Charity	Support of ongoing programs	$ 200
Hospice Minnesota 1600 University Avenue West, Suite 301 St. Paul, MN 55104-3800	Public Charity	New Directions program	$ 10,000
Independent School District Office #196 14445 Diamond Path West Apple Valley, MN 55124	Public Charity	Support of ongoing programs	$ 200
International Health Service of MN P O Box 16149 St. Louis Park, MN 55416	Public Charity	Support of ongoing programs	$ 200
Kids 'n Kinship 14870 Granada Avenue #127 Apple Valley, MN 55124	Public Charity	Support of ongoing programs	$ 200

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PART XV, LINE 3a - Grants and contributions paid during the year:

Name and Address	Foundation Status of Recipient	Purpose of Grant or Contribution	Amount
Lao Assistance Center of Minnesota, Inc. 503 Irving Avenue North, Suite 100 Minneapolis, MN 55405	Public Charity	Preventive care outreach to the families of Laotian and Hmong children and adolescents living in North Minneapolis	$ 95,652
Lao Family Community of Minnesota, Inc. 320 West University Avenue St. Paul, MN 55103-2015	Public Charity	To support further research on Hmong adolescent pregnancy in both Ramsey and Hennepin counties and to disseminate findings	$ 52,000
MELD 219 North Second Street Minneapolis, MN 55401	Public Charity	Peer-based parent education designed to improve health-related outcomes for children in Twin Cities communities of color	$ 60,000
Mesabi Family YMCA 8367 Unity Drive Virginia, MN 55792	Public Charity	Support of ongoing programs	$ 200
Minneapolis Medical Research Foundation Office of Grants and Contracts 914 South 8th Street 600 HFA Building Minneapolis, MN 55404-1249	Public Charity	Integration of preventive dental health services into the well child care visit with the use of Spanish-speaking dental health educators	$ 22,410
Minnesota Council on Foundations 15 South Fifth Street Suite 600 Minneapolis, MN 55402-1013	Public Charity	Support of ongoing programs	$ 5,000
Minnesota Department of Health P.O. Box 64882 St. Paul, MN 55164-0882	Public Charity	Dr. Nathan Stinson's presentation to the community	$ 2,000
Minnesota Friends of the Orphans 70 County Rd CW, Suite 701 St. Paul, MN 55117	Public Charity	Support of ongoing programs	$ 200
Minnesota International Health Volunteers 122 West Franklin Avenue Suite 210 Minneapolis, MN 55404	Public Charity	Somali Health Care Project initiative	$ 76,289
Minnesota Public Health Association P.O. Box 14709 Minneapolis, MN 55414	Public Charity	MPHA annual conference	$ 1,000
Minnesota State University, Mankato Healthcare Education - Industry Partnership 102 Wiecking Center Mankato, MN 56001	Public Charity	Community Health Workers project	$ 109,909

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PART XV, LINE 3a - Grants and contributions paid during the year:

Name and Address	Foundation Status of Recipient	Purpose of Grant or Contribution	Amount
Minnesota State University, Mankato Healthcare Education - Industry Partnership 102 Wiecking Center Mankato, MN 56001	Public Charity	Evaluation and consultation on San Francisco State University's (SFSU) CHW certificate program	$ 5,000
Muslim American Society 4100 East 66th Street Inver Grove Heights, MN 55076	Public Charity	Support of ongoing programs	$ 200
Neighbors, Inc. P O Box 269 218 13th Avenue S South St. Paul, MN 55075	Public Charity	Support of ongoing programs	$ 200
North East Soccer Association P O Box 9400 North St. Paul,, MN 55109	Public Charity	Support of ongoing programs	$ 400
Open Door Health Center 309 Holly Lane Mankato, MN 56001	Public Charity	Health promotion, wellness and primary care services to rural immigrant and refugee children and adolescents in South Central Minnesota	$ 89,000
Park Nicollet Institute 3800 Park Nicollet Boulevard 7 North Minneapolis, MN 55416	Public Charity	residential eating disorders treatment center	$ 139,417
Peta Wakan Tipi 459 North Wheeler Street St. Paul, MN 55104	Public Charity	Dream of Wild health	$ 25,000
Rainbow Animal Rescue, Inc. P O Box 433 Prior Lake, MN 55372	Public Charity	Support of ongoing programs	$ 200
Reading RX P O Box 270541 St. Paul, MN 55127	Public Charity	Support of ongoing programs	$ 200
Red Lake Comprehensive Health Services P.O. Box 249 Red Lake, MN 56671	Public Charity	Preventive dental services to Headstart and elementary school-age children on the Red Lake Nation	$ 60,000
The Saint Paul Covenant 1280 Arcade Street St. Paul, MN 55106	Public Charity	Develop a culturally diverse community based faculty nursing practice in St. Paul's Payne/Phalen planning district	$ 25,000
Scott, Carver, Dakota CAP Agency 14551 County Road 11, Suite 100 Burnsville, MN 55337	Public Charity	Support of ongoing programs	$ 200
Somali Community Resettlement Services, Inc. 1421 Third Avenue Southeast, Suite 205 Rochester, MN 55904	Public Charity	Continued education program	$ 83,000

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PART XV, LINE 3a - Grants and contributions paid during the year:

Name and Address	Foundation Status of Recipient	Purpose of Grant or Contribution	Amount
Somali Health Project 416 East Hennepin Avenue, Suite 109 Minneapolis, MN 55414	Public Charity	Tuberculosis and HIV/AIDS education for the Somali Community	$ 15,000
Southeastern Minnesota Initiative Fund P O Box 188 Wanamingo, MN 55983	Public Charity	Support of ongoing programs	$ 200
University of Minnesota School of Nursing 6-101 Weaver-Densford Hall 308 Harvard Street South East Minneapolis, MN 55455-0342	Public Charity	Improving health care environments for multicultural communities	$ 97,173
White Bear Lake Area Historical Society P O Box 10543 White Bear Lake, MN 55110	Public Charity	Support of ongoing programs	$ 200
Women's Cancer Resource Center 4604 Chicago Avenue South Minneapolis, MN 55407	Public Charity	Continued development of the Woman to Woman project which provides education and support to African American, Hispanic, and Laotian women with breast cancer throughout the Twin Cities	$ 25,000
YWCA Minneapolis 1130 Nicollet Mall Minneapolis, MN 55403	Public Charity	Women's Wellness Program for low-income women in North Minneapolis	$ 20,873
	Total		$ 1,963,604

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PART XV, LINE 3b - Grants and contributions approved for future payment:

Name and Address	Foundation Status of Recipient	Purpose of Grant or Contribution	Amount	Year Approved
Aitkin Community Hospital, Inc. dba Riverwood Health Care Center 200 Bunker Hill Drive Aitkin, MN 56431	Public Charity	Conduct market analysis to help define the future vision for Riverwood Healthcare Center	$ 10,000	2003
Cass Lake Indian Hospital and Clinic 217 Seventh Street Northwest Cass Lake, MN 56633	Public Charity	Partnership with Bemidji State University to improve the hospital's operational effectiveness	$ 10,000	2003
The Center for Cross-Cultural Health 1313 Fifth Street Southeast Suite 100B Minneapolis, MN 55414	Public Charity	Launch a sustainable collaborative partnership to improve healthcare cultural competence within a local community	$ 27,550	2002
CentraCare Health System PO Box 548 110 Sixth Avenue South St. Cloud, MN 56302-0548	Public Charity	Strategic planning process for Long Prairie Memorial Hospital including employment and health services for the growing Hispanic community	$ 10,000	2003
haritiable Funds Transfer, Inc. 701 N. Fairfax Street, Suite 300 Alexandria, VA 22314	Public Charity	United Way programming	$ 21,409	2003
Chicanos Latinos Unidos En Servicios (CLUES) 220 South Robert Street, Suite 103 St. Paul, MN 55107	Public Charity	Pilot Project for Insured Latinos	$ 39,950	2003
Cokato Ambulance Service P.O. Box 1030 Cokato, MN 55321	Public Charity	Recruitment of additional EMTs and training of personnel	$ 8,000	2003
Community Action Council 20730 Holyoke Avenue P.O. Box 1256 Lakeville, MN 55044-1256	Public Charity	Partners for the Promotion of Preventive Health Care for Under-Served Populations	$ 51,000	2003
Cook Area Health Services 20 Fifth Street Southeast Cook, MN 55723	Public Charity	Expansion of the diabetes collaborative chronic care model to all CAHS clinic sites	$ 10,000	2003
Deaf Minnesotans Charitable Fund 2055 Rice Street St. Paul, MN 55113	Public Charity	Increase access to information for deaf people and increase cultural competency for practitioners in the field of end-of-life care	$ 5,000	2003
Grant County Health Center 930 First Street Northeast Elbow Lake, MN 56531	Public Charity	Recruitment and training of high school students to become EMTs	$ 10,000	2003

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Name and Address	Foundation Status of Recipient	Purpose of Grant or Contribution	Amount	Year Approved
Hayfield Community Ambulance Service 10 1st Street Northwest Box 471 Hayfield, MN 55940	Public Charity	Volunteer recruitment and training and office systems improvements	$ 9,000	2003
Hospice Minnesota 1600 University Avenue West, Suite 301 St. Paul, MN 55104-3800	Public Charity	New Directions program	$10,000	2001
Immanuel - St. Joseph's/Mayo Health System P.O. Box 8673 Mankato, MN 56001	Public Charity	Development of a hospital-based palliative care program	$ 10,000	2003
Migrant Health Service, Inc. 810 4th Avenue South, Suite 120 Moorhead, MN 56560	Public Charity	Strategic planning by the staff and Board of Directors	$ 10,000	2003
Mille Lacs Health System 100 North Elm Street P.O. Box A Onamia, MN 56359-0800	Public Charity	To support market research and analysis for strategic planning	$ 10,000	2003
Minneapolis Urban League 2100 Plymouth Avenue North Minneapolis, MN 55411	Public Charity	Expansion of the Mental Health Advocacy Program	$ 25,000	2003
Minnesota Medical Foundation University of Minnesota Gateway 200 Oak Street SE, Suite 300 Minneapolis, MN 55455	Public Charity	Somali Diabetes and Depression Project	$ 23,481	2003
Minnesota State University, Mankato Healthcare Education - Industry Partnership 102 Wiecking Center Mankato, MN 56001	Public Charity	Community Health Workers project	$ 89,865	2003
Neighborhood Health Care Network 2610 University Avenue W, Suite 400 St. Paul, MN 55114-1904	Public Charity	Expand the Community Health Worker (CHW) Program	$ 250,000	2003
Neighborhood House 179 Robie Street East St. Paul, MN 55107	Public Charity	Phase 2 of Plain Talk in St. Paul and replication of the Comadres Program in Rice County	$ 25,000	2003
Pine Medical Center 109 Court Avenue South Sandstone, MN 55072	Public Charity	Support of community-based strategic planning and related feasibility analysis	$ 10,000	2003

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Name and Address	Foundation Status of Recipient	Purpose of Grant or Contribution	Amount	Year Approved
Portico Healthnet 2610 University Avenue, #550 St. Paul, MN 55114-2007	Public Charity	Expand program into new markets	$ 115,000	2003
Rice Health Foundation 301 Becker Avenue SW Willmar, MN 56201	Public Charity	Development of a music therapy program at Rice Hospice	$ 5,000	2003
Roseau Area Hospital and Homes, Inc. 715 Delmore Drive Roseau, MN 56751	Public Charity	Expanding the Health Occupations curriculum at the area high school, developing grief support groups and creating a health library for the community	$ 10,000	2003
Rushford Community Ambulance Service P.O. Box 603 Rushford, MN 55971	Public Charity	Training activities to enhance the community's emergency care system	$ 9,000	2003
Saint Elizabeth's Medical Center 200 Grant Boulevard West Wabasha, MN 55981	Public Charity	Expanding the Commitment to Leadership Excellence initiative	$ 9,650	2003
Southeastern Minnesota Emergency Medical Services 1903 South Broadway Rochester, MN 55904	Public Charity	Regional consortium to train members on the use of Automatic External Defibrillators	$ 9,350	2003
Springfield Medical Center - Mayo Health System 625 North Jackson Street Springfield, MN 56001	Public Charity	Implementation of the Emergency Skills Instructor Training Project	$ 10,000	2003
St. Francis Medical Center 415 Oak Street Breckenridge, MN 56520	Public Charity	Leadership development training for the hospital's middle management team	$ 10,000	2003
St. Mary's Duluth Clinic Health System 407 East Third Street Duluth, MN 55805	Public Charity	Establishing a hospital-based palliative care program	$ 10,000	2003
The Saint Paul Covenant 1280 Arcade Street St. Paul, MN 55106	Public Charity	Develop a culturally diverse community based faculty nursing practice in St. Paul's Payne/Phalen planning district	$ 25,000	2003
United Way of Northeastern Minnesota P.O. Box 66 Chisholm, MN 55719-0066	Public Charity	Support of ongoing programs	$ 5,668	2003

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Name and Address	Foundation Status of Recipient	Purpose of Grant or Contribution	Amount	Year Approved
Vietnamese Social Services of Minnesota Vietnam Center 1159 University Avenue, Suite 100 St. Paul, MN 55104	Public Charity	Vietnamese Open Door to Health Care Project	$ 25,000	2003
Western Mental Health Center, Inc. 1212 East College Drive Marshall, MN 56258	Public Charity	Community needs assessment and survey for a proposed telehealth network project	$ 10,000	2003
YouthLink 41 North 12th Street Minneapolis, MN 55403	Public Charity	Health and wellness clinic	$ 5,000	2003
Zumbro Valley Mental Health Center 315 Elton Hills Drive Northwest Rochester, MN 55901	Public Charity	Improving management and leadership practices to increase organizational capacity	$ 10,000	2003
	Total		$ 943,923	

Paper: Saint Paul Pioneer Press
Title: VOLUNTEER TIME IS EARNING PAY
Date: February 22, 2004

Shelley Motzko gets paid by her employer to volunteer for her charity of choice during the workday.

It is part of a formal volunteer release policy that **Blue Cross Blue Shield** of Minnesota adopted last year to pay employees for up to 20 volunteer hours per year. The company also matches up to $200 to the employees' charities if they volunteer 40 hours within a year.

Many companies have an informal understanding that if workers want to volunteer for a company-sponsored charity, they may do so on company time with their manager's approval.

A small but growing trend is for companies to set up formal policies, giving employees a set amount of paid time off each year and establishing criteria for volunteering, said Nancy Thorman Dahl of the Corporate Volunteerism Council-Twin Cities.

Last year, Motzko, a financial underwriter, signed up for paid time off, then went through three days of training to be a health counselor for the Metropolitan Area Agency on Aging. This year, she advises seniors on Medicare assistance.

Thrivent Financial's shared release time policy matches up to 20 hours per year for employees who volunteer for charities supported by the Minneapolis-based company. Ceridian Corp. offers one paid day off per year to employees who contribute money to United Way during the annual campaign or who volunteer for a charity of their choice.

Wells Fargo gives employees one day of paid time off for company-sponsored initiatives. The bank also offers employees a formal paid leave for up to four months while they volunteer for a nonprofit.

In its first year, employees at **Blue Cross Blue Shield** used 7,000 hours in volunteer time, said Tom Lee, program manager of the Heart of Blue program.

"The real value of offering volunteer release time is that it recognizes two things," Lee said. "Many people want to volunteer but with their hectic schedules it is sometimes hard to do, and second, volunteer needs are not always limited to weekends and nights when an employee isn't working."

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Author: Julie Forster, Pioneer Press
Section: BUSINESS
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Renowned Doctor to Lead New Business Intelligence/Health Data Effort for Blue Cross

Plocher will lead growing field of account reporting and health management data

(EAGAN, Minn. Feb. 28, 2005) — Blue Cross and Blue Shield of Minnesota announced today that it has hired David Plocher, M.D to lead a newly created division of business intelligence and informatics for the state's largest health plan. As a senior vice president, Dr. Plocher will report directly to Blue Cross' president and CEO. His responsibilities include the acquisition, analysis, and communication of member, clinical and business information.

"His area will develop new tools for collecting and analyzing aggregate health information. For example, he will be able to use an employer's data to better counsel them on their specific group's coverage and health programs," said Dr. Mark Banks, president and CEO of Blue Cross.

Dr. Plocher is nationally known for his work developing the first nationwide Centers of Excellence network for solid organ and allogeneic bone marrow transplants, as well as his work building the infrastructure for the national smallpox vaccination program, at the request of the Centers for Disease Control. He is a recognized expert in "data analytics" in the health care industry.

Dr. Plocher has a 25-year career in medicine, teaching, consulting, and corporate leadership, most recently with DeLoitte Consulting LLP, as the national practice leader for health plan medical management and related applications for provider networks. He has more than 20 years of experience working with payers and providers in strategy, operations, and process improvements. During that time, he's also served as editor for several disease management journals and medical management books.

Dr. Plocher graduated from the University of Minnesota with honors and practiced internal medicine and non-invasive cardiology in affiliation with United Hospitals. He previously taught medicine at the University of Minnesota as well.

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2004 Financial Statement Audit Plan

The 2004 financial statement audit plan was not approved due to the external auditors, Ernst & Young, asking for a significant increase in fees in 2005. The auditors were asked to come back with more justification for the requested increase.

Charter Review

The role of the Audit Committee has increased in recent years, due to Sarbanes-Oxley and other factors leading to increased board oversight of corporate operations. At the same time, while the Business Development Committee helps validate and advance strategic initiatives, this committee is probably underutilized. Moreover, there is a significant degree of overlap in accountabilities, since most Business Development Committee action items also require the approval of the Audit Committee. By restructuring the two committees, workloads can be spread more evenly and unnecessary redundancies eliminated.

Under the proposal, the Audit Committee will transfer its authority over general financial matters, such as approval of significant transactions and/or debt issuance, to the renamed Finance and Business Development Committee. The Audit Committee will thus be able to focus on external audit, internal audit and compliance matters. Two matters, approval of the annual corporate plan and review of periodic financial statements, will remain a joint accountability, as it is a foundational document for the work of both committees.

Management recommended placing the Audit Committee chair on the Finance and Business Development Committee and vice versa to assure appropriate coordination between the two committees. Under this arrangement separate Aware Integrated, Inc. and BCBSM Finance and Business Development Committees would need to be established, subject to board approval. The Audit and Business Development Committees approved of these changes.

Business Development Committee:

John Kleinman, M.D., Chair, provided a report on the Business Development Committee meeting of October 5, 2004.

ClearConnect

Staff provided a review of a strategy to develop a Minnesota Local Healthcare Information Infrastructure and to leverage BCBSM's knowledge of transaction clearing and its infrastructure to jump-start a community cooperative. This initiative could improve the quality and safety of patient care and make the delivery of care more efficient and, therefore, less costly. Staff will be meeting with community healthcare leaders to ascertain community commitment.

News and events

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12/21/2004

Board of Pensions named Blue Cross Champion of Health
Blue Cross Blue Shield of Minnesota

EAGAN, Minn. (December 14, 2004) — The Evangelical Lutheran Church in America (ELCA) Board of Pensions was recently named a winner of the 2004 Champions of Health award, sponsored by Blue Cross and Blue Shield of Minnesota (Blue Cross). Blue Cross gave this award to the ELCA Board of Pensions for promoting health and wellness within its own organization and to its members under the initiative "Healthy Leaders Enhance Lives."

The ELCA Board of Pensions was recognized on Tuesday, December 7 by the Champions of Health Prize Patrol for creating a health and wellness culture at its workplace. In addition, Blue Cross donated $500 in the ELCA Board of Pensions' name to the health-related charity of its choice, St. Mary's Health Clinics.

Under the ELCA Board of Pensions' initiative, the goal was to improve the health of their members not only from a physical standpoint, but from a mental aspect as well. The ELCA Board of Pensions' Health and Wellness Team has organized a variety of healthy activities and promotions and the ELCA Board of Pensions has gone above and beyond in their efforts to promote health and wellness. The ELCA Board of Pensions takes the necessary action to make a healthy difference and remains inviting to all employees and members.

"For us to ask our members to become healthy leaders who enhance lives, we needed to model health and wellness ourselves," said John G. Kapanke, President of the ELCA Board of Pensions. "We appreciate receiving the Blue Cross Champions of Health award because it recognizes that organizations need to walk the talk when promoting health."

Champions of Health is sponsored by Blue Cross to celebrate unsung heroes who raise awareness, educate and motivate people about the importance of working together for the health of the community. Serving as a role model for healthy behavior, raising funds for a health-related cause or any affirmative action to encourage a healthy community are a few characteristics representing a Blue Cross Champion of Health. A panel of health experts and community leaders from throughout Minnesota chose the ELCA Board of Pensions and other champions this year.

"Organizations such as the ELCA Board of Pensions change lives by making their communities a healthier place to live. Blue Cross is proud to highlight these efforts and encourages others to get involved," said Mark Banks, M.D., President and CEO of Blue Cross.

In its fifth year, Champions of Health is part of a series of initiatives

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by Blue Cross to help build healthier communities, improve access to health care, bring together communities to find solutions to health care problems, and share knowledge with nonprofit organizations, providers, schools, government agencies, businesses and others to benefit individual and community health. For more information, visit www.bluecrossmn.com.

Blue Cross and Blue Shield of Minnesota, with headquarters in the St. Paul suburb of Eagan, was chartered in 1933 as Minnesota's first health plan and continues to carry out its charter mission today: to promote a wider, more economical and timely availability of health services for the people of Minnesota. A not-for-profit, taxable organization, Blue Cross is the largest health plan based in Minnesota, covering 2.6 million members in Minnesota and nationally through its health plans or plans administered by its affiliated companies. Blue Cross and Blue Shield of Minnesota is an independent licensee of the Blue Cross and Blue Shield Association, headquartered in Chicago.

