Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

INFLUENCES ON MEDICARE'S SKILLED NURSING FACILITY BENEFIT

Richard P. Kusserow
INSPECTOR GERNERAL

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OFFICE OF INSPECTOR GENERAL

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OEI-05-89-01590

EXECUTIVE SUMMARY

PURPOSE

To determine whether recent changes to the Medicare skilled nursing facility (SNF) benefit have left the program vulnerable to unpredictable growth in expenditures.

BACKGROUND

Medicare policies and procedures used to determine SNF eligibility and program payments have undergone few changes since the early seventies. However, as the eighties drew to a close several changes occurred in rapid succession. In April 1988, the Health Care Financing Administration (HCFA) changed the SNF coverage guidelines used by SNFs and fiscal intermediaries (FIs) to decide which patients qualified for benefits. Less than 9 months later, in January 1989, implementation of the Medicare Catastrophic Coverage Act of 1988 (MCCA) changed SNF eligibility requirements and reduced out-of-pocket expenses for SNF patients. One year later, MCCA was repealed and previous SNF eligibility requirements reinstated.

METHODOLOGY

During the course of this inspection, we surveyed 60 SNFs, 10 FIs and 10 Medicaid State agencies in 10 States. We also analyzed a 1 percent sample of Medicare patients who received SNF benefits between October 1, 1987 and June 30, 1990. The sample was analyzed to determine whether the guideline changes and MCCA had an effect on SNF admissions, average length of stay and Medicare payments. Additional data was obtained from the Monthly National Intermediary Benefit Payment Report for the period January 1988 through December 1990.

FINDINGS

- Medicare payments to SNFs more than tripled between 1988 and 1989.

- The 1988 SNF coverage guideline changes accounted for 27 percent of the increase in SNF payments. Small increases in number of SNF admissions and slightly longer length of stays accounted for most of the increase.

- The MCCA had a significant impact on beneficiaries, providers and Medicare program expenditures and resulted in an increase in Medicare expenditures which exceeded 300 percent.

- Barring any unforseen changes, it appears unlikely that admissions and payments will return to anywhere near the levels the Medicare program experienced before MCCA.

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INTRODUCTION

PURPOSE

To determine whether recent changes to the Medicare skilled nursing facility (SNF) benefit have left the program vulnerable to unpredictable growth in expenditures.

BACKGROUND

The Medicare program assists patients in paying for extended care services provided by SNFs participating in Medicare. These extended care services, commonly called SNF benefits, are covered under Part A of the Medicare program and include various skilled nursing and rehabilitative services. The covered services provided by SNFs are similar to the services received by hospital inpatients, but at a lower intensity of care.

Medicare assists patients in paying for their SNF care if the beneficiary meets several eligibility criteria. The criteria require a beneficiary to have been hospitalized for at least 3 days before admission to a SNF. The beneficiary must be admitted to a SNF within 60 days of their hospital discharge. The admission must be medically necessary and a SNF would be the best source to provide the medical care needed by the patient. In addition to these criteria, the beneficiary must be admitted to a certified SNF which meets Medicare's definition of skilled. The services a patient receives while in a SNF must be provided daily following a physician's order.

Medicare allows up to 100 covered days of SNF care per beneficiary spell of illness. A spell of illness would begin on the first day the beneficiary received hospital or SNF services and would end when the patient has not been a hospital or SNF patient for 60 consecutive days.

If a beneficiary is eligible for SNF care, Medicare pays for all covered SNF expenses for the first 20 days. After the 20th day, patients are required to pay for part of their SNF care. In 1991, Medicare beneficiaries' copayments for days 21-100 will be $78.50. After 100 days beneficiaries are financially responsible for all of the expenses they incur for SNF care. Beneficiaries whose personal resources do not allow them to pay for all of the care they need often turn to the Medicaid program for financial assistance. Total Medicare payments for SNF care are minor when compared to total Medicaid and out-of-pocket payments for SNF care.

Many beneficiaries entering SNFs are unable to meet all of Medicare's eligibility requirements for SNF coverage. The primary responsibility for determining whether a patient might be eligible for Medicare SNF benefits falls on SNF personnel. If a SNF believes a patient would qualify for Medicare benefits, it submits a claim for payment.