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MCF NEWS ARCHIVES

10/14/03

Blue Cross Honors 29 Minnesotans as Champions of Health

Twenty-nine unsung health heroes from throughout Minnesota were honored on October 11 as recipients of the 2003 Champions of Health (sm) award, sponsored by Blue Cross and Blue Shield of Minnesota. Award recipients received $500 each to designate to the community health initiative of their choice.

Now in its fourth year, the Champions of Health awards celebrate individuals or organizations that raise awareness or educate the community about a health issue, pursue a cause to help people stay healthy, serve as a role model for healthy behavior, help raise funds for a health-related cause, host a work site program that improves the health of employees, or otherwise motivate people to work together for the health of their community. A panel of health experts and community leaders from throughout Minnesota chose this year's champions, who were nominated by their own community members.

"These health heroes change lives by making their communities healthier places to live. Blue Cross is proud to highlight their efforts and encourage others to get involved," said Blue Cross CEO Mark Banks.

The 2003 Champions of Health award recipients are:

Alexandria:

- Keith Dougherty, volunteers as a peer counselor, caregiver and respite volunteer for Elder Network.
- Rochelle Peyton, advocates for clients of Listening Ear Crisis Center.

Birchwood:

- Helen M. Fleck, helped develop a support system that blends medicine with technology to break down barriers for people with disabilities.

Cottage Grove:

- Alex Chernyaev, helps remove language barriers for Russian speakers and produced health-related pamphlets in Russian.

Duluth:

Arc Northland, serves children with mental health problems and their families with respite care, advocacy and support groups.

Eagan:

- Gretchen Moen, improves the quality of life for people with asthma, by volunteering at a summer camp and serving on a statewide coalition.
- Donna Wills, for her policy work and other activities to improve the lives of those affected by mental illness.

Kelliher:

- Leona and Neil Hand, for their work to bring a health clinic to the small rural community of Kelliher.

Lakeville:

- Jodi Townsend, offers therapeutic horse riding to provide children with disabilities improved mental and physical health.

Luverne:

- Paula Anderson, organized 2003 Shape-Up Challenge, a six-week wellness competition involving 33 teams and 227 people.

Mankato:

- Open Door Health Center, helps nearly 5,000 under-served people with a broad range of health care needs, including preventive and wellness services.

neapolis:

- Osman Ahmed, for health improvement and education activities among Somali immigrants, including diabetes and hepatitis screenings and AIDS and TB awareness.
- Bryan Bass, worked to remove soda vending machines from high school and to increase healthy food choices for students.
- Ellen Johnson, volunteers for Alzheimer's Association on the speaker's bureau, advisory board, support groups and more.
- Laurie Kramer, launched the Mental Health Education Project to raise awareness of mental health issues in the Jewish community.
- Eric Meininger, M.D., provides health outreach to homeless and high-risk youth and to minority communities.

Minnetonka:

- Nancy Fursetzer, helps meet practical and spiritual needs of Jewish patients in hospitals and in hospice.

Mountain Iron:

- Susan Tuomela, helped form support network for parents of children with cancer; serves as bereavement counselor and more.

Wing:

- Dorothy Holmes, formed a local mental health support group, helped start National Alliance

for Mentally Ill, and continues to be active.

Redwood Falls:

- Vera Doidge, developed innovative health and wellness programs and services in her community, such as Diabetes Center, Cancer Care Center and Adult Day Care.

Richfield:

- Jerry Wilson, provides marathon training classes, helping nearly 200 runners complete their first marathons.

Roseville:

- Joe and JoAnn Zwack, for more than 20 years, have helped obtain treatment for mentally ill in prison, and supported affected families.

St. Paul:

- Pete Feigel, shares his inspirational messages based on his personal health challenges in speeches throughout the state.
- Ramsey Tobacco Coalition, working to reduce youth tobacco use through education and advocacy for more tobacco-free areas.
- Miguel Rivera, works to increase rate of insured Twin Cities residents, especially among communities of color.
- Mary S. Heiserman, for her efforts to improve the quality of children's mental health care, including policy changes and programs for communities of color.

Walker:

- Jayne Hanson, volunteers for sexual assault program, increasing awareness, giving speeches, staffing crisis line, supporting victims.

Wells:

- Lisa Mershon, with Cathy Van Hove of Kiester, started the Diabetes Sharing Group, a unique support group that attracts participants from 50 miles away.

Vadnais Heights:

- Laura Dobozenski, volunteers for Arthritis Foundation, speaking, advocating at the Legislature, and co-chairing a major conference.

top

2.0 Variable Definitions - By Section

How Accumulated: Monthly Survey Sample whereby BCBSM sends out roughly 10,000 surveys per month.

TRADE SECRET

Data comes from(source): The results of those surveys returned are tabulated on the mainframe and downloaded to
perations and
les Data Mgmt.

Survey Sample Size: Each month we send out around 9000-9300 surveys based on members having an encounter via inquiry or
claim submittal. Of those approximately 20-25% are returned, and it is these upon which our calculations are based.

Survey Population Size: Surveys are sent to customers asking them to rank their opinions on a basis of 1(low) to 5(high). The
questions they are asked pertain to five areas: CSR Courtesy and Professionalism, Claims Timeliness, Inquiry Timeliness, Contract Benefits, and Satisfaction With Overall Service. Very satisfied is a ranking of 5.

Survey Response Rate: 20-25%

Inclusions/Exclusions:
Most areas of the company are surveyed. Perception by users of provider service, i.e. providers, will begin in Q2 2002.

Careers
Community inv
Company facts
From our CEO
Newsroom
News release
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Fact sheets &
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Story ideas
Public policy is
Values

Obesity Reaches Epidemic Levels in Minnesota

New Blue Cross report reveals increasing numbers, rising costs and growing concern

(EAGAN, Minn., Dec. 8, 2004) — Minnesotans say they are an average of 18 pounds heavier than they want to be and are concerned about the health complications, according to results of a report and survey findings released today by Blue Cross and Blue Shield of Minnesota. Most (82 percent) believe obesity is encouraged by a cultural norm that food is used as a reward. Yet, 30 percent of those surveyed think that anxiety over terrorist attacks has caused people to eat more.

Overweight Minnesotans — especially women — are turning to surgical solutions in record numbers, with the number of bariatric surgeries skyrocketing nearly 149 percent during the past few years, costing an average of $17,000 each with varying rates of complications.

"Obesity is quickly becoming one of the most significant health threats for Minnesotans, because in addition to its own problems, it causes or worsens many other health problems such as arthritis, cancers, diabetes, heart disease, and many others — medical researchers find more all the time," said Dr. Mark W. Banks, president and CEO of Blue Cross.

This report marks the first extensive look at the incidence, consequences and public attitudes around obesity. The findings detail Minnesota's experience of what the national health experts and policymakers describe as an epidemic of obesity.

Key Report Findings

Growing consequences of obesity

Minnesotans say they are an average of 18 pounds heavier than they want to be. At the same time, their concerns about the health problems from being overweight are high. Seven of 10 say overeating is dangerous to your health and 97 percent say obesity can lead to premature death.

Seventy-one percent believe obesity is a disease; 56 percent think it is an addiction.

Those surveyed were able to identify serious health complications from obesity, with 75 percent identifying either heart disease or diabetes.

Eighty-eight percent observe that obese people are subjected to ridicule and discrimination.

Stress/health choices involved

Stress and lifestyle choices are major causes of obesity, according to those surveyed. Stress over family demands, stress at work and eating out were also identified by a high number of Minnesotans — science-based reasons such as lack of physical activity and poor diet were cited by fewer people.

Minnesotans do not think of themselves as obese. Those surveyed believed persons must be an average of 53 pounds overweight to be accurately defined as obese.

Three in four say they have not discussed their weight with their doctor.

Physical activity is best treatment

Minnesotans believe that exercise is the most effective treatment for obesity: 46 percent of Minnesotans cited exercise, 27 percent named diet, while 21 percent named psychological counseling.

Almost half — 45 percent of those surveyed — believe surgery is appropriate for those who are obese.

Bariatric surgery skyrocketing

Between 2001 and 2004 (through April), the incidence of obesity surgery among Minnesotans treated under Blue Cross and Blue Shield of Minnesota private plans has increased 149 percent, to 118 members per 100,000. Women account for 85 percent of the surgeries.

The cost for bariatric surgery averaged $17,000 per person in 2003 for Blue Cross and Blue Shield of Minnesota members (in Minnesota except Medicare), defined by an average facility cost of $14,000 and an average professional cost of $3,000.

From 2001 through 2003, over 2,800 bariatric procedures were performed on Blue Cross and Blue Shield of Minnesota members (in Minnesota except Medicare), at a cost of $42.9 million.

Nationally, about 20 percent of patients do not lose their desired amount of weight from the surgery.

The complete report with survey and claims results is available online at http://www.bluecrossmn.com/public/news/index.html

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Saint Paul Pioneer Press (Minnesota)

November 28, 2004 Sunday

SECTION: BUSINESS; BRIEF; Pg. 4D

LENGTH: 1143 words

HEADLINE: DAVE BEAL

BODY:

Blues Back Higher Cigarette Taxes

Insurers press for $1-a-pack increase, saying proceeds could cut other health-related taxes.

Minnesota's excise tax on cigarettes now ranks below similar levies in 36 other states, a circumstance almost beyond belief.

Just 13 years ago, the state had the highest cigarette tax in the land. Minnesota has been fertile ground for a litany of anti-smoking firsts.

Blue Cross and Blue Shield of Minnesotathinks it's time for a change.

The Eagan-based health insurer is launching a major drive to get legislators and Minnesota **Gov. Tim Pawlenty** to approve a $1-a-pack increase in the tax.

It won't be easy, despite the compelling public health and revenue-generating arguments for such an increase.

If this move succeeds, the state's cigarette tax will triple to $1.48 a pack from 48 cents and vault the state's ranking to ninth place.

Plenty of efforts to boost this tax have fizzled since it was last increased, in 1992, but that's history now. **Phil Stalboerger,**Blue Cross director of legislative affairs, says a shifting public mood has led his associates to assign top priority to the proposal.

The organization will publicly launch its drive in mid-December. Already, it has touted its plan in letters to chambers of commerce. It is reaching out for support from many health care organizations and mapping an ambitious lobbying effort.

"We have never undertaken this kind of effort on the cigarette tax," says Stalboerger.

That commitment counts for a lot.

Blue Cross is the largest health insurer in the state. It stepped forward a decade ago to help the state take on Big Tobacco in gutsy litigation that ended with a landmark triumph. The tobacco industry agreed to a record $6.6 billion settlement in 1998.

Jeanne Weigum, president of the **Association for Non-Smokers Minnesota**, says that Blue Cross provides the quality analysis and the shoe leather needed to build a strong, flexible alliance.

Based on a **Minnesota Revenue Department** analysis, the insurer estimates that a $1 boost in the tax would generate at least $260 million a year for the state. That's after adjusting for the certainty that higher prices for cigarettes would reduce demand for them.

Blue Cross suggests applying the proceeds to do away with three existing levies, thereby slashing premium costs falling directly on small businesses by an average of 3 to 4 percent.

3 LEVIES TARGETED

About $100 million would replace the assessment that finances the Minnesota Comprehensive Health Association's assigned risk pool.

Another $100 million would replace the insurance indemnity tax, which is levied on buyers of health care insurance.

And $60 million would replace a premium tax levied directly on small businesses or individuals.

Stalboerger says the plan meets the rising clamor from thousands of the states' small businesses for relief from soaring health care costs. The **Minnesota Chamber of Commerce** and a mounting stack of surveys say these costs are the top concern of Minnesota's small businesses.

Directly or indirectly, the new revenues from a higher tax could ease the state's tight budget squeeze.

The $1 increase was recommended early this year by a Pawlenty-appointed citizens forum led by former **U.S. Sen. David Durenberger**.

Blue Cross also points to a survey it commissioned last spring from Decision Resources. The survey found that two of every three Minnesotans back a $1 boost in the cigarette tax and seven of eight think that tobacco-related illnesses are an important factor affecting health care costs.

Fresh signs of anti-smoking sentiment have come from the governments of Minneapolis, Bloomington, Golden Valley, and Hennepin and Ramsey counties. All recently approved tough new measures to curb smoking in restaurants and bars.

WHY NOW?

Yet many of these feelings have existed for years in Minnesota. What has changed to drive down the state's cigarette tax ranking so dramatically?

Most of all, many other states faced with serious budget pinches see tobacco tax boosts as an easy route to more revenue.

Just since 2002, 36 states raised this tax, according to the **Minnesota Smoke-Free Coalition**.Fourteen of them moved ahead of Minnesota in the rankings. Republican and Democratic governors in these states have concluded that a notably higher cigarette tax is "prudent heath and fiscal policy," says the coalition.

Many say the Pawlenty administration's firm opposition to tax increases is another reason the tobacco tax hasn't changed here.

Asked whether Pawlenty could support the Blue Cross plan, Minnesota Revenue Commissioner **Dan Salomone**said it "would depend on the specifics of the proposal." The governor has always said such tax packages must be "revenue neutral," meaning tax increases have to be offset by tax decreases.

LEGISLATORS AT ODDS

Previous proposals to increase the tax have run aground after serious disputes among legislators about how to use the proceeds.

State **Rep. Fran Bradley**, the Rochester Republican who heads a key House panel that has dealt with the issue, backed a 29-cent-a-pack increase this year. That would have brought the Minnesota tax up to Wisconsin's level. In the past, he has supported increases of as much as $1.

Bradley says past cigarette tax increases haven't gone anywhere because of serious differences with the DFL-controlled Senate over how the proceeds would be used.

Sen. Linda Berglin, DFL-Minneapolis, head of a Senate panel handling such legislation, says the state should consider using the proceeds from an increase to prevent health care service cuts. Recent proposals to increase the tax failed because the governor didn't support them, she adds.

And of course, tobacco lobbyists oppose increasing the tax. "They're very good at what they do," says Weigum.

The **Minnesota Medical Association**has softened its position backing a cigarette tax only if the proceeds go toward eliminating the provider tax for **MinnesotaCare**, the insurance program for low-income Minnesotans. That improves the chances for the Blue Cross proposal.

But state chamber officials have reservations about the plan, despite the relief it offers small businesses.

Some of the business group's concerns come to the economics of the tax increase. It would be regressive because lower-income people smoke more. It would raise Minnesota's cigarette tax well above those in many neighboring states, a situation that could invite incursions by the tax-evading cigarette bootleggers who have made inroads in the Northeast.

Blue Cross, which knows how to scale the mountainous challenges of tobacco land, has embarked on another big climb.

Dave Beal can be reached at dbeal@pioneerpress.com

LOAD-DATE: November 28, 2004

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REGION

FRIDAY, JANUARY 13, 1995 Section B

Health alliance

Dakota Clinic, Minnesota Blues forming health network

By Patrick Springer
The Forum

Executives of Dakota Clinic and Blue Cross Blue Shield of Minnesota Thursday announced the formation of a health network that will serve an estimated 40,000 subscribers in northwest Minnesota.

The move to create a community integrated service network – which combines health services and insurance in one organization – is the latest in a continuing association between the clinic and insurer.

The joint venture, Dakota Health Care Network Inc., is a 50-50 partnership backed by $6 million in capital, said Michael J. Morrow, chief operating officer and senior vice president of Blue Plus, a health maintenance organization, or HMO, run by the Minnesota Blues.

"We have a vision of improving quality and reducing costs," said Dr. Russel Kuzel, a Dakota Clinic physician and chairman of the joint venture's board.

The network, which still does not have a marketing name, will begin operation in mid-1995, in time for the fall enrollment season. The clinic and insurance company signed a 20-year contract.

Community integrated service networks are health alliances approved by the 1994 Minnesota Legislature as part of MinnesotaCare health reforms. The networks are intended as a means of enabling health providers and insurers to work together to improve efficiency and reduce costs.

The community networks will be guided by citizen advisory committees. "It truly is community driven," Kuzel said.

"This partnership will allow us to create an integrated health care delivery system in northwestern Minnesota that will meet the needs of area residents," said Andy Czajkowski, president and chief executive of the Minnesota Blues.

The partnership will not change Dakota Clinic's working relationship with Dakota Hospital, which recently merged with Heartland Medical Center, clinic representatives said.

Dakota Clinic, based in Fargo, has almost 160 physicians in 18 locations in North Dakota and northwestern Minnesota. Minnesota locations are in Moorhead, Lake Park, Frazee, Detroit Lakes, Park Rapids, Thief River Falls, Walker, Menagha and Fosston.

Blue Cross Blue Shield of Minnesota, based in St. Paul, covers more than 1.3 million members through its own health plans or programs administered by the company.

bodies near downed plane

), it wouldn't be by .wig said.
vas University of North ition student Trevor of Winnipeg, and pas- rd Cadieux, 18, a phys- major at UND, also of oth were ejected from Mathwig said. One was l into his seat.
ors said they did not know why the plane, a rented Piper PA-28, went down.

It was snowing and there were strong northerly winds that reduced visibility to about a quarter mile.

The plane left Grand Forks about 6:30 p.m. Friday for the three-hour flight to Fond du Lac, he said.

Cadieux's father, R.A. Cadieux, said the pair were on their way to visit their brothers, students at Marian College in Fond du Lac.

Acheson had his commercial pilot's certificate, his instrument rating and his multi-engine rating, said Tim Burke, a spokesman for the UND's aviation program.

Instrument rating means Acheson was trained to fly in "poorer" weather, Burke said.

Burke said the last flying fatality among students in the program occurred in the early 1980s.

Acheson's fraternity brothers and friends left Grand Forks Sunday to travel to Fond du Lac to help in the search, Burke said.

Representatives of the Federal Aviation Administration and the National Transportation Safety Board arrived at the crash scene Monday, Mathwig said.

Dakota health plan gets Minnesota OK

Dakota Community Health Plan announced Monday that it has approval from the Minnesota Department of Health to operate as a community integrated service network.

The networks were approved last year by the Minnesota Legislature to enable smaller communities to develop their own provider networks to deliver a broad range of prepaid health services.

Dakota Community Health Plan is a joint venture between Dakota Clinic and Blue Cross and Blue Shield of Minnesota.

"This licensure is the result of significant planning, research and development to offer a new type of health plan unique to the needs of northwestern Minnesota communities," said Dean Greenwaldt, director of account management for Blue Cross Blue Shield's Moorhead office.

The managed care health plan will begin operations this month and begin enrolling members immediately. Initially it will offer plans for small- and medium-size businesses; 96 percent of the businesses in the plan's service area employ two to 49 workers.

The service area encompasses all or part of 16 northwestern Minnesota counties.

Communities range from Warren, Thief River Falls and Grygla on the north to Breckenridge, Fergus Falls and Pelican Rapids on the southern end. The area's western edge is marked by the Minnesota-North Dakota border, while the eastern boundary includes the communities of Cass Lake, Walker and Wadena.

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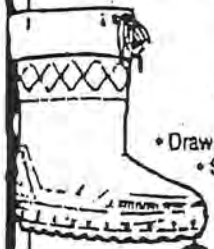
KIDS ALL SEASON BOOTS
• Removeable 6mm foam liner
• Drawstring top for snug fit
• Slip resistant outsold design
• Made in the U.S.A.
$18.95

, after surgery.

t to buy
Bankshares

(AP)
Corp. said Monday that eed to buy Victoria Inc. in a stock swap out $285 million.
said it would exchange on shares for each of 8.5 million common ding the Victoria shares 3.47 at current prices.
of Minneapolis, has 4 billion. Victoria had 1.9 billion at the end of

ills Indian
tax proposal

n (AP)
tional negotiators agreed roposed tax on Indian at would have raised

Notes to Financial Statement

E. Guarantees

During 1998, BCBSM and Dakota Clinic created Dakota Specialty Institute, d/b/a Innovis, a joint venture. The joint venture has developed a new hospital to provide patient-focused integrated medical services to residents in the Red River Valley with the objective of improving healthcare quality, access and cost-effectiveness. BCBSM and Dakota Clinic each have a 50% membership interest in Innovis, a nonprofit corporation. BCBSM has provided a $5,000,000 loan to Innovis and an additional $4,900,000 for operating capital through a line of credit. Additionally, BCBSM and Dakota Clinic have agreed to guarantee Innovis obligations in connection with a credit agreement by and between U.S. Bank, BCBSM and Dakota Clinic in an amount not to exceed $60,000,000.

The agreement also includes a right of off-set up to $30,000,000 against any payments due to Dakota Clinic by BCBSM or Blue Plus under the Joint Venture and Affiliation Agreement between Dakota Clinic, BCBSM and Blue Plus. Finally, BCBSM has provided Innovis an interest-bearing claims advance of $1,500,000.

Effective October 1, 2001, BCBSM transferred its 50% interest in Dakota Community Health Network (DCHN) to its joint venture partner, Dakota Clinic. In lieu of making additional contributions to offset DCHN's negative equity, BCBSM agreed to write-off $1,575,000 due from DCHN. The Affiliation Agreement between BCBSM and Dakota Clinic was restated to reflect the end of the joint venture, but was not otherwise materially amended.

During 1999, BCBSM along with its joint venture partner Affiliated Community Medical Centers, P.A. (ACMC) agreed to guarantee the repayment of up to $15,000,000 of term debt of their joint venture, Affiliated Community Health Network, Inc. (ACHN). While the terms of the guarantee provide for the joint and several liability of BCBSM and ACMC, the two have executed a related contribution agreement whereby each pledges to contribute equally to any payments that would be required under the guarantee.

On February 8, 2001 BCBSM agreed to guarantee the obligation of Riverbend Community Health Network, Inc. in an amount of $16,000,000 in connection with the financing of costs related to the development of a medical office campus in Mankato, Minnesota to be leased by Mankato Clinic, Ltd. and Orthopedic & Fracture Clinic, P.A. together with an ambulatory surgery center to be operated by Mankato Ambulatory Surgery Center, LLC. Mankato Clinic has agreed to share liability for the obligation in an amount equal to 62 ½ %, leaving BCBSM with a liability of up to $6,000,000.

On March 22, 2000, The BCBSM Board of Trustees approved the execution of a guaranty agreement in an amount not to exceed $5,000,000 for a term of 15 years in order for First Plan of Minnesota to obtain financing for two medical clinic facilities in Two Harbors and Proctor, Minnesota.

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Notes to Financial Statement

under the terms of the credit agreement. With accrued interest the total due to BCBSM from Innovis was $15,908,000 as of December 31, 2003. An allowance of $8,390,000 has been recorded for potential impairment, including $1,361,000 and $4,400,000 charged to income in 2003 and 2002, respectively.

In 2002 BCBSM, Blue Plus and Dakota Clinic, Ltd. reached a decision to terminate the Joint Venture and Affiliation Agreement ("Affiliation Agreement") that the parties entered into on December 30, 1994. As a result of such decision and the fact that the covenant for the Dakota Clinic to continue to operate independently under that agreement no longer had value to BCBSM and Blue Plus, a total of $16,200,000 was written off in 2002. BCBSM's share of the loss was $8,100,000. On April 30, 2003 the parties formally terminated the Affiliation Agreement. Other covenants and agreements between the parties relating to the purposes of the affiliation, including a commitment from Dakota Clinic to continue to operate independently in return for a financial commitment from BCBSM and Blue Plus through 2014, were terminated on that date. BCBSM and Blue Plus as the terminating parties paid a termination payment to Dakota Clinic in the amount of $29,764,244 in 2003 in accordance with the termination provisions of the Affiliation Agreement. This final payment, including repayment of a $27,000,000 note payable and interest, resulted in BCBSM reporting a net gain in 2003 equal to $3,468,591. BCBSM's share of the termination payment and the final payment are $14,882,122 and $13,500,000, respectively. Dakota Clinic continues as a participating provider with BCBSM and Blue Plus.

During 1999, BCBSM along with its joint venture partner Affiliated Community Medical Centers, P.A. (ACMC) agreed to guarantee the repayment of up to $15,000,000 of term debt of their joint venture, Affiliated Community Health Network, Inc. (ACHN). While the terms of the guarantee provide for the joint and several liability of BCBSM and ACMC, the two have executed a related contribution agreement whereby each pledges to contribute equally to any payments that would be required under the guarantee.

On December 20, 2002 BCBSM revised its guarantee of the obligation of Riverbend Community Health Network, Inc. in connection with the financing of costs related to the development of a medical office campus in Mankato, Minnesota to be leased by Mankato Clinic, Ltd. and Orthopedic & Fracture Clinic, P.A. together with an ambulatory surgery center to be operated by Mankato Ambulatory Surgery Center, LLC, so that BCBSM's guarantee is now $5,600,000. Mankato Clinic has agreed to share liability for the obligation in an amount equal to 50%, leaving BCBSM with a liability of up to $2,800,000.

F. Material Management, Service Contracts, or Cost Sharing Arrangements

Under terms of contractual agreements for reimbursement of administrative expenses, BCBSM acts as the control plan for various national groups, serves as the writing carrier for the Minnesota Comprehensive Health Association, processes claims under administrative service contracts and provides certain operating and administrative services to wholly-owned subsidiaries and affiliated corporations. BCBSM charged $337,186,000 in 2003 and $308,029,000 in 2002 for services performed under these agreements. These charges are recorded as reductions in administrative expense in the accompanying financial statements.

Included in the total charges for services are charges of $77,775,000 and $78,502,000 in 2003 and 2002, respectively, that were allocated to its wholly-owned subsidiaries and affiliated corporations and other Aware subsidiaries.

G. Control Relationship

All outstanding shares of BCBSM, Inc. are owned by its parent, Aware Integrated, Inc., a non-profit holding company domiciled in the State of Minnesota.

Notes to Financial Statement

BCBSM has provided $16,500,000 and $2,200,000 to Blue Plus and First Plan of Minnesota, respectively, in exchange for surplus notes. Principal and interest payments can only be made if they do not jeopardize minimum statutory capital surplus requirements. As of December 31, 2003 and 2002, no principal or interest has been paid on the First Plan of Minnesota surplus note. The surplus note balance for Blue Plus was $7,500,000 at December 31, 2003. These surplus notes are treated as non-admitted assets.

On January 15, 2002, the Blue Plus Board of Trustees approved and authorized the sale of certain Behavioral Health Services, Inc. assets previously used to perform claims adjudication and other administrative services on behalf of BCBSM business. BCBSM now performs these services. The price paid for the assets was $282,285, thereby providing BHSI with funding to repay its debt obligation with BCBSM.

D. Amounts Due from or to Related Parties

At December 31, 2003 and 2002, the Company reported the following amounts due to and from related parties. Balances due to or from related parties are reviewed monthly and periodically settled.

	Dec. 31, 2003	Dec. 31, 2002
Amounts due to BCBSM:		
Blue Plus	$ -	$ 1,413,514
Affiliated Comm. Health Network, Inc.	1,269,935	1,177,144
Behavioral Health Services, Inc.	2,989,616	2,226,758
Comprehensive Managed Care, Inc.	138,016	157,883
MII Casualty, Inc.	-	107,232
Capital Asset Care, Inc.	-	156,377
Comprehensive Care Services, Inc.	1,279,333	431,179
Atrium Health Plan, Inc.	621,013	607,551
MII Services, Inc.	856,621	10,105
Total due to BCBSM from Affiliates	**$7,154,534**	**$6,287,743**
Amounts due to Other Affiliates:		
Care Delivery Management, Inc.	$ 306,795	$ 142,027
Capital Asset Care, Inc.	197,856	-
Pharmacy Gold, Inc.	185,959	185,959
Aware Integrated, Inc. (parent company)	1,949,065	1,949,065
First Plan	8,036	-
Blue Plus	38,399,855	-
Riverbend Comm. Health Network, Inc.	548,274	427,487
MII Life, Inc.	69,023	1,455,700
Total due to Other Affiliates	**$41,664,863**	**$4,160,238**

E. Guarantees

On October 10, 2002, BCBSM executed a Guaranty in an amount not to exceed the principal amount of $4,108,000 (plus interest, costs and expenses) for a term of 14 years in connection with First Plan of Minnesota's refinancing of prior loans for two medical clinic facilities in Two Harbors and Proctor, Minnesota. The prior Guaranty Agreement dated May 11, 2000 and executed by BCBSM in connection with the initial First Plan of Minnesota financing has been terminated.

During 1998, BCBSM and Dakota Clinic created Dakota Specialty Institute, d/b/a Innovis, a joint venture. BCBSM and Dakota Clinic each have a 50% membership interest in Innovis, a nonprofit corporation. BCBSM has provided a $5,000,000 loan to Innovis, an additional $4,900,000 for operating capital through a line of credit and an interest bearing note in the amount of $1,605,563. Additionally, BCBSM and Dakota Clinic have agreed to guarantee Innovis obligations in connection with a credit agreement by and between U.S. Bank, BCBSM and Dakota Clinic in an amount not to exceed $60,000,000. Innovis pays a fee to BCBSM and Dakota Clinic

Notes to Financial Statement

under the terms of the credit agreement. With accrued interest the total due to CBSM from Innovis was $15,908,000 as of December 31, 2003. An allowance of 8,390,000 has been recorded for potential impairment, including $1,361,000 and $4,400,000 charged to income in 2003 and 2002, respectively.

In 2002 BCBSM, Blue Plus and Dakota Clinic, Ltd. reached a decision to terminate the Joint Venture and Affiliation Agreement ("Affiliation Agreement") that the parties entered into on December 30, 1994. As a result of such decision and the fact that the covenant for the Dakota Clinic to continue to operate independently under that agreement no longer had value to BCBSM and Blue Plus, a total of $16,200,000 was written off in 2002. BCBSM's share of the loss was $8,100,000. On April 30, 2003 the parties formally terminated the Affiliation Agreement. Other covenants and agreements between the parties relating to the purposes of the affiliation, including a commitment from Dakota Clinic to continue to operate independently in return for a financial commitment from BCBSM and Blue Plus through 2014, were terminated on that date. BCBSM and Blue Plus as the terminating parties paid a termination payment to Dakota Clinic in the amount of $29,764,244 in 2003 in accordance with the termination provisions of the Affiliation Agreement. This final payment, including repayment of a $27,000,000 note payable and interest, resulted in BCBSM reporting a net gain in 2003 equal to $3,468,591. BCBSM's share of the termination payment and the final payment are $14,882,122 and $13,500,000, respectively. Dakota Clinic continues as a participating provider with BCBSM and Blue Plus.

During 1999, BCBSM along with its joint venture partner Affiliated Community Medical Centers, P.A. (ACMC) agreed to guarantee the repayment of up to $15,000,000 of term debt of their joint venture, Affiliated Community Health Network, Inc. (ACHN). While the terms of the guarantee provide for the joint and several liability of BCBSM and ACMC, the two have executed a related contribution agreement whereby each pledges to contribute equally to any payments that would be required under the guarantee.

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F. Material Management, Service Contracts, or Cost Sharing Arrangements

Under terms of contractual agreements for reimbursement of administrative expenses, BCBSM acts as the control plan for various national groups, serves as the writing carrier for the Minnesota Comprehensive Health Association, processes claims under administrative service contracts and provides certain operating and administrative services to wholly-owned subsidiaries and affiliated corporations. BCBSM charged $337,186,000 in 2003 and $308,029,000 in 2002 for services performed under these agreements. These charges are recorded as reductions in administrative expense in the accompanying financial statements.

Included in the total charges for services are charges of $77,775,000 and $78,502,000 in 2003 and 2002, respectively, that were allocated to its wholly-owned subsidiaries and affiliated corporations and other Aware subsidiaries.

G. Control Relationship

All outstanding shares of BCBSM, Inc. are owned by its parent, Aware Integrated, Inc., a non-profit holding company domiciled in the State of Minnesota.

Notes to Financial Statement

A-C Related Party Transactions

On June 13, 2005, Atrium Health Plan, Inc. (Atrium) executed an Asset Purchase Agreement between Atrium and Compcare Health Insurance Services Corporation (Compcare), the HMO subsidiary of Blue Cross and Blue Shield of Wisconsin. Pursuant to the Asset Purchase Agreement, Atrium agreed to sell substantially all of its assets, including all individual, small group and large group contracts, Medicare and Medicaid contracts, providers contracts and broker contracts, to Compcare. With the exception of subscriber prepayments and certain liabilities relating to the purchased assets, Compcare did not assume any of Atrium's current liabilities. The sale closed September 1, 2005. Atrium has agreed to provide certain transition services to Compcare until October 31, 2005.

D. Amounts Due from or to Related Parties

At December 31, 2004 and September 30, 2005, the Company reported the following amounts due to and from related parties. Balances due to or from related parties are reviewed monthly and periodically settled.

	Dec. 31, 2004	Sept. 30, 2005
Amounts due to BCBSM:		
First Plan	$ 1,105,751	$ 558,320
Affiliated Comm. Health Network, Inc.	864,764	988,597
SupportSource, Inc.	3,083,036	2,850,436
Aware Integrated, Inc.	-	76,300
Comprehensive Managed Care, Inc.	-	260,676
Capital Asset Care, Inc.	116,547	14,665
Atrium Health Plan, Inc.	788,835	-
MII Services, Inc.	40,975	77,173
Total due to BCBSM from Affiliates	**$5,999,908**	**$4,826,167**
Amounts due to Other Affiliates:		
Care Delivery Management, Inc.	$ 38,148	$ 363,443
Pharmacy Gold, Inc.	299,059	387,395
Comprehensive Care Services, Inc.	1,609,805	2,134,302
Comprehensive Managed Care, Inc.	272,016	-
Blue Plus	37,891,167	5,262,707
Riverbend Comm. Health Network, Inc.	645,921	715,356
Blue Plus	-	309,241
MII Life, Inc.	1,218,652	1,472,372
Total due to Other Affiliates	**$41,974,768**	**$10,644,816**

E. Guarantees

During 1998, BCBSM and Dakota Clinic created Dakota Specialty Institute, d/b/a Innovis, a joint venture. BCBSM and Dakota Clinic each had a 50% membership interest in Innovis, a nonprofit corporation. BCBSM has provided a $5,000,000 loan to Innovis, an additional $4,900,000 for operating capital through a line of credit and an interest bearing note in the amount of $1,605,563. Additionally, BCBSM and Dakota Clinic agreed to guarantee Innovis obligations in connection with a credit agreement by and between U.S. Bank, BCBSM and Dakota Clinic in an amount not to exceed $60,000,000. Innovis paid a fee to BCBSM and Dakota Clinic under the terms of the credit agreement. With accrued interest the total due to BCBSM from Innovis was $17,221,000 as of December 31, 2004. An allowance of $9,702,000 has been recorded for potential impairment, including $1,312,000 and $1,361,000 charged to income in 2004 and 2003, respectively.

Notes to Financial Statement

In June of 2005, BCBSM terminated its membership interest in Innoivs and received $17,997,000 as full payment for amounts due. This resulted in a $10,478,000 gain recorded as other income. In addition, BCBSM was relieved of its guarantee obligation to USBank.

F. Material Management, Service Contracts, or Cost Sharing Arrangements

No material change.

G. Control Relationship

No change

H. Reduction of Asset Value of Securities

Not Applicable

I. Investment in SCA that exceeds 10% of Admitted Assets

No change

J. SCA impaired assets

None

11. Debt

No material change.

12. Retirement Plans and other Post Retirement Benefits

A. Defined Benefit Plan

No change

B. Defined Contribution Plan

No change

C. Multiemployer Plans

None

D. Consolidated/Holding Company Plans

None

E. Postemployment Benefits and Compensated Absences

No material change

13. Capital and Surplus, Shareholder's Dividends and Quasi-Reorganizations.

(1) Capital Stock

No change

(2) Preferred Stock

Not Applicable

IN-FORUM

nnovis Health sale finalized

By Patrick Springer
The Forum - 07/01/2005

Fargo's Dakota Clinic is now the sole owner of Innovis Health after buying out the interest held by Blue Cross Blue Shield of Minnesota in a deal completed Thursday.

Terms of the transaction, including the dollar figure, weren't disclosed by either party after the five-year partnership involving the south Fargo hospital was dissolved.

"The documents making Dakota Clinic the sole member of Innovis Health have been signed and executed, making the membership transfer from Blue Cross Blue Shield of Minnesota officially complete," Dr. Greg Glasner, chairman of the Dakota Clinic board, said in a prepared statement.

He was unavailable for further comment Thursday. A spokeswoman for Blue Cross Blue Shield of Minnesota, however, said the clinic's sole ownership of the hospital will allow it to pursue its own growth strategy.

"The agreement allows Blue Cross to be paid the amounts that we loaned to Innovis," said Jan Hennings for the Minnesota Blues. "Blue Cross has received interest at the market rate agreed upon. We believe we received fair value."

The building housing Dakota Clinic and the 74-bed Innovis hospital at 3000 32nd Ave. S. has an assessed value of $54.9 million on land appraised at $3.6 million, for a total of $58.5 million, according to the Fargo city assessor's office.

The Dakota Clinic-Innovis Health center pays local property taxes of $1.3 million. City officials in Fargo said they have received no notification that the buyout will alter the hospital's tax status.

Earlier, when Innovis was exploring a purchase by not-for-profit Catholic Health Initiatives, based in Denver, local government officials were worried that the hospital would drop off the property tax rolls.

Dakota Clinic is expected to name new top management for the hospital, which has 850 employees, possibly today. Two weeks ago, the clinic confirmed that Innovis CEO Paul Wilson would step down, but gave no reason for his departure.

Wilson, who took the helm at Innovis in 2002, declined to comment Thursday through a spokeswoman. The hospital opened in 2000.

The Innovis Health partnership between Dakota Clinic and Blue Cross Blue Shield of Minnesota stemmed from an earlier collaboration - an integrated health network combining the delivery of health services and health insurance - that was formed in the early 1990s.

Minnesota state laws were changed seven years ago to remove some of the advantages of the community integrated service networks. "That's when the environment changed," Hennings said.

In response, Dakota Clinic and Blue Cross Blue Shield of Minnesota dissolved their joint network. Now that the hospital partnership has been dissolved, the former partners have returned to a traditional payer-provider relationship, she said.

Readers can reach Forum reporter Patrick Springer at (701) 241-5522

BlueCross BlueShield of Minnesota

Robert J. Milis
Vice President & General Counsel

October 5, 2000

Commissioner James Bernstein
Attention: Kevin M. Murphy
Department of Commerce
133 East Seventh Street
St. Paul, MN 55101

Via Courier

P.O. Box 64560
St. Paul, MN
55164-0560
651.662.8029
1.888.878.0139
ext. 28029
Fax 651.662.1099
robert_j_milis@
bluecrossmn.com

Re: Dividend Payment by BCBSM, Inc.

Dear Commissioner Bernstein:

This letter and the attached Report of Dividend Form shall serve as notice of a declaration of a dividend declared by BCBSM, Inc. The BCBSM, Inc. Board of Trustees at a board meeting on October 4, 2000 declared a dividend of $10,000,000 to be paid to its parent non-profit corporation, Aware Integrated, Inc.

Prior to the declaration of the dividend, this matter was reviewed with your staff, including Kevin Murphy and Jacqueline Gardner. The purpose of this dividend is to help BCBSM, Inc. resolve the recent audit finding of the Department of Commerce for eliminating the existing intercompany receivable between BCBSM, Inc. and Comprehensive Managed Care, Inc. (CMCI). This dividend will enable Aware Integrated, Inc. to provide additional capital to CMCI so that CMCI can repay BCBSM, Inc.

As noted in the attached form, BCBSM, Inc. plans to make its dividend payment on or after October 25, 2000. In accord with Minnesota Statutes Section 60D.20, BCBSM, Inc. will proceed with payment of the dividend unless we are advised to the contrary.

Yours very truly,

Robert J. Milis

RJM:mmc
Enc.

cc: Timothy M. Peterson
Timothy A. Schultz

Blue Cross and Blue Shield of Minnesota is an independent licensee of the Blue Cross and Blue Shield Association

MINNESOTA DEPARTMENT OF COMMERCE

ICT 16 2000

COPY

October 12, 2000

Mr. Robert J. Milis, Vice President & General Counsel
Blue Cross and Blue Shield of Minnesota
P.O. Box 64560
St. Paul, MN 55164-0560

Re: Dividend notification

Dear Mr. Milis:

We have received your letter dated October 5, 2000, regarding the $10 million dividend that Blue Cross and Blue Shield of Minnesota intends to pay to Aware Integrated, Inc. We do not disapprove payment of the $10 million dividend.

If you have any questions related to this letter, please contact David Rosaaen, Senior Analyst at (651) 297-5743; FAX (651) 296-9434.

Sincerely,

Jacqueline L. Gardner
Insurance Solvency Manager

JLG:dr

55026-2099

133 East Seventh Street, St. Paul, 55101-2333
Telephone (651) 296-4026 • Fax (651) 296-9434 • TTY/TDD (651) 296-2860
e-mail: commerce@state.mn.us
Web Site: www.commerce.state.mn.us

An Equal Opportunity Employer

BlueCross BlueShield of Minnesota

Tim Peterson
Chief Financial Officer,
Vice President Finance

December 10, 2004

Mr. Glenn Wilson, Commissioner
Minnesota Department of Commerce
85 7th Place East, Suite 500
St. Paul, MN 55101-2198

VIA COURIER

Re: Notice of Dividend

Dear Commissioner Wilson:

Enclosed for filing please find a Report of Dividend from BCBSM, Inc. d/b/a Blue Cross and Blue Shield of Minnesota (Blue Cross) in connection with a dividend it has declared to its non-profit parent company, Aware Integrated, Inc.

P.O. Box 64560
St. Paul MN
55164-0560
651.662.6243
1.888.878.0139 ext.26243
Fax 651.662.1813
timothy_m_peterson@bluecrossmn.com

The Blue Cross Board of Trustees by resolution duly adopted on December 8, 2004 authorized Blue Cross to pay a dividend in the amount of $9,000,000 to Aware Integrated, Inc., the sole member of Blue Cross. The payment date of such dividend is on or after December 27, 2004.

This dividend is considered an ordinary dividend pursuant to Minnesota Statutes Section 60D.20, subd. 2, which governs this type of transaction as a result of the Guaranty and Voluntary Compliance Agreement entered into by and between the Department of Commerce, Blue Cross and Aware Integrated, Inc. in 1994. Blue Cross last issued a dividend in the year 2000 in the amount of $10,000,000.

In addition to the 2003 year end information furnished in the Report of Dividend, you should note that, as of September 30, 2004, Blue Cross maintained a surplus of approximately $670 million. As of the same date, Blue Cross had risk based capital of 833%, which would be reduced to approximately 822% upon payment of the dividend. Further, as of September 30, 2004, Blue Cross' net gain from operations, following the same criteria as set forth in Paragraph 7(c) of the Report of Dividend, was approximately $63 million for the year to date.