Most of the decisions made by SNFs concerning SNF eligibility are not questioned by the fiscal intermediaries (FIs) that adjudicate the claims for the government. About 20 percent of the coverage decisions made by SNFs are reviewed for accuracy. The FI reviews are intended to

ensure that SNFs make sound medical necessity decisions concerning whether or not an individual patient qualifies for Medicare coverage. The reviews also serve as a deterrent to discriminatory submission of claims.

The FIs monitor the error rate of each SNF's claims. If a SNF's error rate remains within acceptable tolerances, the SNF is granted what is called a waiver. If a SNF exceeds the tolerances, it will lose its waiver and all of its claims could be subject to FI review. This intensified FI review could delay future payments and might result in the SNF having to return money to the program.

The policies and procedures used to determine Medicare SNF eligibility and program payments have undergone few changes since the early seventies. However, as the eighties drew to a close, several changes occurred in rapid succession. In April 1988, the Health Care Financing Administration (HCFA) changed the SNF coverage guidelines used by SNFs and FIs to decide which patients qualified for benefits. Less than 9 months later, in January 1989, implementation of the Medicare Catastrophic Coverage Act of 1988 (MCCA) changed SNF eligibility requirements and reduced out-of-pocket expenses for SNF patients. One year later, MCCA was repealed and previous SNF eligibility requirements reinstated.

METHODOLOGY

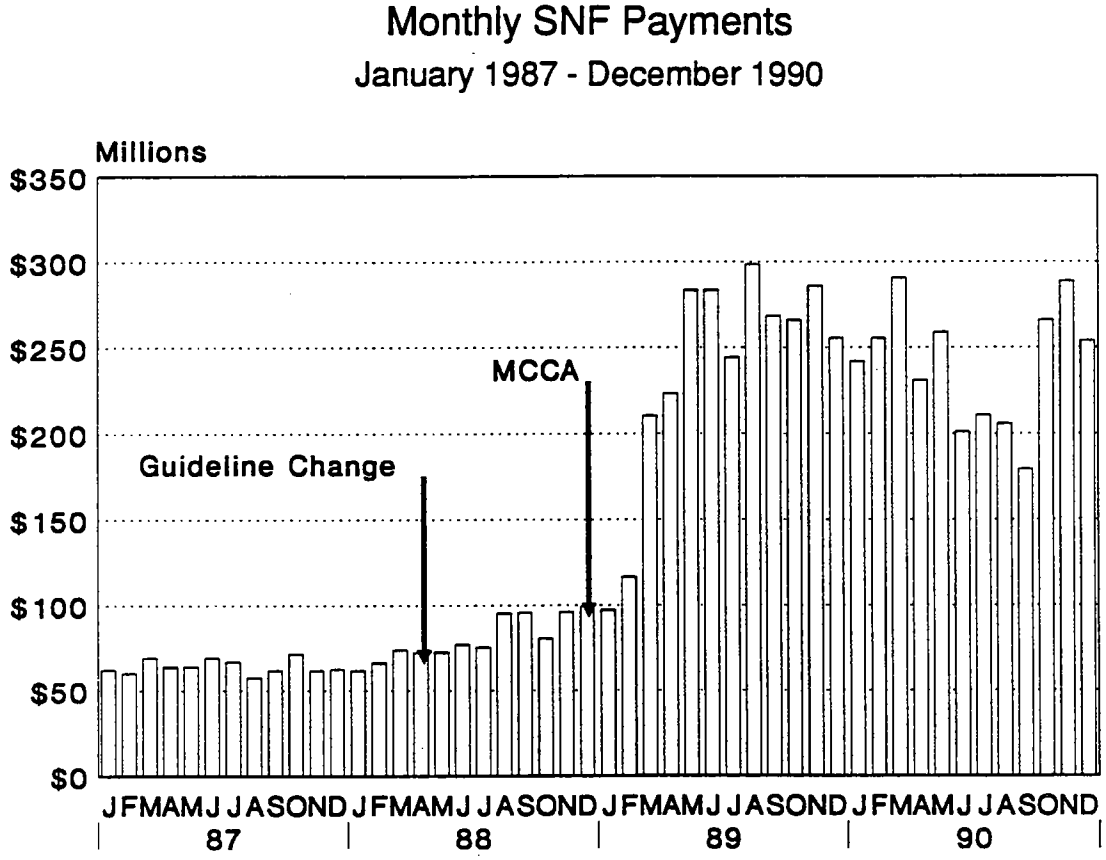
During the course of this inspection, we surveyed 60 SNFs, 10 FIs and 10 Medicaid State agencies in 10 States. We selected the States at random, based on a weighted sample of Medicare SNF beds in each State. Individual SNFs were selected based on bed size, type of ownership and other factors. Structured discussion guides were used to gather qualitative data on respondents' recollections regarding SNF actions following HCFA's coverage guideline clarification, and following enactment and repeal of MCCA.