The Blue Cross Board of Trustees determined that the issuance of the dividend is prudent, will go to a non-profit organization with mission and goals similar to Blue Cross and will benefit the subscribers of Blue Cross. Blue Cross believes it can best satisfy its general mission and meet the intensifying competition of for-profit health plans by making resources available to promote specialty operations through Aware Integrated, Inc. Some of the emerging opportunities include consumer engagement tools and information, health savings accounts and care management. Blue Cross believes that the success of Prime Therapeutics as a pharmacy benefit manager serving multiple Blue Cross/Blue Shield plans serves as concrete evidence that this type of strategy can bring direct benefit to Blue Cross and its members.

Please contact either Kathy Mock (651-662-2580) or me if you need any additional information concerning this dividend.

Sincerely,

Tim Peterson
Sr. Vice President, Chief Financial Officer

cc: Ms. Kathy Mock

Blue Cross and Blue Shield of Minnesota is an independent licensee of the Blue Cross and Blue Shield Association

Enclosed.

REQUEST NO. 156

Please provide a copy of the letter of intent and any other documents between CoVel and BCBSM with respect to the proposed or actual sale of Comprehensive Managed Care, Inc. and Expert Link. If the closing of the sale has not taken place, please describe the status of the matter.

RESPONSE:

Aware Integrated, Inc. and CorVel Healthcare Corporation were unable to reach final agreement as to the sale of certain assets of Comprehensive Managed Care, Inc. (CMC) and Care Delivery Management, Inc. (CDMI) and therefore terminated the letter of intent. Aware Integrated, Inc. subsequently closed its independent medical management business (Expert Link) of CDMI, and the workers' compensation managed care business of CMC. The remaining CMC line of business, disability management (Disability Solutions) was transferred to CDMI. The letter of intent and additional documents with respect to the proposed CorVel transaction are enclosed.

REQUEST NO. 157

Please describe how Aware Integrated, Inc. used the proceeds from the $9 million dividend issued in 2004 by BCBSM, including how much remained unexpended as of December 31, 2005. If AII transferred any of the funds to an affiliate, identify the amount transferred, the name of the affiliate and how the affiliate utilized the funds. If the affiliate did not use all of the funds, identify how much remained unexpended as of December 31, 2005.

RESPONSE:

The dividend proceeds will be used to help fund programs that will promote specialty

health-related operations to benefit BCBSM subscribers and help BCBSM meet the demands of the competitive marketplace. For example, Aware Integrated, Inc. has committed approximately $4.2 million to capitalize the newly formed Blue Healthcare Bank, a bank that more than thirty Blues Plans and their affiliates have agreed to fund. The purpose of the bank will be to help BCBSM and others facilitate the more complex health care transactions that occur under the new consumer-directed plans, typically high-deductible health plans coupled with personal savings accounts such as health savings accounts (HSAs), health reimbursement accounts, or flexible spending accounts. By taking the banking functions associated with these plans in-house, with many Blues Plans participating, rather than relying on outside banks, BCBSM and the other Blues Plans believe they will be able to provide these services on more affordable terms to their subscribers. This is essentially the same strategy BCBSM employed with Prime Therapeutics, the pharmacy benefit manager (PBM) it established with other Blues Plans a few years ago. Prime's corporate offices are based in Minnesota, and it employs about 400 staff in this state.

Dated this 26th day of January, 2006.

ROBINS, KAPLAN, MILLER & CIRESI L.L.P.

Scott R. Strand (#147151)

2800 LaSalle Plaza
800 LaSalle Ave. S.
Minneapolis, MN 55402-2015
(612) 349-8500

ATTORNEYS FOR BCBSM

COPY

Agreement

This Agreement dated this 1st day of June, 2002, by and between Care Delivery Management, Inc. (CDMI), and Blue Cross Blue Shield of Minnesota (BCBSM) Government Programs of Minnesota (client), sets forth the rights and responsibilities of each party as they relate to car seat gift certificate fulfillment provided by CDMI to certain BCBSM Government Programs enrollees.

NOW, THEREFORE, the parties agree as follows:

I. Responsibilities of CDMI

A. Throughout the term of this contract, CDMI, through its designated agents, shall fulfill car seat gift certificate requests to covered persons. The activities covered under the terms of this contract are defined in Exhibit A.

B. CDMI, through its designated agents, agrees to be available by telephone at all times between the hours of 8:00 a.m. through 4:30 p.m. CST, exclusive of weekends and holidays.

C. CDMI will immediately notify BCBSM Government Programs of any licensure limitation of its designated agents herein.

D. Upon request by BCBSM Government Programs, CDMI will provide written reports setting forth car seat gift certificate recipients.

II. Responsibility of BCBSM Government Programs

A. BCBSM Government Programs shall publicize the car seat program.

III. Confidentiality of Information

All medical information and/or data concerning specific hospitals, physicians, other providers, or covered persons obtained as a result of services provided under this Agreement shall be treated as confidential by CDMI in compliance with all state and Federal laws and regulations and shall not be released or disclosed to any party other than BCBSM Government Programs.

CONFIDENTIAL
TRADE SECRET

IV. Indemnification

BCBSM Government Programs shall indemnify and hold CDMI and its designated agents harmless from any claim, injury, damage, or judgement including any legal and incidental expenses incurred by CDMI in connection herewith, resulting from the performance of services in accordance with this Agreement. CDMI shall indemnify and hold BCBSM Government Programs and its designated agents harmless from any claim, injury, damage or judgement caused by or resulting from the negligence of CDMI, its officers, employees, or its designated agents, resulting from the performance of services in accordance this Agreement.

V. Compensation

A. CDMI will provide the services listed in Exhibit A at the unit rate specified in Exhibit B. CDMI may change the unit rate specified in Exhibit B upon thirty- (30) days prior notice to BCBSM Government Programs. Notice will be provided by submission of a new Exhibit B. The new rates will become effective thirty (30) days after the date indicated on the schedule.

B. Fees for car seat gift certificate recipients shall be billed in the first month following issuance. All payments of fees and other amounts owed by BCBSM Government Programs are due in cash or cash equivalents to CDMI within thirty (30) days of the date of the invoice, unless otherwise specified. Overdue payment shall bear interest at the rate of the lessor of one and one half percent (1 ½%) per month or the maximum rates allowable under applicable state law.

VI. Independent Contractor

CDMI is an independent contractor for BCBSM Government Programs. CDMI will procure, through employment or contract, the human resources necessary to perform specific services listed in Exhibit A, together with such other consulting services in the area of utilization management as may be agreed to by the parties.

VII. Prohibition Against Assignment

Neither party may assign this agreement.

CONFIDENTIAL
TRADE SECRET

VIII. Term/Termination

A. The term of this contract shall be from 6/1/02 to 05/31/03 and shall automatically renew each year thereafter unless terminated by either party hereunder.

B. Either party may terminate this contract with or without cause on thirty- (30) days written notice to the other party.

IX. Amendment

Mutual written consent of BCBSM Government Programs and CDMI shall be required to amend this Agreement.

BCBSM Government Programs		**Care Delivery Management, Inc**	
By:	Cynthia Wade Mead	By:	John Hanser
Date:	3-17-03	Date:	3-17-03
By:		By:	
Date:		Date:	

BCBSM Government Programs

By: _____

Date: _____

By: _____

Date: _____

CONFIDENTIAL
TRADE SECRET

Exhibit A

Schedule of Services

Utilization Management

CDMI will be available to provide BCBSM Government Programs car seat gift certificate fulfillment as follows:

$50.00 Gift Certificate Center gift certificate mailed to member's home with letter.

CONFIDENTIAL
TRADE SECRET

Exhibit B

Schedule of Charges

Cost:

$55.00 per gift certificate

CONFIDENTIAL
TRADE SECRET

Care Delivery Management, Inc. (CDMI)

3535 Blue Cross Road, Eagan, Minnesota 55122

Consultant Agreement

01678680

46-2596

Name of Agreement/Project	Healthy Start / Best Beginnings Gift Certificates					
Date of Agreement	March 1, 2004					
Location of Services	☐ Onsite ☒ Offsite					
Consultant Company Name	Gift Certificate Center					
Address 1	121 South 8th Street					
Address 2						
City, State, Zip	Minneapolis, MN 55402					
Federal ID #						
Consultant Contact	Peggy O'Leary					
Voice Phone	612-672-8627					
Fax Phone	612-664-8691					
CDMI Manager	Judy Kassa		Phone	22897	Mail Route	W101
Start Date	3/1/04	End Date	2/28/05	Max. Total $	650,000	
Requisition Type:	RV	GL Account:	66400	Cost Center:	407-04	
Requisition # Assigned	10031460	Material Group	KCA	WBS Code(s) (if applicable)		

1. Scope of Work:

The Consultant shall provide the following "Services" to Care Delivery Management, Inc. (CDMI):

1.1. Fulfillment of gift certificates for the Healthy Start, Best Beginnings and Car Seat programs

1.2. In the event of any inconsistencies between any documents, proposals or specifications referenced as Exhibits or Attachments in Section 1.1 and this Consultant Agreement, this Consultant Agreement shall control.

2. Deliverables To Be Furnished by Consultant:

Vendor is to provide Premiere Choie Awards (PCA) and mail out to the receipient. Vendor will mail merchant gift certificate to the recipeint upon redemption of PCA my mail or at PremiereChoiceAward.com. Vendor's Service Fees include all postage and materials, except carseat insert, which is to be proivded to GCC by CDMI. Four separate accounts need to be maintained for the programs (Healthy Start, Best Beginnings, Car Seats and Target Corporation). Reports, including a listing of all PCAs sent out, to whom they were sent and the date sent, is available at

BCBSM 91129

PremiereChoiceAward.com. Vendor is to provide VIP level customer service. All award increments are in $50.00 increments.

3. Personnel Who Will Perform Services:

3.1 The following Consultant Personnel will perform Services on this project:

Gift Certificate Center, Inc.

3.2 CDMI will present the attached Confidential Information Policy to all of Consultant's employees or subcontracted personnel who are assigned to perform Services under this Consultant Agreement and require their individual signature as a condition for performing Services hereunder.

4. Compensation

4.1 For the Consulting Services described herein, CDMI shall pay Consultant the following fees and/or rates:

A serivce fee of 8% of face value for each PCA and the face value of the PCA

4.2 Total fees under this Agreement will not exceed $650,000.

4.3 Expenses will not be reimbursed by CDMI under this agreement.

5. Invoicing and Payment

5.1 Consultant shall submit Invoices for each order showing the following:

- Title Identifying the project
- Name of CDMI Project Manager
- CDMI PO Number
- Dates and hours of service for each employee of Consultant, respective rate per hour and extended cost (if applicable) for invoicing period or other basis on which fee is charged.
- Description of Services performed
- Total Amount of Current Invoice

5.2 Mail Invoice to:

CDMI
Blue Cross Blue Shield of Minnesota.
Attn. Accounts Payable Mail RTE T1-09
3535 Blue Cross Road
Eagan, Minnesota 55122

5.3 Payments will be made within thirty (30) days after CDMI's receipt of a properly submitted invoice. Invoices not submitted in accordance with the above will be returned to Consultant without payment for correction. All questions regarding invoice payment shall be directed to the CDMI Accounts Payable Department.

6. Agreement

Consultant shall provide the Services identified above in accordance with the provisions of this Consultant Agreement and the "Care Delivery Management, Inc. Consultant Terms & Conditions" pages 1 through 6 dated April 14, 2003 which are attached and made a part of this Consultant Agreement, and which together constitute the "Agreement".

In Witness whereof, the parties have executed this Consultant Agreement on the date(s) indicated below.

Care Delivery Management, Inc. :	**Contractor: Gift Certificate Center, Inc.**
By John Hansen	By Maria Bavender
Signature	Signature
John Hansen	Maria Bavender
Print Name	Print Name
4-2-04	4/1/04
Date	Date

Care Delivery Management, Inc.
Consultant Terms and Conditions
03/30/04

1. SCOPE OF WORK

Care Delivery Management, Inc. (hereafter referred to as "CDMI") hereby engages the Consultant, as an independent contractor, to perform and furnish the Services and work product/deliverables described in the Consultant Agreement to which these Terms and Conditions are attached. All Services are to be performed in accordance with the Consultant Agreement and if no other schedule of performance is provided, Services are to begin immediately and proceed at a pace consistent with industry practice, time being of the essence to CDMI.

2. PERSONNEL

Consultant will furnish qualified workers to perform the Services at the times and location(s) designated by the CDMI project manager. Consultant is responsible for overseeing and managing the tasks and functions for the Services provided under the Consultant Agreement. Consultant will make reasonable efforts to honor specific requests by CDMI with regard to the workers who are assigned and any other aspect of obtaining the desired results under the Consultant Agreement. Consultant shall not subcontract with any third party for the performance of any Services to be provided under this Agreement without in each instance obtaining the prior written consent of CDMI to Consultant's use of such third party subcontractor, which consent may be withheld in CDMI's sole and absolute discretion. Consultant shall require each such third party for which CDMI's consent may be given, to agree in writing to perform in accordance with, and subject to the terms of this Agreement prior to the performance of Services by such third party. Neither CDMI's consent to the use of any subcontractor, nor the failure of performance thereof by such subcontractor, shall relieve, release or affect Consultant's duties, liabilities or obligations hereunder, and Consultant shall at all times be and remain liable hereunder. Contractor and its personnel shall in the performance of this Agreement, comply with all reasonable rules, policies and procedures as may be adopted by CDMI from time to time.

3. TERM/TERMINATION

This Agreement is effective for a term ("Term") commencing on the Start Date and continuing until the End Date, or until the contracted Services have been completed, or the maximum dollar amount has been reached, whichever occurs first. Additional Services may be contracted by a written amendment to the Consultant Agreement which is signed by the parties. CDMI reserves the right at any time to immediately terminate this Agreement without cause upon fifteen (15) days written notice to Consultant, and upon such termination without cause, CDMI shall be responsible for payment of fees for Services performed by Consultant to the date of termination, and, if fixed fee, any fees shall be pro-rated to the date of termination. In the event of material breach by either party, notice of breach shall be given by the nonbreaching party. In the event such breach is not cured within 10 days of receipt of such notice, the nonbreaching party may immediately terminate this Agreement and in addition may exercise any other right or remedy provided herein or at law or in equity.

4. CHARGES

CDMI agrees to pay Consultant at the rate specified in the Consultant Agreement for the Services outlined therein. Consultant shall invoice CDMI in accordance with the Consultant Agreement and CDMI shall remit payment to Consultant within the time period specified in the Consultant Agreement. Consultant is solely responsible for paying its employees and any subcontracted personnel for Services performed under this Agreement. In no event shall CDMI be liable to Consultant's employees or subcontracted personnel for payment for any Services provided under the Consultant Agreement. CDMI is not liable to pay or reimburse any type of expense which is not listed in the Consultant Agreement unless otherwise agreed upon in writing. Consultant assumes responsibility for the timely payment of all income tax, unemployment and workers' compensation insurance, and all other employment-related taxes arising out of the performance of Services under the Consultant Agreement.

5. INDEPENDENT CONTRACTOR RELATIONSHIP

Consultant is an independent contractor, and is not an employee, servant, agent, partner, or joint venture of CDMI. CDMI shall identify and request the Services to be performed, but Consultant shall determine the

BCBSM 91132

legal means by which all Services are to be accomplished. CDMI is not responsible for withholding, and shall not withhold, FICA or any other employment-related taxes of any kind from any payments made to Consultant. Neither Consultant, its employees, nor any subcontracted personnel shall be entitled to receive any benefits which employees of CDMI are entitled to receive, nor shall Consultant, its employees or subcontracted personnel be entitled to workers' compensation, unemployment compensation, medical insurance, life insurance, paid vacations, paid holidays, pension, profit sharing or Social Security on account of Services performed under the Consultant Agreement.

6. CONFIDENTIALITY

Consultant acknowledges and agrees that in the course of performing Services hereunder, Consultant might be given or obtain access to Confidential Information of CDMI. Consultant shall not disclose, nor shall the Consultant permit it's employees or subcontractors to disclose, to any employee or subcontractor of Consultant not specifically assigned to perform Services hereunder, or to any person, entity or organization not a party to this Agreement, any such Confidential Information of CDMI.

"Confidential Information" shall for purposes of this Agreement include, without limitation, all information in any form which relates to the business, expertise and/or operations of CDMI and/or its affiliates, including, without limitation, information in any form generally understood to be trade secret, proprietary or confidential and/or that is related to its corporate strategic goals, plans, strategies, products and services, commercial and financial information, system functionality charts and descriptions, program code logic, trade secret information, and information about employees, health care providers, customers and/or business partners. "Confidential Information" shall also include any notes, analyses, cost data, compilations, studies, interpretations, or documents which contain or are based upon any Confidential Information, regardless of whether any such materials or information are specifically labeled as "confidential", and any other information in any form generally understood to be proprietary, trade secret or confidential, or which under all the circumstances ought reasonably to be treated as proprietary, trade secret or confidential. Confidential Information shall also include "Individually Identifiable Health Information" (defined below). Consultant shall not use such Confidential Information of CDMI except in furtherance of the purposes of this Agreement. All Confidential Information disclosed is provided "AS IS". Consultant shall have no rights of ownership or otherwise in any Confidential Information disclosed CDMI hereunder and all such rights are expressly reserved to CDMI and/or the rightful owner thereof. Consultant will otherwise protect the confidentiality of CDMI's Confidential Information in at least the same manner it protects the confidentiality of its own proprietary and Confidential Information of like kind.

Consultant acknowledges and agrees that in the course of performance of Consultant's obligations under this Agreement, Consultant might be given or obtain access to information which contains Individually Identifiable Health Information. For purposes of this Agreement **"Individually Identifiable Health Information"** has the same meaning as set forth in 42 U.S.C. Section 1320d, which is any information, including demographic information, collected from an individual that has been received or created by CDMI and related to the past, present or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present or future payment for the provision of health care to an individual, and identifies the individual or with respect to which there is a reasonable basis to believe that the information can be used to identify the individual.

Consultant agrees that Consultant will appropriately safeguard Individually Identifiable Health Information made available to or obtained by Consultant, its employees and/or subcontracted personnel. Furthermore, Consultant shall not use such Individually Identifiable Health Information except in furtherance of providing Services in accordance with this Agreement. In the implementation of the foregoing and without limiting the obligations of Consultant otherwise set forth in this Agreement or imposed by applicable law, Consultant agrees to comply with applicable requirements of state and federal law relating to Individually Identifiable Health Information (including, without limitation, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and regulations promulgated thereunder (e.g. 45 CFR 164, subp. E)) and with respect to any Service or other activity Consultant performs on behalf of CDMI, to the extent CDMI would be required to comply with such requirements.

In amplification and not in limitation of the provisions of this Agreement including this Section of this Agreement, Consultant agrees that Consultant will:

a. Not use or further disclose Individually Identifiable Health Information other than as permitted or required by this Agreement;

b. Not use or further disclose such information in a manner that would violate the requirements of applicable law, if done by CDMI;

c. Use appropriate safeguards to prevent use or disclosure of such information other than as provided for by this Agreement;

d. Report to CDMI any use or disclosure of such information not provided for by this Agreement of which Consultant becomes aware;

e. Ensure that any subcontracted personnel to whom Consultant provides Individually Identifiable Health Information received from CDMI or otherwise in connection with providing Services, agree to the same restrictions and conditions that apply to Consultant with respect to such information;

f. Make available Individually Identifiable Health Information in accordance with applicable law; and

g. Make Consultant's internal practices, books, and records relating to the use and disclosure of Individually Identifiable Health Information received from CDMI or otherwise in connection with providing Services available to the Secretary of the United States Health & Human Services and state regulatory authorities for purposes of determining CDMI's compliance with applicable law (in all events, Consultant shall immediately notify CDMI upon receipt by Consultant of any such request, and shall provide CDMI with copies of any such materials).

The restrictions of this Section do not apply to information, other than Individually Identifiable Health Information, that (a) is, as of the time of its disclosure, or thereafter becomes, part of the public domain through a source other than Consultant, its employees or subcontracted personnel; (b) was known to Consultant as of the time of its disclosure by CDMI to Consultant and not subject to any restrictions regarding disclosure, use or reproduction; (c) is independently developed by Consultant without reference to Confidential Information; or (d) is learned or acquired from a third party without restriction against disclosure, use or reproduction.

Consultant shall not remove from the premises of CDMI any such Confidential Information or other property of, or disclosed by, CDMI without first having obtained the prior written consent of CDMI. CDMI may present its **"Confidential Information Policy"** form (and as such Confidential Information Policy form may be revised by CDMI from time to time) to all of Consultant's employees and subcontractors who are assigned to perform Services hereunder and CDMI may require their individual signature thereon as a condition to Consultant's performance of Services.

In the event Consultant receives a subpoena or other validly issued administrative or judicial process demanding Confidential Information of or disclosed by CDMI, Consultant shall promptly notify CDMI and tender to it the defense of such demand. Unless the demand shall have been timely limited, quashed or extended, Consultant shall thereafter be entitled to comply with such demand to the extent required by law.

BCBSM 91134

Consultant agrees that upon the request of CDMI for any reason, to promptly deliver to CDMI all Confidential Information of or disclosed by CDMI, including all copies, reproductions, summaries, analyses or extracts thereof in its possession or in the possession of any of its employees or subcontracted personnel.

Consultant agrees that breach of this Section by Consultant may result in irreparable harm to CDMI for which there is no adequate remedy at law. Therefore, in addition to any and all other remedies available at law or in equity, CDMI shall be entitled to injunctive relief, specific performance or equivalent relief enjoining the breach or threatened breach of this Section. In the event of any actions brought pursuant to this Section, the prevailing party shall be entitled to be reimbursed for reasonable attorneys' fees incurred in bringing any such suit, action, or proceeding.

7. OWNERSHIP RIGHTS IN WORK PRODUCTS AND NON-COMPETE

CDMI shall have sole ownership of all intellectual property rights and other property rights in and to all materials and products excluding website pages and associated source code generated as a result of the Services contracted in the Consultant Agreement which are specifically identified as CDMI owned product in the Consultant Agreement ("work product"), and all such work product shall be left with CDMI upon completion of the contracted Services. Consultant assigns to CDMI all of Consultant's rights or potential rights to any proprietary business concepts, business methods, business processes, or business adaptations which are developed by Consultant either solely or jointly with others for CDMI during the term of the Consultant Agreement and are specifically identified as proprietary to CDMI in the Consultant Agreement. All work product shall be deemed to be "work-made-for-hire" under the United States Copyright Act, as amended; provided that if such work product does not qualify as "work-made-for-hire" under the United States Copyright Act, as amended, then Consultant irrevocably transfers, assigns and conveys all right, title and interest in the work product to CDMI.8. **INDEMNITY AND INSURANCE**

To the fullest extent permitted by law, Consultant shall indemnify, defend and hold harmless CDMI, its subsidiaries, affiliates, tenants, officers, directors, trustees agents and employees from all claims, demands, losses, damages, injuries, liabilities, expenses, judgments, liens, encumbrances, orders and awards (all of which are collectively referred to as "Claims"), together with attorneys' fees and litigation expense on account of:

1) injury to, or death of, any person, including agents, employees, subcontractors, suppliers or materialmen;
2) loss of, or damage to, property;
3) claims of subcontractors, suppliers, materialmen or workmen;
4) royalties, license fees and claims for infringement of a third party's patent, trade secret, trade mark, copyright or other intellectual property right; and
5) claims against CDMI for express or implied indemnity or contribution arising by reason of any of the above;

but only to the extent that any such Claims arise out of Consultant's performance of the Services, Consultant's breach or default of this Agreement, and/or the negligent and/or willful acts or omissions of Consultant, its employees, agents or subcontractors.

In addition to any other insurance requirements set forth in this Agreement, Consultant shall at its own cost and expense, maintain (and cause its subcontractors, if any, to maintain) the following insurance coverage's in full force and effect throughout the Term of this Agreement:

1) Commercial general liability insurance, including without limitation, coverage for bodily injury, property damage, personal injury, contractual liability (applying to this Agreement), and products-completed operations liability, having a combined single limit of not less than $1,000,000 per occurrence. Such policy shall not contain explosion, collapse and/or underground exclusions.
2) Comprehensive automobile liability insurance, including hired and non-owned vehicles, with a combined single limit of not less than $1,000,000 per occurrence.

3) Applicable workmen's compensation in statutory limits, and Employer's Liability insurance in the amount of at least $500,000 per occurrence.

4) Such other insurance which might reasonably be required from time to time by CDMI.

5) Any other insurance commonly used by Consultants for services of the type performed pursuant to the Consultant Agreement.

6) The greater of the limits shown above or in the Consulting Agreement, where they conflict, shall be applicable to the Consultant Agreement.

Consultant shall deliver to CDMI, prior to commencement of any Services hereunder, copies of policies of such insurance or certificates evidencing the existence and amounts of same with loss payable clauses satisfactory to CDMI. Such policies shall name CDMI as an additional named insured on the Commercial General Liability Insurance; the Comprehensive Automobile Liability Insurance, and Employers Liability policies. No policy shall be cancelable or subject to reduction of coverage except after thirty (30) days' prior written notice to CDMI.

Notwithstanding any other provision in this Agreement to the contrary, Consultant agrees to look solely to CDMI, its successors or assigns for the payment or performance of any of CDMI's obligations hereunder, and Consultant agrees that no trustees, officers or employees of CDMI shall be personally liable for such payment or performance.

9. AMENDMENT

This Agreement may be amended only by mutual written agreement of the parties.

10. GOVERNING LAW

The formation, interpretation and performance of this Agreement and any disputes arising out of it shall be governed by the laws of the state of Minnesota, and, to the extent applicable, the laws of the United States of America.

11. NOTICES

Every notice or other communication to be given by either party to the other with respect to this Agreement, shall be in writing and shall not be effective for any purpose unless the same be delivered personally or by United States certified mail, postage prepaid, addressed if to CDMI as follows:

Care Delivery Management, Inc.
3535 Blue Cross Road
Eagan, Minnesota 55122

Attn: Purchasing Manager

and if to Consultant at the address set forth in the Consultant Agreement; or at such other address or addresses as CDMI or Consultant, respectively, may from time to time designate by notice given as above provided.

12. WARRANTIES

Consultant warrants that (a) all Services performed hereunder will be performed in a good, professional, workmanlike, and competent manner, in conformity with all applicable professional standards and the requirements of these Terms and Conditions and the Consultant Agreement, (b) Contractor, its employees and permitted subcontractor personnel, if any, shall have and maintain the requisite technical knowledge, skills, abilities, licenses and qualifications to provide the Services, (c) Contractor will comply with all applicable local, state and federal ordinances, laws and regulations in providing the Services, and (d) all work product to be provided CDMI as a result of the Services will comply, function and perform in accordance with specifications and requirements set forth in the Consulting Agreement, if any.

13. Entire Agreement

BCBSM 91136

These Terms and Conditions and the Consultant Agreement to which they are attached and hereby made a part thereof, together with any Exhibits or Attachments to the Consultant Agreement, to the extent specifically referenced in and incorporated into the Consultant Agreement, constitute the entire "Agreement" between the parties and supercede all previous discussions, proposals and/or written or oral agreements, if any, relative to the subject matter hereof. In the event of any inconsistency between these Terms and Conditions, the Consultant Agreement, the Exhibits or Attachments, if any, these Terms and Conditions shall control.

14. Assignment

Neither party shall have the right to assign this Agreement without the prior written consent of the other party, and any attempted assignment shall be null and void; provided, however, that CDMI may without consent, assign this Agreement to any entity that, directly or indirectly, through one or more intermediaries, controls, or is controlled by, or is under common control with, CDMI.

15. Severability

If any term or provision of this Agreement should be or become invalid or prohibited under applicable law, such provision shall be ineffective to the extent of any such prohibition without impairing the remaining provisions in any way..

16. Attorney's Fees

In the event that any action, suit or other proceeding is instituted to remedy, prevent, or obtain relief from, a breach of this Agreement, or arises out of a breach of this Agreement, the prevailing party shall be entitled to recover all of such party's reasonable attorney's fees, costs and expenses incurred in connection therewith.

17. Time

Time is of the essence in the performance of this Agreement.

18. Waiver

No waiver of or to this Agreement shall be valid unless in writing and signed by the party to be charged with such waiver. No waiver of, or failure to exercise, any option, right or privilege under this Agreement by either of the parties hereto on any occasion or occasions shall be construed to be a waiver of the same or similar option, right or privilege on any other occasion.

19. Survival

No expiration or earlier termination of this Agreement shall affect the rights and obligations of the respective parties hereto which have accrued prior to the effective date of expiration or termination.

BCBSM 91137

COPY

Agreement

This Agreement dated this 1st day of June, 2002 by and between Care Delivery Management, Inc. (CDMI), and BlueCross BlueShield of Minnesota (client), sets forth the rights and responsibilities of each party as they relate to preterm birth prevention services provided by CDMI to certain BlueCross BlueShield of Minnesota enrollees.

WHEREAS, CDMI has proven expertise and experience in the area of the preterm birth risk assessment program (" Healthy Start");

WHEREAS, CDMI desires to offer and BlueCross BlueShield desires to purchase such services for the benefit of its members who participate in the BlueCross BlueShield fully insured group products offered by BlueCross BlueShield (covered persons);

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NOW, THEREFORE, the parties agree as follows:

I. Responsibilities of CDMI

A. Throughout the term of this contract, CDMI, through its designated agents, shall provide " Healthy Start" services to covered persons. The purpose of " Healthy Start" is to provide education and support to covered persons and to identify and reduce preterm birth risks. The managed care activities covered under the terms of this contract are defined in Exhibit A.

B. CDMI, through its designated agents, agrees to be available by telephone at all times between the hours of 8:00 a.m. through 4:30 p.m. CST, exclusive of weekends and holidays.

C. CDMI will immediately notify BlueCross BlueShield of any licensure limitation of its designated agents herein.

D. CDMI recognizes the right of BlueCross BlueShield to make all final payment and administrative decisions with regard to payment of claims on behalf of covered persons.

E. Upon request by BlueCross BlueShield, CDMI will provide written reports setting forth participation and outcome of " Healthy Start," along with a summary of case management activities.

F. For the purpose of "Healthy Start" services only, CDMI agrees to develop and make available to BlueCross BlueShield communication materials to publicize the program. Risk assessments, along with case management, will be coordinated by a registered nurse having expertise in obstetrical care. An incentive program will be made available to BlueCross BlueShield at the fee level listed in Exhibit B. The incentive fee includes shipping and handling charges.

II. Responsibility of BlueCross BlueShield

A. BlueCross BlueShield shall publicize and encourage covered persons to participate in the preterm birth prevention program called " Healthy Start".

III. Confidentiality of Information

All medical information and/or data concerning specific hospitals, physicians, other providers, or covered persons obtained as a result of services provided under this Agreement shall be treated as confidential by CDMI in compliance with all state and Federal laws and regulations and shall not be released or disclosed to any party other than BlueCross BlueShield.

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TRADE SECRET

IV. Indemnification

BlueCross BlueShield shall indemnify and hold CDMI and its designated agents harmless from any claim, injury, damage, or judgement including any legal and incidental expenses incurred by CDMI in connection herewith, resulting from the performance of services in accordance with this Agreement. CDMI shall indemnify and hold BlueCross BlueShield and its designated agents harmless from any claim, injury, damage or judgement caused by or resulting from the negligence of CDMI, its officers, employees, or its designated agents, resulting from the performance of services in accordance this Agreement.

V. Compensation

A. CDMI will provide the services listed in Exhibit A and such other consulting services as may be agreed to by the parties at the unit rate specified in Exhibit B. CDMI may change the unit rate specified in Exhibit B upon thirty- (30) day's prior notice to BlueCross BlueShield. Notice will be provided by submission of a new Exhibit B. The new rates will become effective thirty (30) days after the date indicated on the schedule.

B. Fees for "Healthy Start" shall be billed the first month of each month based on membership counts for the prior month.

C. All payments of fees and other amounts owed by BlueCross BlueShield are due in cash or cash equivalents to CDMI within thirty (30) days of the date of the invoice, unless otherwise specified. Overdue payment shall bear interest at the rate of the lessor of one and one half percent (1 ½%) per month or the maximum rates allowable under applicable state law.

VI. Independent Contractor

CDMI is an independent contractor for BlueCross BlueShield. CDMI will procure, through employment or contract, the human resources necessary to perform specific services listed in Exhibit A, together with such other consulting services in the area of utilization management as may be agreed to by the parties.

VII. Prohibition Against Assignment

Neither party may assign this agreement.

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VIII. Term/Termination

A. The term of this contract shall be from 6/1/02 to 05/31/03 and shall automatically renew each year thereafter unless terminated by either party hereunder.

B. Either party may terminate this contract with or without cause on thirty- (30) days written notice to the other party.

IX. Amendment

Mutual written consent of BlueCross BlueShield and CDMI shall be required to amend this Agreement.

BlueCross BlueShield		Care Delivery Management, Inc	
By:	Timothy M. Peterson	By:	
Date:	May 30, 2002	Date:	5-17-02
By:		By:	
Date:		Date:	

BlueCross BlueShield

By: _____

Date: _____

By: _____

Date: _____

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Exhibit A

Schedule of Services

CDMI will be available to provide BlueCross BlueShield pre-term birth prevention services as follows:

1. **Communication Materials:**
   - posters
   - brochures
   - stuffers
   - postcards
   - magnets
   - renewal packet notice with bounce back card and fulfillment
   - other various promotional trinkets

2. **Program Components:**
   - educational book and various materials
   - comprehensive risk assessment
   - active nurse case management of mother
   - comprehensive history evaluation
   - nurse line resource
   - resource assistance
   - monthly or more frequent follow-up with mother as needed
   - 6 week post-partum follow up with mother
   - $50.00 gift certificates for Wal-Mart or Target

3. **Promotional Activities:**
   - quarterly post card mailed to subscriber's home to gain awareness of program
   - invitation sent to subscriber based on receipt of risk assessment or other request for services

4. **Account Servicing:**
   - attend on site visits as requested by group or BlueCross BlueShield personnel
   - attend renewal meetings or other group visits as requested
   - representation at annual Agent Conferences

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Exhibit B

Schedule of Charges

Program Cost:	$.30 per member per month

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BCBSMN - Gift Certificate Program				
		Purchase Order	Monthly	Yearly
Date	Contract No.	Amount	Totals	Totals
03/06/2003	4500032248	540.00		
03/10/2003	4500032296	216.00		
03/11/2003	4500032369	10,260.00		
03/27/2003	4500032742	17,226.00	**28,242.00**	
04/04/2003	4500032876	810.00		
04/09/2003	4500032973	25,110.00		
04/21/2003	4500033217	7,290.00		
04/22/2003	4500033275	19,656.00	**52,866.00**	
05/06/2003	4500033584	1,674.00		
05/19/2003	4500033944	16,254.00		
05/21/2003	4500033986	324.00		
05/23/2003	4500034072	7,074.00	**25,326.00**	
06/10/2003	4500034407	8,154.00		
06/19/2003	4500034662	1,674.00		
06/24/2003	4500034762	3,132.00		
06/27/2003	4500034907	6,318.00	**19,278.00**	
07/15/2003	4500035242	13,230.00		
07/28/2003	4500035525	14,688.00	**27,918.00**	
08/07/2003	4500035755	594.00		
08/13/2003	4500035848	54.00		
08/20/2003	4500036037	598.00		
08/26/2003	4500036137	21,006.00	**22,252.00**	
09/04/2003	4500036275	1,080.00		
09/08/2003	4500036356	18,738.00		
09/09/2003	4500036373	432.00		
09/23/2003	4500036719	15,444.00	**35,694.00**	
10/01/2003	4500036908	756.00		
10/09/2003	4500037061	864.00		
10/17/2003	4500037289	1,134.00		
10/21/2003	4500037356	270.00		
10/22/2003	4500037394	15,930.00		
10/30/2003	4500037596	1,080.00		
10/31/2003	4500037619	11,934.00	**31,968.00**	
11/12/2003	4500037831	1,080.00		
11/12/2003	4500037834	3,842.00		
11/19/2003	4500038023	23,382.00	**28,304.00**	
12/03/2003	4500038278	1,026.00		
12/04/2003	4500038295	270.00		
12/08/2003	4500038371	16,096.00		
12/10/2003	4500038438	1,296.00		
12/17/2003	4500038576	16,270.00		
12/24/2003	4500038832	918.00		
12/31/2003	4500038927	13,038.00	**48,914.00**	**320,762.00**

BCBSMN - Gift Certificate Program				
Date	Contract No.	Purchase Order Amount	Monthly Totals	Yearly Totals
01/16/2004	4500039316	1,890.00		
01/28/2004	4500039539	25,134.00		
01/30/2004	4500039613	9,566.00	**36,590.00**	
02/11/2004	4500039811	756.00		
02/13/2004	4500039884	15,502.00		
02/19/2004	4500039979	12,170.00		
02/25/2004	4500040094	1,350.00	**29,778.00**	
03/04/2004	4500040307	16,532.00		
03/08/2004	4500040361	270.00		
03/10/2004	4500040430	54.00		
03/22/2004	4500040665	918.00		
03/24/2004	4500040750	216.00		
03/25/2004	4500040783	26,394.00		
03/31/2004	4500040908	864.00	**45,248.00**	
04/02/2004	4500040963	5,404.00		
04/13/2004	4500041147	648.00		
04/14/2004	4500041186	972.00		
04/21/2004	4500041329	20,192.00		
04/26/2004	4500041433	1,026.00		
04/29/2004	4500041505	6,912.00	**35,154.00**	
05/05/2004	4500041636	864.00		
05/10/2004	4500041699	3,024.00		
05/17/2004	4500041897	25,534.00		
05/19/2004	4500041975	6,588.00		
05/26/2004	4500042112	1,080.00	**37,090.00**	
06/02/2004	4500042208	17,994.00		
06/10/2004	4500042364	4,032.00		
06/11/2004	4500042412	108.00		
06/23/2004	4500042619	1,080.00		
06/29/2004	4500042734	918.00		
06/30/2004	4500042770	31,230.00	**55,362.00**	
07/08/2004	4500042897	162.00		
07/12/2004	4500042962	1,188.00		
07/19/2004	4500043103	1,404.00	**2,754.00**	
08/02/2004	4500043354	34,680.00		
08/04/2004	4500043418	13,068.00		
08/10/2004	4500043562	1,350.00		
08/23/2004	4500043824	6,916.00		
08/25/2004	4500043900	16,844.00	**72,858.00**	
09/03/2004	4500044122	1,970.00		
09/10/2004	4500044227	27,078.00		
09/14/2004	4500044299	1,026.00		
09/24/2004	4500044558	11,942.00		

BCBSMN - Gift Certificate Program				
		Purchase Order	Monthly	Yearly
Date	Contract No.	Amount	Totals	Totals
09/29/2004	4500044620	378.00		
09/30/2004	4500044671	54.00	**42,448.00**	
10/08/2004	4500044856	378.00		
10/12/2004	4500044917	24,790.00		
10/20/2004	4500045100	5,870.00		
10/22/2004	4500045134	324.00		
10/28/2004	4500045261	378.00		
10/29/2004	4500045303	8,856.00	**40,596.00**	
11/04/2004	4500045433	378.00		
11/10/2004	4500045592	31,984.00		
11/22/2004	4500045817	10,538.00		
11/23/2004	4500045859	3,618.00		
11/30/2004	4500045941	270.00	**46,788.00**	
12/03/2004	4500046042	432.00		
12/10/2004	4500046213	23,362.00		
12/14/2004	4500046252	494.00		
12/16/2004	4500046387	10,066.00		
12/21/2004	4500046507	486.00		
12/28/2004	4500046658	7,668.00		
12/30/2004	4500046790	4,050.00	**46,558.00**	**491,224.00**

BCBSMN - Gift Certificate Program									
					Monthly Totals				
Invoice Date	Program Name	# Provided	Amount Each	Total	Best Beginnings	Car Seat	Healthy Start	HS Loss	Target
01/08/2004	Best Beginnings	4	54.00	216.00	216.00	-	-	-	-
01/08/2004	Car Seat	71	54.00	3,834.00	-	3,834.00	-	-	-
01/08/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
01/08/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
01/08/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
01/08/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
01/08/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
01/08/2004	Target	26	54.00	1,404.00	-	-	-	-	1,404.00
01/15/2004	Best Beginnings	1	54.00	54.00	54.00	-	-	-	-
01/15/2004	Car Seat	68	54.00	3,672.00	-	3,672.00	-	-	-
01/15/2004	Healthy Start	119	54.00	6,426.00	-	-	6,426.00	-	-
01/15/2004	Healthy Start	1	54.00	54.00	-	-	54.00	-	-
01/15/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
01/15/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
01/15/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
01/15/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
01/15/2004	Target	21	54.00	1,134.00	-	-	-	-	1,134.00
01/22/2004	Best Beginnings	4	54.00	216.00	216.00	-	-	-	-
01/22/2004	Car Seat	48	54.00	2,592.00	-	2,592.00	-	-	-
01/22/2004	Healthy Start	105	54.00	5,670.00	-	-	5,670.00	-	-
01/22/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
01/22/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
01/22/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
01/22/2004	Target	24	54.00	1,296.00	-	-	-	-	1,296.00
01/29/2004	Best Beginnings	1	54.00	54.00	54.00	-	-	-	-
01/29/2004	Car Seat	47	54.00	2,538.00	-	2,538.00	-	-	-
01/29/2004	Healthy Start	99	54.00	5,346.00	-	-	5,346.00	-	-
01/29/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
01/29/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
01/29/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
01/29/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
01/29/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
01/29/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
01/29/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
01/29/2004	Target	19	54.00	1,026.00	-	-	-	-	1,026.00
				36,558.00	**540.00**	**12,636.00**	**17,496.00**	**1,026.00**	**4,860.00**
02/05/2004	Best Beginnings	2	54.00	108.00	108.00	-	-	-	-
02/05/2004	Car Seat	51	54.00	2,754.00	-	2,754.00	-	-	-
02/05/2004	Healthy Start	93	54.00	5,022.00	-	-	5,022.00	-	-