We also analyzed a 1 percent sample of Medicare patients who received SNF benefits between October 1, 1987 and June 30, 1990. The records came from the Medicare Automated Data Retrieval System which contains a complete Part A and Part B claims history for a patient. The sample was analyzed to determine whether the guideline changes and MCCA had an effect on SNF admissions, average length of stay (LOS) and Medicare payments. Additional data was obtained from the Monthly National Intermediary Benefit Payment Reports for the period January 1988 through December 1990.

FINDINGS

Finding 1. ***Medicare payments to SNFs more than tripled between 1988 and 1989.***

Medicare payments to SNFs more than tripled between 1988 and 1989. In April 1988, HCFA revised the guidelines used by SNFs and FIs to determine whether or not a person would be eligible for Medicare SNF coverage. The revised guidelines provided a clearer understanding of the types of conditions the Medicare program would cover under its SNF benefit and added nearly $20 million to Medicare's average monthly outlay for skilled care.



HCFA 456

Enactment of MCCA, less than a year later, had an even greater impact on Medicare expenditures for skilled care. The unprecedented $2 billion expansion in Medicare SNF payments under MCCA was due to an increase in the number of certified beds, increased admissions, changes in coinsurance, increased covered days and longer lengths of stay (LOS).

Repeal of MCCA, less than a year after its enactment, failed to significantly reduce the amount of money the Medicare program spent on skilled care. The changes in the coverage guidelines in 1988, coupled with more skilled beds brought to the Medicare program by MCCA, have kept Medicare payments for SNF care high.

Finding 2. ***The 1988 SNF coverage guideline changes accounted for 27 percent of the increase in SNF payments. Small increases in the number of SNF admissions and slightly longer length of stays account for most of the increase.***

In April 1988, HCFA revised the guidelines used by SNFs and FIs to determine whether or not a person would be eligible for Medicare SNF coverage. The revised guidelines provided a clearer understanding of the types of conditions the Medicare program would cover under it's SNF benefit.

The HCFA revised SNF coverage guidelines for many reasons. By 1988, HCFA was faced with ever increasing numbers of court cases challenging Medicare SNF coverage decisions. There was also growing concern within HCFA over inappropriate coverage decisions made by FIs and variation among FI reviewers. These concerns, along with a threatened petition for rulemaking that would have left changes in SNF coverage in the hands of the courts, prompted HCFA to take action to change coverage guidelines.

➤ **Revised guidelines made it easier for SNFs to obtain Medicare coverage for some beneficiaries.**

Revised guidelines brought the Medicare program some patients whose clinical or functional needs were previously addressed in a different setting or not at all. Diagnosis or prognosis were no longer the sole factors in deciding whether or not a patient required skilled care. Even in cases where full or partial recovery is not possible, the revised guidelines instructed FIs to consider coverage of skilled services that prevent patient deterioration or maintain a patient's current capabilities. By providing SNFs and FIs with specific examples of the types of conditions the Medicare program would cover under the SNF benefit, SNF and FI coverage decisions became less subjective.

For many patients, the SNF guideline revision did not make pursuing Medicare SNF benefits any more attractive than they had been previously. According to some SNFs, some patients chose to forego Medicare SNF benefits to avoid extra paperwork or to get other services not covered by Medicare, such as in-house laundry services. Other SNFs indicated that many of the patients they admitted were not interested in pursuing Medicare benefits when billing and reimbursement from Medicaid was much more predictable than under Medicare.