BCBS...N - Gift Certificate Program									
					Monthly Totals				
Invoice Date	Program Name	# Provided	Amount Each	Total	Best Beginnings	Car Seat	Healthy Start	HS Loss	Target
02/05/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
02/05/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
02/05/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
02/05/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
02/05/2004	Target	29	54.00	1,566.00	-	-	-	-	1,566.00
02/12/2004	Best Beginnings	4	54.00	216.00	216.00	-	-	-	-
02/12/2004	Car Seat	43	54.00	2,322.00	-	2,322.00	-	-	-
02/12/2004	Healthy Start	113	54.00	6,102.00	-	-	6,102.00	-	-
02/12/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
02/12/2004	Target	13	54.00	702.00	-	-	-	-	702.00
02/19/2004	Best Beginnings	1	54.00	54.00	54.00	-	-	-	-
02/19/2004	Car Seat	42	54.00	2,268.00	-	2,268.00	-	-	-
02/19/2004	Healthy Start	88	54.00	4,752.00	-	-	4,752.00	-	-
02/19/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
02/19/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
02/19/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
02/19/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
02/19/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
02/19/2004	Target	18	54.00	972.00	-	-	-	-	972.00
02/26/2004	Best Beginnings	2	54.00	108.00	108.00	-	-	-	-
02/26/2004	Healthy Start	104	54.00	5,616.00	-	-	5,616.00	-	-
02/26/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
02/26/2004	Target	21	54.00	1,134.00	-	-	-	-	1,134.00
02/27/2004	Car Seat	48	54.00	2,592.00	-	2,592.00	-	-	-
03/02/2004	Car Seat	46	54.00	2,484.00	-	2,484.00	-	-	-
				39,366.00	**486.00**	**12,420.00**	**21,492.00**	**594.00**	**4,374.00**
03/04/2004	Best Beginnings	2	54.00	108.00	108.00	-	-	-	-
03/04/2004	Car Seat	69	54.00	3,726.00	-	3,726.00	-	-	-
03/04/2004	Healthy Start	103	54.00	5,562.00	-	-	5,562.00	-	-
03/04/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
03/04/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
03/04/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
03/04/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
03/04/2004	Target	22	54.00	1,188.00	-	-	-	-	1,188.00
03/11/2004	Best Beginnings	2	54.00	108.00	108.00	-	-	-	-
03/11/2004	Healthy Start	113	54.00	6,102.00	-	-	6,102.00	-	-
03/11/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
03/11/2004	Target	14	54.00	756.00	-	-	-	-	756.00
03/18/2004	Best Beginnings	3	54.00	162.00	162.00	-	-	-	-
03/18/2004	Car Seat	42	54.00	2,268.00	-	2,268.00	-	-	-

BCBSMN - Gift Certificate Program									
					Monthly Totals				
Invoice Date	Program Name	# Provided	Amount Each	Total	Best Beginnings	Car Seat	Healthy Start	HS Loss	Target
03/18/2004	Healthy Start	115	54.00	6,210.00	-	-	6,210.00	-	-
03/18/2004	Healthy Start	1	54.00	54.00	-	-	54.00	-	-
03/18/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
03/18/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
03/18/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
03/18/2004	Target	21	54.00	1,134.00	-	-	-	-	1,134.00
03/25/2004	Best Beginnings	3	54.00	162.00	162.00	-	-	-	-
03/25/2004	Car Seat	37	54.00	1,998.00	-	1,998.00	-	-	-
03/25/2004	Healthy Start	100	54.00	5,400.00	-	-	5,400.00	-	-
03/25/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
03/25/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
03/25/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
03/25/2004	Target	13	54.00	702.00	-	-	-	-	702.00
				36,234.00	**540.00**	**7,992.00**	**23,328.00**	**594.00**	**3,780.00**
04/01/2004	Best Beginnings	3	54.00	162.00	162.00	-	-	-	-
04/01/2004	Car Seat	29	54.00	1,566.00	-	1,566.00	-	-	-
04/01/2004	Healthy Start	99	54.00	5,346.00	-	-	5,346.00	-	-
04/01/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
04/01/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
04/01/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
04/01/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
04/01/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
04/01/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
04/01/2004	Target	20	54.00	1,080.00	-	-	-	-	1,080.00
04/08/2004	Best Beginnings	1	54.00	54.00	54.00	-	-	-	-
04/08/2004	Car Seat	31	54.00	1,674.00	-	1,674.00	-	-	-
04/08/2004	Healthy Start	1	54.00	54.00	-	-	54.00	-	-
04/08/2004	Healthy Start	79	54.00	4,266.00	-	-	4,266.00	-	-
04/08/2004	Healthy Start	1	54.00	54.00	-	-	54.00	-	-
04/08/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
04/08/2004	Target	16	54.00	864.00	-	-	-	-	864.00
04/15/2004	Best Beginnings	6	54.00	324.00	324.00	-	-	-	-
04/15/2004	Car Seat	43	54.00	2,322.00	-	2,322.00	-	-	-
04/15/2004	Healthy Start	85	54.00	4,590.00	-	-	4,590.00	-	-
04/15/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
04/15/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
04/15/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
04/15/2004	Target	10	54.00	540.00	-	-	-	-	540.00
04/22/2004	Best Beginnings	4	54.00	216.00	216.00	-	-	-	-
04/22/2004	Car Seat	48	54.00	2,592.00	-	2,592.00	-	-	-

BCBSMN - Gift Certificate Program									
					Monthly Totals				
Invoice Date	Program Name	# Provided	Amount Each	Total	Best Beginnings	Car Seat	Healthy Start	HS Loss	Target
04/22/2004	Healthy Start	110	54.00	5,940.00	-	-	5,940.00	-	-
04/22/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
04/22/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
04/22/2004	Target	23	54.00	1,242.00	-	-	-	-	1,242.00
04/29/2004	Best Beginnings	6	54.00	324.00	324.00	-	-	-	-
04/29/2004	Car Seat	55	54.00	2,970.00	-	2,970.00	-	-	-
04/29/2004	Healthy Start	124	54.00	6,696.00	-	-	6,696.00	-	-
04/29/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
04/29/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
04/29/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
04/29/2004	Target	21	54.00	1,134.00	-	-	-	-	1,134.00
				44,820.00	**1,080.00**	**11,124.00**	**26,946.00**	**810.00**	**4,860.00**
05/06/2004	Best Beginnings	8	54.00	432.00	432.00	-	-	-	-
05/06/2004	Car Seat	16	54.00	864.00	-	864.00	-	-	-
05/06/2004	Healthy Start	90	54.00	4,860.00	-	-	4,860.00	-	-
05/06/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
05/06/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
05/06/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
05/06/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
05/06/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
05/06/2004	Target	19	54.00	1,026.00	-	-	-	-	1,026.00
05/13/2004	Best Beginnings	1	54.00	54.00	54.00	-	-	-	-
05/13/2004	Car Seat	39	54.00	2,106.00	-	2,106.00	-	-	-
05/13/2004	Healthy Start	111	54.00	5,994.00	-	-	5,994.00	-	-
05/13/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
05/13/2004	Target	24	54.00	1,296.00	-	-	-	-	1,296.00
05/20/2004	Best Beginnings	3	54.00	162.00	162.00	-	-	-	-
05/20/2004	Car Seat	49	54.00	2,646.00	-	2,646.00	-	-	-
05/20/2004	Healthy Start	92	54.00	4,968.00	-	-	4,968.00	-	-
05/20/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
05/20/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
05/20/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
05/20/2004	Target	18	54.00	972.00	-	-	-	-	972.00
05/27/2004	Best Beginnings	1	54.00	54.00	54.00	-	-	-	-
05/27/2004	Car Seat	40	54.00	2,160.00	-	2,160.00	-	-	-
05/27/2004	Healthy Start	117	54.00	6,318.00	-	-	6,318.00	-	-
05/27/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
05/27/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
05/27/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
05/27/2004	Target	8	54.00	432.00	-	-	-	-	432.00

BCBSMN - Gift Certificate Program									
					Monthly Totals				
Invoice Date	Program Name	# Provided	Amount Each	Total	Best Beginnings	Car Seat	Healthy Start	HS Loss	Target
				34,992.00	702.00	7,776.00	22,140.00	648.00	3,726.00
06/03/2004	Best Beginnings	2	54.00	108.00	108.00	-	-	-	-
06/03/2004	Car Seat	19	54.00	1,026.00	-	1,026.00	-	-	-
06/03/2004	Healthy Start	61	54.00	3,294.00	-	-	3,294.00	-	-
06/03/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
06/03/2004	Target	10	54.00	540.00	-	-	-	-	540.00
06/07/2004	Car Seat	2	54.00	108.00	-	108.00	-	-	-
06/10/2004	Best Beginnings	4	54.00	216.00	216.00	-	-	-	-
06/10/2004	Car Seat	50	54.00	2,700.00	-	2,700.00	-	-	-
06/10/2004	Healthy Start	112	54.00	6,048.00	-	-	6,048.00	-	-
06/10/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
06/10/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
06/10/2004	Target	21	54.00	1,134.00	-	-	-	-	1,134.00
06/17/2004	Best Beginnings	2	54.00	108.00	108.00	-	-	-	-
06/17/2004	Car Seat	45	54.00	2,430.00	-	2,430.00	-	-	-
06/17/2004	Healthy Start	95	54.00	5,130.00	-	-	5,130.00	-	-
06/17/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
06/17/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
06/17/2004	Target	14	54.00	756.00	-	-	-	-	756.00
06/24/2004	Best Beginnings	4	54.00	216.00	216.00	-	-	-	-
06/24/2004	Car Seat	40	54.00	2,160.00	-	2,160.00	-	-	-
06/24/2004	Healthy Start	103	54.00	5,562.00	-	-	5,562.00	-	-
06/24/2004	Target	13	54.00	702.00	-	-	-	-	702.00
				32,508.00	648.00	8,424.00	20,034.00	270.00	3,132.00
07/01/2004	Best Beginnings	5	54.00	270.00	270.00	-	-	-	-
07/01/2004	Car Seat	32	54.00	1,728.00	-	1,728.00	-	-	-
07/01/2004	Healthy Start	119	54.00	6,426.00	-	-	6,426.00	-	-
07/01/2004	Healthy Start	1	54.00	54.00	-	-	54.00	-	-
07/01/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
07/01/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
07/01/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
07/01/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
07/01/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
07/01/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
07/01/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
07/01/2004	Target	22	54.00	1,188.00	-	-	-	-	1,188.00
07/08/2004	Best Beginnings	6	54.00	324.00	324.00	-	-	-	-
07/08/2004	Car Seat	44	54.00	2,376.00	-	2,376.00	-	-	-
07/08/2004	Healthy Start	80	54.00	4,320.00	-	-	4,320.00	-	-

BCBSMN - Gift Certificate Program									
					Monthly Totals				
Invoice Date	Program Name	# Provided	Amount Each	Total	Best Beginnings	Car Seat	Healthy Start	HS Loss	Target
07/08/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
07/08/2004	Target	9	54.00	486.00	-	-	-	-	486.00
07/15/2004	Best Beginnings	9	54.00	486.00	486.00	-	-	-	-
07/15/2004	Car Seat	46	54.00	2,484.00	-	2,484.00	-	-	-
07/15/2004	Healthy Start	101	54.00	5,454.00	-	-	5,454.00	-	-
07/15/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
07/15/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
07/15/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
07/15/2004	Target	10	54.00	540.00	-	-	-	-	540.00
07/22/2004	Best Beginnings	4	54.00	216.00	216.00	-	-	-	-
07/22/2004	Car Seat	60	54.00	3,240.00	-	3,240.00	-	-	-
07/22/2004	Healthy Start	131	54.00	7,074.00	-	-	7,074.00	-	-
07/22/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
07/22/2004	Target	22	54.00	1,188.00	-	-	-	-	1,188.00
07/29/2004	Best Beginnings	3	54.00	162.00	162.00	-	-	-	-
07/29/2004	Car Seat	93	54.00	5,022.00	-	5,022.00	-	-	-
07/29/2004	Healthy Start	125	54.00	6,750.00	-	-	6,750.00	-	-
07/29/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
07/29/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
07/29/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
07/29/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
07/29/2004	Target	17	54.00	918.00	-	-	-	-	918.00
				51,570.00	**1,458.00**	**14,850.00**	**30,078.00**	**864.00**	**4,320.00**
08/05/2004	Best Beginnings	2	54.00	108.00	108.00	-	-	-	-
08/05/2004	Car Seat	34	54.00	1,836.00	-	1,836.00	-	-	-
08/05/2004	Healthy Start	64	54.00	3,456.00	-	-	3,456.00	-	-
08/05/2004	Healthy Start	1	54.00	54.00	-	-	54.00	-	-
08/05/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
08/05/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
08/05/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
08/05/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
08/05/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
08/05/2004	Target	17	54.00	918.00	-	-	-	-	918.00
08/12/2004	Best Beginnings	6	54.00	324.00	324.00	-	-	-	-
08/12/2004	Car Seat	85	54.00	4,590.00	-	4,590.00	-	-	-
08/12/2004	Healthy Start	153	54.00	8,262.00	-	-	8,262.00	-	-
08/12/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
08/12/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
08/12/2004	Target	30	54.00	1,620.00	-	-	-	-	1,620.00
08/19/2004	Best Beginnings	5	54.00	270.00	270.00	-	-	-	-

BCBSMN - Gift Certificate Program									
					Monthly Totals				
Invoice Date	Program Name	# Provided	Amount Each	Total	Best Beginnings	Car Seat	Healthy Start	HS Loss	Target
08/19/2004	Car Seat	55	54.00	2,970.00	-	2,970.00	-	-	-
08/19/2004	Healthy Start	117	54.00	6,318.00	-	-	6,318.00	-	-
08/19/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
08/19/2004	Target	25	54.00	1,350.00	-	-	-	-	1,350.00
08/26/2004	Car Seat	15	54.00	810.00	-	810.00	-	-	-
08/26/2004	Healthy Start	98	54.00	5,292.00	-	-	5,292.00	-	-
08/26/2004	Healthy Start	1	54.00	54.00	-	-	54.00	-	-
08/26/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
08/26/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
08/26/2004	Target	17	54.00	918.00	-	-	-	-	918.00
				39,690.00	**702.00**	**10,206.00**	**23,436.00**	**540.00**	**4,806.00**
09/02/2004	Best Beginnings	6	54.00	324.00	324.00	-	-	-	-
09/02/2004	Car Seat	46	54.00	2,484.00	-	2,484.00	-	-	-
09/02/2004	Healthy Start	119	54.00	6,426.00	-	-	6,426.00	-	-
09/02/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
09/02/2004	Target	22	54.00	1,188.00	-	-	-	-	1,188.00
09/09/2004	Best Beginnings	2	54.00	108.00	108.00	-	-	-	-
09/09/2004	Car Seat	46	54.00	2,484.00	-	2,484.00	-	-	-
09/09/2004	Healthy Start	97	54.00	5,238.00	-	-	5,238.00	-	-
09/09/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
09/09/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
09/09/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
09/09/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
09/09/2004	Target	15	54.00	810.00	-	-	-	-	810.00
09/16/2004	Best Beginnings	4	54.00	216.00	216.00	-	-	-	-
09/16/2004	Car Seat	48	54.00	2,592.00	-	2,592.00	-	-	-
09/16/2004	Healthy Start	1	54.00	54.00	-	-	54.00	-	-
09/16/2004	Healthy Start	117	54.00	6,318.00	-	-	6,318.00	-	-
09/16/2004	Target	23	54.00	1,242.00	-	-	-	-	1,242.00
09/23/2004	Best Beginnings	5	54.00	270.00	270.00	-	-	-	-
09/23/2004	Car Seat	50	54.00	2,700.00	-	2,700.00	-	-	-
09/23/2004	Healthy Start	125	54.00	6,750.00	-	-	6,750.00	-	-
09/23/2004	Healthy Start	1	54.00	54.00	-	-	54.00	-	-
09/23/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
09/23/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
09/23/2004	Target	19	54.00	1,026.00	-	-	-	-	1,026.00
09/30/2004	Best Beginnings	4	54.00	216.00	216.00	-	-	-	-
09/30/2004	Car Seat	39	54.00	2,106.00	-	2,106.00	-	-	-
09/30/2004	Healthy Start	122	54.00	6,588.00	-	-	6,588.00	-	-
09/30/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-

BCBSMN - Gift Certificate Program									
					Monthly Totals				
Invoice Date	Program Name	# Provided	Amount Each	Total	Best Beginnings	Car Seat	Healthy Start	HS Loss	Target
09/30/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
09/30/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
09/30/2004	Target	26	54.00	1,404.00	-	-	-	-	1,404.00
				51,138.00	**1,134.00**	**12,366.00**	**31,428.00**	**540.00**	**5,670.00**
10/07/2004	Best Beginnings	4	54.00	216.00	216.00	-	-	-	-
10/07/2004	Car Seat	36	54.00	1,944.00	-	1,944.00	-	-	-
10/07/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
10/07/2004	Target	27	54.00	1,458.00	-	-	-	-	1,458.00
10/14/2004	Best Beginnings	3	54.00	162.00	162.00	-	-	-	-
10/14/2004	Car Seat	64	54.00	3,456.00	-	3,456.00	-	-	-
10/14/2004	Healthy Start	119	54.00	6,426.00	-	-	6,426.00	-	-
10/14/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
10/14/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
10/14/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
10/14/2004	Target	20	54.00	1,080.00	-	-	-	-	1,080.00
10/21/2004	Best Beginnings	2	54.00	108.00	108.00	-	-	-	-
10/21/2004	Car Seat	53	54.00	2,862.00	-	2,862.00	-	-	-
10/21/2004	Healthy Start	128	54.00	6,912.00	-	-	6,912.00	-	-
10/21/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
10/21/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
10/21/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
10/21/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
10/21/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
10/21/2004	Target	27	54.00	1,458.00	-	-	-	-	1,458.00
10/28/2004	Best Beginnings	5	54.00	270.00	270.00	-	-	-	-
10/28/2004	Car Seat	35	54.00	1,890.00	-	1,890.00	-	-	-
10/28/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
10/28/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
10/28/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
10/28/2004	Target	21	54.00	1,134.00	-	-	-	-	1,134.00
				30,024.00	**756.00**	**10,152.00**	**13,338.00**	**648.00**	**5,130.00**
11/04/2004	Car Seat	33	54.00	1,782.00	-	1,782.00	-	-	-
11/04/2004	Healthy Start	1	54.00	54.00	-	-	54.00	-	-
11/04/2004	Healthy Start	109	54.00	5,886.00	-	-	5,886.00	-	-
11/04/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
11/04/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
11/04/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
11/04/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
11/04/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-

BCB...N - Gift Certificate Program									
					Monthly Totals				
Invoice Date	Program Name	# Provided	Amount Each	Total	Best Beginnings	Car Seat	Healthy Start	HS Loss	Target
11/04/2004	Target	26	54.00	1,404.00	-	-	-	-	1,404.00
11/11/2004	Best Beginnings	2	54.00	108.00	108.00	-	-	-	-
11/11/2004	Car Seat	55	54.00	2,970.00	-	2,970.00	-	-	-
11/11/2004	Healthy Start	109	54.00	5,886.00	-	-	5,886.00	-	-
11/11/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
11/11/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
11/11/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
11/11/2004	Target	26	54.00	1,404.00	-	-	-	-	1,404.00
11/18/2004	Best Beginnings	6	54.00	324.00	324.00	-	-	-	-
11/18/2004	Car Seat	39	54.00	2,106.00	-	2,106.00	-	-	-
11/18/2004	Healthy Start	107	54.00	5,778.00	-	-	5,778.00	-	-
11/18/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
11/18/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
11/18/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
11/18/2004	Target	22	54.00	1,188.00	-	-	-	-	1,188.00
11/29/2004	Best Beginnings	2	54.00	108.00	108.00	-	-	-	-
11/29/2004	Car Seat	21	54.00	1,134.00	-	1,134.00	-	-	-
11/29/2004	Healthy Start	1	54.00	54.00	-	-	54.00	-	-
11/29/2004	Healthy Start	150	54.00	8,100.00	-	-	8,100.00	-	-
11/29/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
11/29/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
11/30/2004	Target	22	54.00	1,188.00	-	-	-	-	1,188.00
				40,176.00	**540.00**	**7,992.00**	**25,758.00**	**702.00**	**5,184.00**
12/02/2004	Best Beginnings	2	54.00	108.00	108.00	-	-	-	-
12/02/2004	Car Seat	38	54.00	2,052.00	-	2,052.00	-	-	-
12/02/2004	Healthy Start	74	54.00	3,996.00	-	-	3,996.00	-	-
12/02/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
12/02/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
12/02/2004	Target	15	54.00	810.00	-	-	-	-	810.00
12/09/2004	Best Beginnings	1	54.00	54.00	54.00	-	-	-	-
12/09/2004	Car Seat	1	54.00	54.00	-	54.00	-	-	-
12/09/2004	Car Seat	45	54.00	2,430.00	-	2,430.00	-	-	-
12/09/2004	Healthy Start	118	54.00	6,372.00	-	-	6,372.00	-	-
12/09/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
12/09/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
12/09/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
12/09/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
12/09/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
12/09/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
12/09/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-

BCBSMN - Gift Certificate Program									
					Monthly Totals				
Invoice Date	Program Name	# Provided	Amount Each	Total	Best Beginnings	Car Seat	Healthy Start	HS Loss	Target
12/09/2004	Target	22	54.00	1,188.00	-	-	-	-	1,188.00
12/16/2004	Best Beginnings	5	54.00	270.00	270.00	-	-	-	-
12/16/2004	Healthy Start	118	54.00	6,372.00	-	-	6,372.00	-	-
12/16/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
12/16/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
12/16/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
12/16/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
12/16/2004	Target	24	54.00	1,296.00	-	-	-	-	1,296.00
12/20/2004	Car Seat	46	54.00	2,484.00	-	2,484.00	-	-	-
12/23/2004	Car Seat	41	54.00	2,214.00	-	2,214.00	-	-	-
12/23/2004	Healthy Start	134	54.00	7,236.00	-	-	7,236.00	-	-
12/23/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
12/23/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
12/23/2004	HS Loss	1	54.00	54.00	-	-	-	54.00	-
12/23/2004	Target	31	54.00	1,674.00	-	-	-	-	1,674.00
12/30/2004	Best Beginnings	3	54.00	162.00	162.00	-	-	-	-
12/30/2004	Car Seat	21	54.00	1,134.00	-	1,134.00	-	-	-
12/30/2004	Healthy Start	72	54.00	3,888.00	-	-	3,888.00	-	-
12/30/2004	Target	9	54.00	486.00	-	-	-	-	486.00
				45,144.00	**594.00**	**10,368.00**	**27,864.00**	**864.00**	**5,454.00**
		2004 TOTALS		**482,220.00**	**9,180.00**	**126,306.00**	**283,338.00**	**8,100.00**	**55,296.00**