Other forces also appear to have limited the number of patients who might have benefited from Medicare's more permissive coverage guidelines. Many SNFs operate at greater than 90 percent capacity and in some areas of the United States, the number of beds available for skilled care falls short of demand. The types of patients likely to benefit from the revised guidelines were those who would probably require SNF services for a longer period of time. These long-term, service-intensive and high-overhead patients may not have been attractive to some nursing homes. When Medicare ceased to pay for the entire cost of skilled care for these patients after 20 days, SNFs would have to collect the cost of care from individual patients or settle for Medicaid payments which might not cover costs.

➤ **The SNFs and FIs varied in their acceptance of the revised coverage guidelines.**

Medicare encouraged SNFs to bill the program for patients whose coverage might have been uncertain in the past. Following the changes to the coverage guidelines, 20 out of 60 SNFs interviewed stated that their admissions policies changed and that they actively pursued coverage for: (1) nasogastric, jejunostomy and gastrostomy patients, (2) insulin dependent diabetics who could not self administer the injection, and (3) patients with multiple medical conditions which, in the aggregate, required a skilled level of care. These SNFs, and all of the FIs with whom we spoke, attributed the increases they saw in Medicare covered days directly to the changes HCFA made in the SNF coverage guidelines.

The changes in coverage guidelines did not effect all SNFs. Seven SNFs stated that they experienced little or no increases in their payments or admissions after HCFA modified SNF coverage guidelines. Several more reported that they were not able to meet the medical and social needs of patients found in the expanded pool. They felt that they did not have the staff nor the equipment to adequately care for the patients, especially patients fed by tubes. The revisions to the SNF coverage guidelines did not provide sufficient financial incentive for SNFs to take on additional staff and other operating overhead to expand their existing capacities for skilled care. Other reasons also provide insight as to why some SNFs did not readily respond to the revised guidelines for SNF coverage. Several of the SNFs reported that FIs were slow to inform them of the guideline revisions. Analysis of data and SNF responses seems to show that the more readily an FI adopted the guideline changes and educated providers, the greater the increase in SNF admissions and payments. Those FIs that saw the change in guidelines as not being a fundamental change, and made little attempt to educate providers, saw little or no change in admissions or payments for SNF care.

Some SNFs reported a certain amount of distrust of FI information regarding the guideline changes. This skepticism on the part of some SNFs was also observed by some FIs, who reported that they saw a reluctance by providers to bill for services covered under the revised guidelines. A few SNFs admitted that they proceeded slowly and cautiously in adopting the revised coverage guidelines. They feared loss of their waiver status. And, they did not wish to expand their overhead to accommodate the patients found in the expanded pool if the Medicare program's commitment to revised guidelines would be short lived.

➤ **The small increase in SNF admissions, coupled with more covered days of care, added $20 million to Medicare's average monthly outlay for SNF benefits.**

After the April 1988 guidelines revisions, Medicare's average monthly payment for SNF care rose 27 percent to $90 million. Medicare's average monthly payment for SNF care was $71 million before the guideline changes. After the guideline changes went into effect Medicare saw a 16 percent increase in the number of SNF admissions and a 13 percent increase in the average length of a patient's stay. On average, more than 31,000 patients were admitted to SNFs each month after the guideline revision compared to 27,000 admissions per month before the change. The average LOS for the last 6 months of 1988 was 26 days, up 13 percent from the average LOS of 23 days before the guideline changes.

The nature of the medical conditions covered by Medicare after April 1988 probably accounts for the increase in average LOS. One out of three SNFs attributed increases in their Medicare covered days to patients fed by tubes, insulin dependent diabetics and patients with multiple debilitating medical conditions who often require SNF services for longer periods of time.

The revised coverage guidelines did not have a uniform impact on all FIs. The average monthly SNF expenditure was not the same for all FIs indicating that the revised guidelines had different effects in different areas of the country. Most of the FIs had increases in their SNF expenditures ranging from less than 1 percent to over 120 percent. A number of FIs had decreases in their SNF expenditures ranging from 3 percent to over 35 percent (See Appendix A).