BCBSMN - Gift Certificate Program									
					Monthly Totals				
Invoice Date	Program Name	# Provided	Amount Each	Total	Best Beginnings	Car Seat	Healthy Start	HS Loss	Target
01/06/2005	Best Beginnings	3	54.00	162.00	162.00	-	-	-	-
01/06/2005	Car Seat	25	54.00	1,350.00	-	1,350.00	-	-	-
01/06/2005	Healthy Start	90	54.00	4,860.00	-	-	4,860.00	-	-
01/06/2005	HS Loss	1	54.00	54.00	-	-	-	54.00	-
01/06/2005	HS Loss	1	54.00	54.00	-	-	-	54.00	-
01/06/2005	Target	16	54.00	864.00	-	-	-	-	864.00
01/08/2005	Healthy Start	173	54.00	9,342.00	-	-	9,342.00	-	-
01/13/2005	Best Beginnings	3	54.00	162.00	162.00	-	-	-	-
01/13/2005	Car Seat	50	54.00	2,700.00	-	2,700.00	-	-	-
01/13/2005	Healthy Start	134	54.00	7,236.00	-	-	7,236.00	-	-
01/13/2005	HS Loss	1	54.00	54.00	-	-	-	54.00	-
01/13/2005	HS Loss	1	54.00	54.00	-	-	-	54.00	-
01/13/2005	HS Loss	1	54.00	54.00	-	-	-	54.00	-
01/13/2005	HS Loss	1	54.00	54.00	-	-	-	54.00	-
01/13/2005	HS Loss	1	54.00	54.00	-	-	-	54.00	-
01/13/2005	HS Loss	1	54.00	54.00	-	-	-	54.00	-
01/13/2005	Target	25	54.00	1,350.00	-	-	-	-	1,350.00
01/20/2005	Best Beginnings	6	54.00	324.00	324.00	-	-	-	-
01/20/2005	Car Seat	40	54.00	2,160.00	-	2,160.00	-	-	-
01/20/2005	HS Loss	1	54.00	54.00	-	-	-	54.00	-
01/20/2005	HS Loss	1	54.00	54.00	-	-	-	54.00	-
01/20/2005	HS Loss	1	54.00	54.00	-	-	-	54.00	-
01/20/2005	Target	33	54.00	1,782.00	-	-	-	-	1,782.00
01/27/2005	Best Beginnings	4	54.00	216.00	216.00	-	-	-	-
01/27/2005	HS Loss	1	54.00	54.00	-	-	-	54.00	-
01/27/2005	HS Loss	1	54.00	54.00	-	-	-	54.00	-
01/27/2005	Target	17	54.00	918.00	-	-	-	-	918.00
				34,128.00	**864.00**	**6,210.00**	**21,438.00**	**702.00**	**4,914.00**
04/22/2005	HS Loss	1	54.00	54.00	-	-	-	54.00	-
				54.00	-	-	-	**54.00**	-
		2005 TOTALS		**34,182.00**	**864.00**	**6,210.00**	**21,438.00**	**756.00**	**4,914.00**

About Blue Cross

Blue Cross and Blue Shield of Minnesota, chartered in 1933, was one of the state's first health plans. Its founding mission was to promote a wider, more economical and timely availability of health services for the people of Minnesota. We've remained true to that mission for more than 70 years.

Membership

Blue Cross is the largest health plan in Minnesota, providing health care coverage to more than 2.6 million members, more than 1.7 million living in Minnesota. Blue Cross has achieved record enrollment each of the past five years, adding nearly 400,000 members since the beginning of 2001 from such new accounts as General Mills/Pillsbury, Northwest Airlines, Target, organized labor groups, and a variety of other organizations. Blue Cross also serves as a health care safety net for more than 126,000 Minnesotans enrolled in government-sponsored programs, more than 172,000 individual members through its Medicare supplement programs, and another 140,000 Medicare members carried through employment groups. In addition, Blue Cross covers employees of more than 315 public schools and around 345 city, county and other government agencies.

Financial stability

A not-for-profit, taxable organization, Blue Cross and its affiliates — under the parent corporation Aware Integrated Inc. — had total gross revenues in 2004 of more than $6.6 billion. More than 88 percent of health care premiums it received were paid back out for health care claims. In addition, Blue Cross and its affiliates paid more than $106.8 million in 2004 in taxes and assessments.

Network strength and service

Blue Cross offers its customers access to 96 percent of health care providers statewide. It's the only Minnesota health plan with true statewide coverage and access to providers in all areas of the state. The National Committee for Quality Assurance has awarded its highest accreditation status, for service and clinical quality, to the three main components of Blue Cross' managed care business. Headquartered in the St. Paul suburb of Eagan, Blue Cross and Blue Shield of Minnesota has more than 4,000 full-time employees. In addition to its Eagan headquarters, Blue Cross operates district offices throughout rural Minnesota and runs business operations centers in Virginia and Aurora, Minnesota. Blue Cross and Blue Shield of Minnesota and its licensed affiliates are independent licensees of the Blue Cross and Blue Shield Association in Chicago.

Health improvement

Blue Cross empowers people to improve their health through its relationships with providers, benefit designs that cover preventive services, and care management efforts. Blue Cross focuses extensive efforts on three areas: tobacco reduction, influenza prevention, and heart disease prevention and management. Additional initiatives include Blue Cross' groundbreaking care support programs for chronic conditions and diseases, as well as programs for healthy pregnancies and births, diabetes, hypertension, and mammography, plus nurse phone lines, and health education/consumer information.

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BlueLink TPA

A full-service provider of third-party administrative services for self-funded companies located in Minnesota.

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A state-regulated, traditional health maintenance organization (HMO) that offers health plans and care networks throughout Minnesota, conducts research and promotes quality improvement.

Care Delivery Management Inc.

Offers a variety of care management services, such as the Healthy Start® program, which encourages better health and care for new mothers and their babies.

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A Minnesota stock insurance corporation authorized to write life insurance in Minnesota.

Downloads and Documents

2004 annual financial statement (PDF)

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Part II Balance Sheets Attached schedules and amounts in the description column should be for end-of-year amounts only. (See instructions.)

		Beginning of year	End of year	
		(a) Book Value	(b) Book Value	(c) Fair Market Value
Assets	1 Cash—non-interest-bearing	1,991,321	375,745	375,745
	2 Savings and temporary cash investments	0	0	0
	3 Accounts receivable ► 0			
	Less: allowance for doubtful accounts ► 0	0	0	0
	4 Pledges receivable ► 0			
	Less: allowance for doubtful accounts ► 0	11,202,092	0	0
	5 Grants receivable	0	0	0
	6 Receivables due from officers, directors, trustees, and other disqualified persons (attach schedule) (see page 15 of the instructions)	0	0	0
	7 Other notes and loans receivable (attach schedule) ► 0			
	Less: allowance for doubtful accounts ► 0	0	0	0
	8 Inventories for sale or use	0	0	0
	9 Prepaid expenses and deferred charges	0	0	0
	10 a Investments—U.S. and state government obligations (attach schedule)	12,448,160	18,229,948	18,229,948
	b Investments—corporate stock (attach schedule)	21,008,076	33,105,930	33,105,930
	c Investments—corporate bonds (attach schedule)	0	0	0
	11 Investments—land, buildings, and equipment: basis ► 0			
	Less: accumulated depreciation (attach schedule) ► 0	0	0	0
	12 Investments—mortgage loans	0	0	0
	13 Investments—other (attach schedule)	0	0	0
	14 Land, buildings, and equipment: basis ► 0			
	Less: accumulated depreciation (attach schedule) ► 0	0	0	0
	15 Other assets (describe ► See statement attached)	188,883	336,687	336,687
	16 **Total assets** (to be completed by all filers—see page 16 of the instructions. Also, see page 1, item I)	46,838,532	52,048,310	52,048,310
Liabilities	17 Accounts payable and accrued expenses	953,104	597,471	
	18 Grants payable	0	0	
	19 Deferred revenue	0	0	
	20 Loans from officers, directors, trustees, and other disqualified persons	0	0	
	21 Mortgages and other notes payable (attach schedule)	0	0	
	22 Other liabilities (describe ►Deferred tax liability)	19,500	55,200	
	23 **Total liabilities** (add lines 17 through 22)	972,604	652,671	
Net Assets or Fund Balances	**Organizations that follow SFAS 117, check here ►☐ and complete lines 24 through 26 and lines 30 and 31.**			
	24 Unrestricted	0	0	
	25 Temporarily restricted	0	0	
	26 Permanently restricted	0	0	
	Organizations that do not follow SFAS 117, check here ►☐ and complete lines 27 through 31.			
	27 Capital stock, trust principal, or current funds	0	0	
	28 Paid-in or capital surplus, or land, bldg., and equipment fund	0	0	
	29 Retained earnings, accumulated income, endowment, or other funds	45,865,928	51,395,639	
	30 **Total net assets or fund balances** (see page 17 of the instructions)	45,865,928	51,395,639	
	31 **Total liabilities and net assets/fund balances** (see page 17 of the instructions)	46,838,532	52,048,310	

Part III Analysis of Changes in Net Assets or Fund Balances

1	Total net assets or fund balances at beginning of year—Part II, column (a), line 30 (must agree with end-of-year figure reported on prior year's return)	1	45,865,928
2	Enter amount from Part I, line 27a	2	3,477,744
3	Other increases not included in line 2 (itemize) ► Unrealized gain on investments	3	2,051,967
4	Add lines 1, 2, and 3	4	51,395,639
5	Decreases not included in line 2 (itemize) ► N/A	5	0
6	Total net assets or fund balances at end of year (line 4 minus line 5)—Part II, column (b), line 30	6	51,395,639

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Form **990-PF**

Department of the Treasury
Internal Revenue Service

Return of Private Foundation

or Section 4947(a)(1) Nonexempt Charitable Trust
Treated as a Private Foundation

Note: The organization may be able to use a copy of this return to satisfy state reporting requirements.

Rec'd $25.00

OMB No. 1545-0052

2000

For the calendar year 2000, or tax year beginning , and ending

G Check all that apply: [ ] Initial return [ ] Final return [ ] Amended return [ ] Address change [ ] Name change

Use the IRS label. Otherwise, please print or type.	Name of organization BCBSM FOUNDATION, INC.		A Employer identification number 36-3525653
	Number and street (or P.O. box number if mail is not delivered to street address) 3535 BLUE CROSS ROAD	Room/suite	B Telephone number (see page 9 of the instr.)
	City or town ST. PAUL	State MN	Zip + 4 55122

C If exemption application is pending, check here [ ]

D 1. Foreign organizations, check here [ ]
2. Organizations meeting the 85% test, check [ ]

E If private foundation status was terminated under section 507(b)(1)(A), check here [ ]

F If the foundation is in a 60-month termination under section 507(b)(1)(B), check here [ ]

H Check organization: [X] Section 501(c)(3) exempt private foundation
[ ] Section 4947(a)(1) nonexempt charitable trust [ ] Other taxable private foundation

I Fair market value of all assets at end of year (from Part II, column (c), line 16) 33,002,088

J Accounting method: [ ] Cash [X] Accrual [ ] Other (specify) _____
(Part I, col. (d) must be on cash basis.)

Part I Analysis of Revenue and Expenses (The total of amounts in columns (b), (c), and (d) may not necessarily equal the amounts in column (a).)		(a) Revenue and expenses per books	(b) Net investment income	(c) Adjusted net income	(d) Disbursements for charitable purposes (cash basis only)
Revenue	1 Contributions, gifts, grants, etc., received	752,000			
	2 Distributions from split-interest trusts				
	3 Interest on savings and temporary cash investments	64,691	64,691		
	4 Dividends and interest from securities	1,622,941	1,622,941		
	5a Gross rents				
	b (Net rental income/loss _____)				
	6a Net gain or (loss) from sale of assets not on line 10	-23,603			
	b G.S.P for assets on 6a				
	7 Capital gain net income (Part IV, line 2)		0		
	8 Net short-term capital gain			0	
	9 Income modifications				
	10a Gross sales less returns				
	b Less: C.O.G.S.				
	c Gross profit or (loss) (attach schedule)				
	11 Other income (attach schedule)				
	12 Total. Add lines 1 through 11	2,416,029	1,687,632	0	
Expenses	13 Compensation of officers, directors, trustees, etc.	171,767			
	14 Other employee salaries and wages	43,176			
	15 Pension plans, employee benefits	21,435			
	16a Legal fees (attach schedule)				
	b Accounting fees (attach schedule)				
	c Other professional fees	332,855			119,892
	17 Interest				
	18 Taxes (attach schedule)	33,000			
	19 Depreciation and depletion				
	20 Occupancy	2,730			
	21 Travel, conferences, and meetings	23,164			
	22 Printing and publications				
	23 Other expenses (attach schedule)	83,180	77,002		
	24 Total operating and administrative expenses. Add lines 13 through 23	711,307	77,002	0	119,892
	25 Contributions, gifts, grants paid	832,905			1,239,847
	26 Total expenses and disbursements. Add lines 24 and 25	1,544,212	77,002	0	1,359,739
	27 Subtract line 26 from line 12:				
	a Excess of revenue over expenses and disbursements	871,817			
	b Net investment income (if negative, enter -0-)		1,610,630		
	c Adjusted net income (if negative, enter -0-)			0	

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Form **990-PF**

ATTORNEY GENERAL'S OFC

2005 MAY 17 AM 11:19

Return of Private Foundation

or Section 4947(a)(1) Nonexempt Charitable Trust
Treated as a Private Foundation

Note: The organization may be able to use a copy of this return to satisfy state reporting requirements.

OMB No. 1545-0052

2004

Department of the Treasury
Internal Revenue Service

For calendar year 2004, or tax year beginning , and ending

G Check all that apply: ☐ Initial return ☐ Final return ☐ Amended return ☐ Address change ☐ Name change

Use the IRS label. Otherwise, print or type. See Specific Instructions.

Name of organization: BCBSM Foundation, Inc.

Number and street (or P.O. box number if mail is not delivered to street address): P.O. Box 64560

Room/suite:

City or town, state, and ZIP code: St. Paul MN 55164

A Employer identification number: 36-3525653

B Telephone number (see page 10 of the instructions): (866) 812-1593

C If exemption application is pending, check here ▶ ☐

D 1. Foreign organizations, check here ▶ ☐

2. Foreign organizations meeting the 85% test, check here and attach computation ▶ ☐

E If private foundation status was terminated under section 507(b)(1)(A), check here ▶ ☐

F If the foundation is in a 60-month termination under section 507(b)(1)(B), check here ▶ ☐

H Check type of organization: ☒ Section 501(c)(3) exempt private foundation
☐ Section 4947(a)(1) nonexempt charitable trust ☐ Other taxable private foundation

I Fair market value of all assets at end of year (from Part II, col. (c), line 16) ▶$ 52,048,310

J Accounting method: ☐ Cash ☒ Accrual ☐ Other (specify) _____
(Part I, column (d) must be on cash basis.)

Part I Analysis of Revenue and Expenses (The total of amounts in columns (b), (c), and (d) may not necessarily equal the amounts in column (a) (see page 11 of the instructions).)

		(a) Revenue and expenses per books	(b) Net investment income	(c) Adjusted net income	(d) Disbursements for charitable purposes (cash basis only)
Revenue	1 Contributions, gifts, grants, etc., received (attach schedule)	4,013,850			
	2 Check ▶ ☐ if the foundation is not required to attach Sch. B				
	3 Interest on savings and temporary cash investments	10,150	10,150	0	
	4 Dividends and interest from securities	1,227,801	1,227,801	0	
	5 a Gross rents	0	0	0	
	b Net rental income or (loss) 0				
	6 a Net gain or (loss) from sale of assets not on line 10	869,354			
	b Gross sales price for all assets on line 6a 18,963,292				
	7 Capital gain net income (from Part IV, line 2)		3,914,437		
	8 Net short-term capital gain			0	
	9 Income modifications			0	
	10 a Gross sales less returns and allowances 0				
	b Less: Cost of goods sold 0				
	c Gross profit or (loss) (attach schedule)	0		0	
	11 Other income (attach schedule)	5,911	5,911	0	
	12 Total. Add lines 1 through 11	6,127,066	5,158,299	0	
Operating and Administrative Expenses	13 Compensation of officers, directors, trustees, etc.	65,041	0	0	20,657
	14 Other employee salaries and wages	266,906	0	0	197,737
	15 Pension plans, employee benefits	47,422	0	0	38,273
	16 a Legal fees (attach schedule)	0	0	0	0
	b Accounting fees (attach schedule)	0	0	0	0
	c Other professional fees (attach schedule)	180,433	0	0	161,615
	17 Interest	0	0	0	0
	18 Taxes (attach schedule) (see page 14 of the instructions)	52,200	0	0	0
	19 Depreciation (attach schedule) and depletion	0	0	0	
	20 Occupancy	0	0	0	0
	21 Travel, conferences, and meetings	28,912	0	0	19,932
	22 Printing and publications	0	0	0	0
	23 Other expenses (attach schedule)	134,422	117,644	0	2,777
	24 Total operating and administrative expenses. Add lines 13 through 23	775,336	117,644	0	440,991
	25 Contributions, gifts, grants paid	1,873,986			2,285,551
	26 Total expenses and disbursements. Add lines 24 and 25	2,649,322	117,644	0	2,726,542
	27 Subtract line 26 from line 12:				
	a Excess of revenue over expenses and disbursements	3,477,744			
	b Net investment income (if negative, enter -0-)		5,040,655		
	c Adjusted net income (if negative, enter -0-)			0	

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Blues Plans Building Their Own Bank to Administer Health Savings Accounts

Reprinted from the December 2005 issue of The AIS Report on Blue Cross and Blue Shield Plans, a hard-hitting independent monthly newsletter on business strategies, products and markets, mergers and alliances, and financing of BC/BS plans.

The nation's Blues plans are following in the footsteps of UnitedHealth Group — one of their most formidable competitors for national accounts — by collectively building a bank to administer health savings accounts (HSAs) for their members. But the nation's largest member, WellPoint, Inc., says that while it supports the development of the bank, it will stick with its existing banking partners for now.

"If done properly, this [type of bank formation] may stem the losses health plans will have due to the movement of health care to financial products," says Craig Swanson, a consultant and founding partner of The Sequoi Group. Swanson also was a co-founder of Definity Health, a consumer-directed health (CDH) vendor now owned by UnitedHealth Group. Unfortunately, he adds, health plans are trying to mold banking into their own archaic way of doing business. "A bolt-on to a flawed model only makes things more complicated and creates a system that is more prone to error."

The Salt Lake City-based Blue Healthcare Bank, which is slated to open in early 2007, is the latest sign that Blues plans see significant growth potential in the fledgling CDH market. The BlueCross BlueShield Association also said late

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last month that it had entered into an agreement with VISA USA that will allow its affiliate Blues plans to offer a co-branded VISA debit card to their members. Terms of the deal were not disclosed. The debit card can be used by members to access their health savings account (HSA) dollars when paying for health-related services.

Just two years ago, only a handful of Blues plans had an account-based CDH product. Today, most if not all of the nation's Blues plans are selling products that include an HSA or health reimbursement arrangement (HRA). Many Blues plans now sell both types of plans. Collectively, Blues plans have more than 1 million enrollees in these account-based plans — a number that likely will grow significantly on Jan. 1.

The bank will help Blues plans hang on to a larger slice of their CDH business by giving their members an alternative to large, third-party HSA administrators such as Mellon Financial Corp., JPMorgan Chase and Wells Fargo. Along with serving as an HSA custodian, the new bank will provide "administrative and financial support" for members who have HRAs and/or health flexible spending accounts (FSAs), according to the Blues association. The new firm will be similar to United's Exante Bank, which had about 52,000 HSAs and held $34 million in HSA assets as of September 2005.

"Certainly, the Blues as a group feel that CDH products have become large enough that they can make

really grand investments" in them, says Shellie Stoddard, a financial analyst in Standard and Poor's New York City office. "They are branding a VISA [debit] card and will have their own Blues-branded bank. They seem to see [CDH] as the wave of the future."

The decision to launch a bank was prompted by "the rapid convergence of health care and finance," said Blues association CEO Scott Serota. He explained the impetus for the new bank, and outlined some of its capabilities, during a Dec. 5 conference call. He called the creation of the bank "a significant milestone" for the association. The new bank, he added, will operate as a "shared asset" that can be used by any of the association's 39 affiliate plans.

The bank is being launched to support Blues plans and their members' health care transactions, rather than to turn a profit, Serota said. "It is not designed for any other purposes," he told listeners. The bank, he added, will operate more as a "virtual bank" than as a bricks-and-mortar institution.

The nation's Blues plans "don't want to be left behind in the whole HSA movement," says Mike Taylor, a consultant in the Boston office of Towers Perrin. "I view this as a sort of brand protection, in that [Blues plans] have the pre-eminent brand and want to protect it as much as they can. It also gives them a chance to broaden their brand appeal," he

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says.

While some Blues plans might use the new bank as their sole HSA partner, others are likely to maintain their established partnerships to give their members a broader range of choice, predicts Katy Henrickson, senior analyst with Cambridge, Mass.-based Forrester Research. "We have always predicted that health plans will need multiple banking partners for their HSA business," she explains. "Employers tend to switch health plans every couple of years, but they might not be willing to switch banks. It makes sense to have a menu of [HSA administrators] to choose from."