Finding 3. ***The MCCA had a significant impact on beneficiaries, providers and Medicare program expenditures and resulted in an increase in Medicare expenditures which exceeded 300 percent.***

Less than a year after HCFA revised the SNF coverage guidelines, MCCA was implemented. Unlike the coverage guideline changes, MCCA had no impact on the medical conditions needed to qualify for SNF care. The MCCA liberalized earlier eligibility requirements and reduced patient out-of-pocket expenses for SNF care. The MCCA:

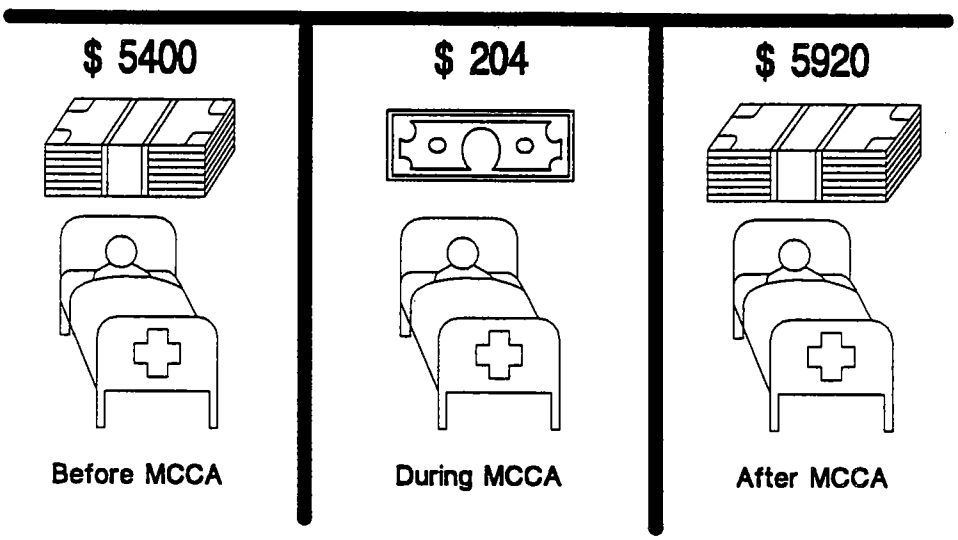
- *Removed the 3 day prior hospital stay required before a SNF admission;*
- *Increased the number of SNF days covered by Medicare from 100 to 150;*
- *Eliminated spell of illness providing a renewed benefit period of 150 days each year for any qualifying medical condition; and*
- *Changed patient coinsurance, reducing patient financial liability and shifting most of the cost to the Medicare program.*

The cumulative effect of these changes increased Medicare payments for SNF care dramatically.

➤ **The significant reduction in coinsurance during MCCA provided an incentive for patients to pursue Medicare SNF coverage.**

The significant reduction in coinsurance during MCCA provided an incentive for patients to pursue Medicare SNF coverage. Before MCCA, Medicare paid the entire cost of patient SNF care for the first 20 days. After the 20th day, patients paid approximately $67.50 per day in coinsurance. A patient receiving SNF benefits for 100 days in 1988 would have paid $5400 in coinsurance. Under MCCA, patient out-of-pocket expenses were reduced to $25.50 per day for the first 8 days of coverage. The reduced coinsurance for SNF benefits in 1989 lowered a beneficiary's total financial liability to a maximum of $204.