An article in the Dec. 5 issue of *The Wall Street Journal* noted that WellPoint — the nation's largest health plan operator and one of the largest players in the CDH space — "would stick with its banking partners, JPMorgan Chase and Mellon." In response to that comment, Serota said that WellPoint, like all of the other affiliates, will be a partial owner in the bank and will automatically be a participant. While WellPoint has no immediate plans to use the bank, "there is always the possibility of offering additional choices to employees," says WellPoint spokesperson Jim Kappel. WellPoint's HRA- and HSA-based plans cover about 430,000 lives.

Blues plans that use the bank will be able to offer members "seamless integration" between their health plan and their HSAs, according to Serota. Members, he explained, will be able to present a debit card at a provider's office. The provider will immediately be able to determine how much to deduct from the HSA based on the health plan's discounted rate and the member's deductible. "This will all be done with minimal participation from the member or the provider," he told listeners. Serota declined to comment on the cost of launching the bank, or on the income it is likely to generate.

"This illustrates that the Blues association, and Blues plans in general, are waking up to the realization that they will have to create differentiated, deep and broad consumerism strategies and capabilities if they want to compete effectively with United, Aetna [Inc.] and CIGNA [Corp.], who are making significant investments in these areas," says Alexander Domaszewicz, an employee benefits consultant in the Newport Beach, Calif., office of Mercer Health & Benefits. "Creating flexible and integrated financial services is an important part of the tapestry of consumerism they are all trying to weave."

The Blues association says it will seek regulatory approval for the bank — from the Federal Deposit Insurance Corp. and from Utah officials — after Jan. 1. Collectively, the nation's Blues plans provide coverage to more than 93 million people.

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Back to basics; Minn. Blues to abandon hospital ownership

Modern Healthcare, September, 2003 by Patrick Reilly

CLICK TO BUY

Byline: Patrick Reilly

Blue Cross and Blue Shield of Minnesota, the first Blues plan to develop a hospital from the ground up, has decided to retreat from hospital ownership by selling 74-bed Innovis Health, Fargo, N.D., to Catholic Health Initiatives.

The Minnesota Blues and its partner, Dakota Clinic, a 178-physician multispecialty group practice, announced last week that they had signed a letter of intent with Catholic Health after 18 months ...

"Do" costs:

	2000	2001	2002	2003	2004	2005	Total
Total payments to Vendors:	0	0	0	711,672	3,777,935	4,089,963	8,579,571
Center for Prevention employee time:				115,142	204,137	256,285	575,564
Travel costs for employees:					2,149	2,157	4,306
Other BCBSMN employees' time (Market Research, Media Relations, Compliance & Regulatory):				2,881	11,540	7,934	22,356
	$ -	**$ -**	**$ -**	**$ 829,696**	**$ 3,995,761**	**$ 4,356,340**	**$ 9,181,796**

BCBSM 144071

BCBSM's Response to Document Request No. 167

The Car Seat Program for government programs enrollees provides $50 certificates good for purchase of a car seat. The program is designed to promote use of child car seats and prevent childhood injuries. The program is open to all Medicaid or MinnesotaCare recipients enrolled with either Blue Plus or First Plan with a child two years old or under, who are at least six months pregnant.

CDMI has administered the program since May 2002. Member requests for car seats are directed to CDMI. CDMI verifies eligibility and completes the gift certificate choice with the member. CDMI submits a weekly list of eligible recipients to the gift certificate vendor, Premier Choice Awards (d/b/a, Gift Certificate Center), who sends the gift certificate to members.

The $55 fee charged by CDMI consists of the following elements:

$50	Gift certificate face amount
$ 4	Premier Choice Awards fee for fulfillment services
$ 1	CDMI fee for processing requests

Number of gift certificates and amounts paid to CDMI by BCBSM for each year (excludes 2000-April 2002for which data is not readily available)

2002	2003	2004	2005
1378	2560	2525	2597
$75,640	$140,800	$138,985	$138,380

BCBSM
Expenses reclassed out of claims
December 31, 2003

BCBSM Number		2003
	Blue Card Fees:	
122145	Fully Insured Access Fees	4,336,632
122145	ASC Access Fees	28,236,840
	Total Access Fees	32,573,472
122142	Standard AEA fees	18,042,119
	Subtotal	50,615,591
	Unidentified Standard Blue Card Fees	1,224,240
Resp 125(b)(4)	Total Blue Card Fees	51,839,831
122145	Disease Management Fees	34,473,418
	Total	86,313,249

BCBSM CID Request number 125
Adjusted Administrative Expense PMPM
31-Dec-03

	Administrative Expense	Cost Containment Expense	Other Claims Adj Expense	Total	Claims
PMPM	$ 18.41	$ -	$ 8.46	$ 26.87	
2003 total expenses incurred from Annual Statement	$ 144,751,611	$ -	$ 66,544,860	$ 211,296,471	$ 1,464,253,474
Adjustments:					
Insured cost containment previously reported as claims (detail attached)		$ 25,686,926		$ 25,686,926	$ (25,686,926)
Reclass expense for cost containment	$ (11,105,000)	$ 35,196,000	$ (24,091,000)	$ -	
Blue Card access fees received	$ 6,104,582	$ (15,261,456)	$ 9,156,874	$ -	
Reimbursements from uninsured plans per page 14 line 19	$ 77,741,055		$ 138,868,181	$ 216,609,236	
Reimbursements from uninsured plans for cost containment previously reported as claims (detail attached)		$ 41,359,963		$ 41,359,963	$ (41,359,963)
Standard AEA fees included as claims expense			$ 18,042,119	$ 18,042,119	$ (18,042,119)
Pension adjustment to GAAP	$ (5,580,000)			$ (5,580,000)	
Broker fee recoveries	$ 11,843,729			$ 11,843,729	
MCHA Assessments	$ (26,449,437)			$ (26,449,437)	
Foundation Contribution	$ (12,000,000)			$ (12,000,000)	
Other Misc. Adjustments	$ 265,882			$ 265,882	
Total	$ 185,572,440	$ 86,981,433	$ 208,521,042	$ 481,074,916	$ 1,379,164,466
PMPM WITH ASC expense and members	$ 7.69	$ 3.61	$ 8.64	$ 19.94	
2003 total revenue	$ 1,780,376,227				
2003 insured member months	7,864,740				
2003 ASC member months	16,259,256				
2003 total member months	24,123,996				

2003 Cost Containment Expenses

These amounts were included as claims expense in 2003. They meet the definition of cost containment expenses as described in SSAP No. 85. As a result these types of costs are now reported as a component of claims adjustment expenses.

	Total	ASC	Fully Insured
Flu Stop	$ 544,134	$ 325,729	$ 218,405
Accordant	1,229,333	163,155	1,066,177
PTI pharmacy benefit management	6,182,051	3,811,548	2,370,503
American Healthways	21,519,323	7,537,945	13,981,378
Nurse Phonecare	3,433,363	1,261,646	2,171,717
Healthy Start	1,565,214	23,100	1,542,114
Blue Card access fees within claims FI	4,336,632	-	4,336,632
Blue Card access fees within claims SI	28,236,840	28,236,840	-
Total	$ 67,046,889	$ 41,359,963	$ 25,686,926

The following adjustments are required to reallocate administrative expense and other claims adjustment expense to cost containment.

	Administrative Expense	Cost Containment Expense	Other Claims Adj Expense
Case Mgmt Activities		$ 5,978,000	$ (5,978,000)
Utilization Review		$ 7,666,000	$ (7,666,000)
Detection and Prevention for Fraud		$ 269,000	$ (269,000)
Network Mgmt	$ (7,820,000)	$ 16,639,000	$ (8,819,000)
Consumer Education	$ (3,285,000)	$ 3,285,000	
Appeals		$ 1,359,000	$ (1,359,000)
Total adjustment	$ (11,105,000)	$ 35,196,000	$ (24,091,000)

The above costs meet the definition of cost containment as stated in the Statement of Statutory Accounting Principle No. 55, paragraph 4.a.

c. With respect to "Outside Sales Agent Fees":

(1) Was this change approved and implemented? If so, at what date?

(2) Where were the outside sales agent fees reported prior to the change?

(3) Where do "Outside Sales Agent Fees" appear in BCBSM's 2003 and 2004 Annual Statements?

d. Using the attached template, provide a 2003 and 2004 detailed calculation of the PMPM cost for BCBSM members. The template starting point for total administrative expense and cost containment expense was obtained from Page 14 of the BCBSM Annual Statement. Provide a detailed explanation, by type and dollar amount, of any increases or decreases to this starting point to arrive at total expenses used for the PMPM calculation.

e. Were the 2003 financial statements "restated" for the proposed reporting changes. If so, provide a schedule of the restated amounts. If not, explain why the statements were not restated.

f. Were all the reporting changes described on page 31 incorporated into BCBSM's 2004 Annual Statement? If not, explain which changes, were not incorporated, the dollar amounts involved and why the changes were not made.

SUPPLEMENTAL RESPONSE:

a. (1) This change was made effective for calendar year 2004 consistent with new guidance included in NAIC Statement of Statutory Accounting Principles (SSAP) No. 85

(2) No, only those Blue Card fees that are considered a network access fee. When a member of another Blue Plan travels to Minnesota and utilizes the

services of one of BCBSM's contracted providers, BCBSM receives both an administrative expense allowance (AEA) and an access fee from the other Blue Plan. In this situation, BCBSM is considered the "Host Plan" and the other Blue Plan is the "Home/Control Plan." The fees earned are either at standard rates established by the Blue Cross and Blue Shield Association or they can be at custom rates negotiated between BCBSM and the other plans. The AEA serves to reimburse the Host Plan for costs incurred in processing the claim and paying the providers of health care. The access fee is paid to the Host Plan for allowing the Home Plan and their members access to the Host Plan's network of providers. For statutory accounting purposes, as the Host Plan, BCBSM is considered an administrator of an uninsured health plan in these circumstances since BCBSM has no insurance risk. As a result, these receipts are credited to expense as required by SSAP No. 47, paragraph 6 and reported on line 25 of page 14 of the Annual Statement (*see* Bates number 37560). Only the access fee is credited to column one as an item of cost containment. This is prescribed accounting per the guidance provided in SSAP Nos. 85 and 47.

(3) As stated in SSAP No. 85, paragraph 3, "Certain claim adjustment expenses reduce the number or cost of health services thereby resulting in lower premiums or lower premium increases. These claim adjustment expenses shall be classified as cost containment expenses." Network

access fees are specifically listed as an example of a type of cost containment expenses in paragraph 4 of SSAP No. 85.

(4) The network access fees are intended to reimburse the Host Plan for the costs incurred in developing and maintaining its provider networks.

(5) In 2004, Blue Card fees received were reported on line 25 as an aggregate write-in item. The detail for write-in items is provided on page 54 of the Annual Statement (*see* Bates No. 37621). The access fee is reported on line 2507 in column 1 as cost containment expenses and totaled $15,855,702. The Host Plan AEA totaled $14,291,563 and is reported on line 2504 of page 54. Of this total, $3,215,602 is reported in column 1 as cost containment expenses, $6,391,408 is reported in column 2 as claim adjustment expenses, and $3,144,553 is reported in column 3 as general administrative expenses.

b. (1) This change was also effective for the calendar year 2004.

(2) The standard Blue Card fees previously included in claims represent the AEA fees that BCBSM paid to other Host Plans who provided services to BCBSM members (principally employees not residing in Minnesota) through their networks of providers. These AEA fees were historically included as part of the claim cost paid to the Host Plans. Beginning in 2004, however, those standard Blue Card fees were separately identified and charged as an item of administrative expense. These fees were reported on line 14 as an item of other claim adjustment expense. The total of these standard AEA fees was $20,224,341 for 2004. In addition,

another $17,696,218 of custom (negotiated) Blue Card fees, which have always been recorded as administrative expenses, are included in this column of line 14. Also, another $35,166,228 was paid for Blue Card access fees and reported on line 14 as a cost containment item.

(3) Yes, this includes the total paid for standard and custom Blue Card AEA and network access fees.

(4) BCBSM included $51,839,831 of standard Blue Card fees in claims in 2003. No Blue Card fees were reported as claims expense in 2004.

c. (1) For internal reporting purposes, the change to include outside sales agents' fees as an administrative expense item was made for calendar year 2004. For statutory accounting purposes, these amounts have always been reported as general administrative expense items and included on page 14, line 3 of the Annual Statement, net of amounts recovered from self-insured groups.

(2) For internal reporting and Aware Integrated, Inc. GAAP reporting, these fees were reported as a separate line item to arrive at gross margin. For statutory accounting and reporting purposes, as stated above, these costs have always been reported as an administrative expense item.

(3) These costs are reported on page 14, line 3 as an item of general administrative expense.

d. Blue Cross's response to this interrogatory is still being developed.

e. Certain reported amounts for 2003 were reclassified to conform with the reporting for 2004. These reclassifications of 2003 amounts were made to audited financial

statements only. The instructions for the NAIC annual statements do not allow for restatement.

Aware Integrated Inc. ($'s in thousands)

	As originally reported	As adjusted	Difference
Claims	$2,161,988	$2,083,718	$(78,270)
Administrative expense	399,250	477,520	78,270

BCBSM, Inc. ($'s in thousands)

	As originally reported	As adjusted	Difference
Total Medical & Hospital	$1,464,254	$1,438,567	$(25,687)
Administrative Expense	211,296	236,983	25,687

Blue Plus ($'s in thousands)

	As originally reported	As adjusted	Difference
Total Medical & Hospital	$575,577	$565,805	$(9,772)
Administrative Expense	44,813	54,585	9,772

The adjustment for Aware Integrated, Inc. is larger than the adjustments to the statutory-based health plan reports due to the impact of the accounting for ASC business. For statutory reporting, ASC recoveries are reported as recovery of claims and administrative expense, whereas under GAAP reporting, these amounts are reported on a premium-equivalent basis.

f. The changes were made to the Annual Statement, except for outside agent fees, which, as previously stated, have always been included on page 14.

REQUEST NO. 126

Provide a copy of all documents from any member of the BCBSM Family and to the Minnesota Department of Commerce and/or the Minnesota Department of Health which relate or

ROBINS, KAPLAN, MILLER & CIRESI L.L.P.

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ATTORNEYS AT LAW

SCOTT R. STRAND
612-349-8440

September 13, 2005

VIA MESSENGER

Kristine Eiden
Chief Deputy Attorney General
102 State Capitol
St. Paul, MN 55101

Re: In re BCBSM, Inc.--Civil Investigative Demand

Dear Ms. Eiden:

Enclosed are supplemental documents in response to Document Requests Nos. 53, 58, and 86. One document—a June 15, 1993 memorandum from Robert Milis, general counsel, to Andrew Czajkowski, CEO, regarding investment in BCS Plan Investors Corporation (BPIC)—has been withheld on grounds of attorney-client privilege and entered on the privilege log. Also, also with respect to Document Request No. 53, please find a revised Aware Integrated, Inc. chart, dated September 7, 2005, on investments in entities whose securities are not publicly traded.

In your Document Request No. 86, you also asked for an explanation for the increase from 2003 to 2004 in the amount reported on the DOC Underwriting and Investment Exhibit Part 3, Line 14—Outsourced Services. The reason for the increase was a new Statement of Statutory Accounting Principles, SSAP No. 85, from the National Association of Insurance Commissioners (NAIC), which changed the way cost containment expenses were to be reported. "Cost containment expenses" are those costs which serve to reduce the incidence of claims, including such activities as disease and care management, nurse phone care, network access fees and other costs. Prior to 2004, a portion of those costs were reported as a component of claims expense, including disease management fees paid to vendors such as American Healthways and Accordant and standard BlueCard fees paid to other Blues plans for BCBSM members' use of their provider networks. Starting in 2004, however, those expenses must be included in the totals reported on the Underwriting and Investment Exhibit Part 3—Analysis of Expenses.

If you have any questions, please give me a call.

Sincerely,

ROBINS, KAPLAN, MILLER & CIRESI L.L.P.

Scott R. Strand

SRS:lmz
Enclosures

UNDERWRITING AND INVESTMENT EXHIBIT

PART 3 - ANALYSIS OF EXPENSES

		Claim Adjustment Expenses		3	4	5
		1 Cost Containment Expenses	2 Other Claim Adjustment Expenses	General Administrative Expenses	Investment Expenses	Total
1.	Rent ($ 15,037,789 for occupancy of own building)		9,764,767	5,273,022		15,037,789
2.	Salaries, wages and other benefits	20,939,000	119,627,537	102,011,319		242,577,856
3.	Commissions (less $ 1,266,612 ceded plus $ assumed)			63,859,628		63,859,628
4.	Legal fees and expenses		510,047	1,201,559		1,711,606
5.	Certifications and accreditation fees		1,618			1,618
6.	Auditing, actuarial and other consulting services	3,107,000	3,815,682	8,109,435		15,032,117
7.	Traveling expenses	285,000	554,551	1,112,982		1,952,533
8.	Marketing and advertising		161,044	4,833,913		4,994,957
9.	Postage, express and telephone		4,514,968	10,229,863		14,744,831
10.	Printing and office supplies	1,225,000	1,311,631	1,111,469		3,648,100
11.	Occupancy, depreciation and amortization		2,377,824	913,815		3,291,639
12.	Equipment	580,000	12,500,194	5,840,339		18,920,533
13.	Cost or depreciation of EDP equipment and software		18,304,977	9,980,000		28,284,977
14.	Outsourced services including EDP, claims, and other services	77,216,000	46,103,655	1,001,085		124,320,740
15.	Boards, bureaus and association fees	107,000	21,418	3,729,103		3,857,521
16.	Insurance, except on real estate		52,054	851,681		903,735
17.	Collection and bank service charges					
18.	Group service and administration fees					
19.	Reimbursements by uninsured accident and health plans	(65,260,224)	(140,672,039)	(84,113,178)		(290,045,441)
20.	Reimbursements from fiscal intermediaries					
21.	Real estate expenses				11,855,721	11,855,721
22.	Real estate taxes				2,341,430	2,341,430
23.	Taxes, licenses and fees:					
	23.1 State and local insurance taxes			(2,770,000)		(2,770,000)
	23.2 State premium taxes			16,124,700		16,124,700
	23.3 Regulator authority licenses and fees		12,646	81,820		94,466
	23.4 Payroll taxes	1,197,000	7,556,647	5,413,273		14,166,920
	23.5 Other (excluding federal income and real estate taxes)					
24.	Investment expenses not included elsewhere					
25.	Aggregate write-ins for expenses	(17,521,061)	(16,908,178)	16,420,874		(18,008,365)
26.	Total expenses incurred (Lines 1 to 25)	21,874,715	69,611,043	171,216,702	14,197,151	(a) 276,899,611
27.	Less expenses unpaid December 31, current year	8,725,890	41,012,949	65,684,703	3,094,988	118,518,530
28.	Add expenses unpaid December 31, prior year		45,033,556	83,605,462	2,318,700	130,957,718
29.	Amounts receivable relating to uninsured accident and health plans, prior year					
30.	Amounts receivable relating to uninsured accident and health plans, current year					
31.	Total expenses paid (Lines 26 minus 27 plus 28 minus 29 plus 30)	13,148,825	73,631,650	189,137,461	13,420,863	289,338,799
DETAILS OF WRITE-INS						
2501.	MISCELLANEOUS ADMIN	357,000	(307,185)	(1,447,104)		(1,397,289)
2502.	MCHA AND OTHER ASSESSMENTS			34,302,985		34,302,985
2503.	LOSS ADJUSTMENT		1,013,000			1,013,000
2598.	Summary of remaining write-ins for Line 25 from overflow page	(17,878,061)	(17,613,993)	(16,435,007)		(51,927,061)
2599.	Totals (Lines 2501 through 2503 + 2598)(Line 25 above)	(17,521,061)	(16,908,178)	16,420,874		(18,008,365)

(a) Includes management fees of $ to affiliates and $ to non-affiliates.

STATEMENT OF REVENUE AND EXPENSES (Continued)

		1 Current Year	2 Prior Year
	CAPITAL & SURPLUS ACCOUNT		
33.	Capital and surplus prior reporting year	691,771,117	608,412,061
	GAINS AND LOSSES TO CAPITAL & SURPLUS		
34.	Net income or (loss) from Line 32	59,523,595	9,451,581
35.	Change in valuation basis of aggregate policy and claim reserves		
36.	Change in net unrealized capital gains (losses) less capital gains tax of $.....1,678,000	40,704,433	73,099,581
37.	Change in net unrealized foreign exchange capital gain or (loss)		
38.	Change in net deferred income tax	(39,572,000)	4,910,000
39.	Change in nonadmitted assets	(50,581,013)	4,772,307
40.	Change in unauthorized reinsurance		
41.	Change in treasury stock		
42.	Change in surplus notes		
43.	Cumulative effect of changes in accounting principles		
44.	Capital Changes:		
	44.1 Paid in		
	44.2 Transferred from surplus (Stock Dividend)		
	44.3 Transferred to surplus		
45.	Surplus adjustments:		
	45.1 Paid in		
	45.2 Transferred to capital (Stock Dividend)		
	45.3 Transferred from capital		
46.	Dividends to stockholders	(9,000,000)	(9,000,000)
47.	Aggregate write-ins for gains or (losses) in surplus	82,756	125,587
48.	Net change in capital and surplus (Lines 34 to 47)	1,157,771	83,359,056
49.	Capital and surplus end of reporting year (Line 33 plus 48)	692,928,888	691,771,117
	DETAILS OF WRITE-INS		
4701.	SERP MINIMUM RESERVE ADJUSTMENT	82,756	125,587
4702			
4703			
4798.	Summary of remaining write-ins for Line 47 from overflow page		
4799.	TOTALS (Lines 4701 through 4703 plus 4798) (Line 47 above)	82,756	125,587