Out of Pocket Costs for a 100 day SNF stay

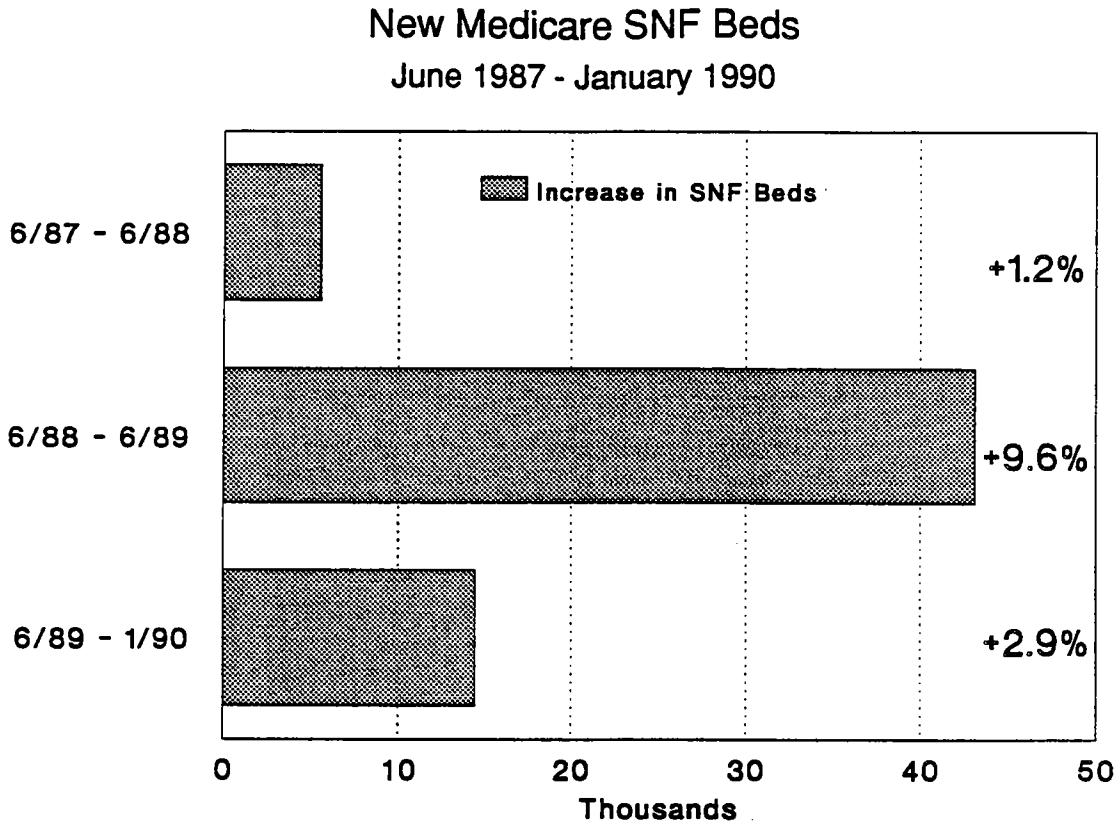


The MCCA not only reduced patient financial liability but also increased the number of days Medicare would pay for SNF care. Before MCCA, Medicare covered up to 100 days per spell of illness. For most patients, permanently confined to SNFs because of illness, the spell of illness eligibility requirement meant that in their lifetime, they would probably never receive more than 100 Medicare covered SNF days. During MCCA, patients who qualified for SNF benefits could expect Medicare to pay for up to 150 days of SNF benefits each year.

Before MCCA, approximately 5 percent of Medicare beneficiaries admitted to SNFs had stays of 100 covered days. Under MCCA, 12 percent of the beneficiaries admitted to SNFs had covered stays equal to or greater than 100 days.

➤ **The MCCA provided a financial incentive for SNFs to expand.**

Unlike the guideline revision 8 months earlier, MCCA provided a clear financial incentive for SNFs to bill Medicare. The financial incentives of MCCA were so strong that some nursing facilities which did not participate in the Medicare program reported having had some of their beds certified for participation in the Medicare program. Other facilities, already participating in the Medicare program, reported that they increased their skilled care beds. More than 1300 new SNFs opened their doors to Medicare beneficiaries between June 1988 and January 1990. Over 57,000 additional skilled care beds were certified during the same period.



HCFA,
Bureau of Data Management and Strategy

Many of the patients admitted to SNFs during MCCA may have been receiving care in the facility before MCCA was enacted. Nearly 75 percent of the SNFs we interviewed reported that they looked at their in-house patient population to see if any patients would qualify under MCCA and that most of their increase in Medicare admissions during MCCA came from their in-house patient population. Admissions from home, doctor's offices and emergency rooms were also reported, but the incidence of such SNF admissions was not significant.

Repeal of the 3 day hospitalization requirement made obtaining additional Medicare SNF benefits for qualified patients already residing in nursing homes as easy as moving them from noncertified beds to Medicare certified beds. Nearly a third of all the patients who received SNF benefits in the first quarter of 1989 did not have a prior 3 day hospitalization, indicating that they probably were moved from noncertified to certified beds within a SNF.

Some SNFs felt they had a legal obligation to pursue Medicare SNF benefits for any potentially eligible patients in their facilities. Other SNFs saw it as a financially practical matter when Medicare paid more than other sources. A few reported that their Medicaid State agency advised them to bill Medicare for Medicaid recipients that might qualify under the MCCA.

Some SNFs saw little or no change under MCCA. Most of the SNFs that reported little or no change were either hospital based or specialized in rehabilitation. Hospital based SNFs saw almost all their SNF admissions continue to come from the hospital. Other SNFs, especially

those specializing in rehabilitation, continued to treat the same type of patient they had before. The increased pool of patients and additional covered days allowed by the MCCA had minimal effect on these facilities.

Before enactment of MCCA, the pool of Medicare beneficiaries potentially eligible for SNF benefits was limited. Repeal of the 3 day hospitalization requirement increased the size of the pool from which SNFs could select potential admissions. Instead of limiting the pool to the 7.5 million beneficiaries discharged from hospitals MCCA expanded the pool to include the entire Medicare Part A population which in 1989 exceeded 30 million individuals. Under MCCA, every beneficiary in the Medicare program became potentially eligible for 150 days of SNF benefits each year, provided they had a qualifying medical condition.

After MCCA's implementation, Medicare saw an immediate increase in SNF admissions, covered days and LOS. In 1988, roughly 350,000 Medicare patients were admitted to SNFs. In 1989, that number rose to 585,000, a 67 percent increase. Not only were more patients being admitted to SNFs in 1989, they were staying longer. Prior to the enactment of MCCA, the average LOS was about 26 days per admission. In the first 6 months following the enactment of MCCA, the average LOS had risen to 36 days per admission.

The increases in SNF admissions and longer stays accounted for nearly 87 percent of the $2 billion increase in SNF spending Medicare experienced during MCCA. The remaining 23 percent of the increase in SNF spending is accounted for by the changes in patient coinsurance that accompanied MCCA.

Finding 4. ***Barring any unforseen changes, it appears unlikely that admissions and payments will return to anywhere near the levels the Medicare program experienced before MCCA.***

The enactment of MCCA provided the catalyst which changed the SNF care environment by bringing more skilled care facilities and beds into the Medicare program. The demand for skilled care remains high and it appears that keeping as many beds as possible certified for skilled care would be in a SNFs best financial interest.

Many SNFs made a considerable investment in the Medicare program during MCCA. Nursing homes which had previously avoided participation in the Medicare program were lured into certifying some beds for skilled care. Other facilities expanded their certified beds. Patient turnover, in these beds, should keep Medicare payment levels for SNF care high.

The repeal of MCCA has reduced the amount Medicare pays for SNF care to some degree. The reduction is primarily due to reinstatement of a $74.00 per day coinsurance for skilled care exceeding 20 days. This coinsurance will probably deter some patients from pursuing SNF benefits beyond 20 days. This reduction in program outlays, brought about by increased coinsurance payments, is likely to be offset by increased use of the certified beds brought into the program during MCCA. Stays are likely to be shorter. Patients will leave certified beds sooner only to be replaced by other patients.

A fragile mix of interdependent variables influences the future direction of Medicare SNF payments. This fragile mix includes:

- *increases or decreases in hospital based or specialized SNFs,*
- *Federal, State and local changes in laws and regulations,*
- *tightening or relaxing of SNF claim reviews by payers,*
- *changes in coverage and other program policies,*
- *increases or decreases in the number of certified beds; and,*
- *increases or decreases in the amount paid for SNF care by Medicare, Medicaid or other payers.*

Growth in Medicare SNF payments should remain predictable as long as these and other external and internal forces in the SNF community remain constant.

APPENDIX A

The following table shows the average monthly SNF payments made by 43 FIs. The table also shows the percentage of change between periods for these 43 FIs. Only FIs with 48 months of data were used in the analysis. The four periods used to measure differences in FIs are:

- *pre-guideline (January 1987 - April 1988), the period before HCFA changed SNF coverage,*
- *post-guideline (May 1988 - December 1988), the period after the SNF coverage guideline changes,*
- *MCCA (January 1989 - May 1990), the period during which MCCA was in effect and includes 150 days after the repeal of MCCA, and;*
- *post-MCCA (June 1990 - December 1990), the period after the 150 days grace period mentioned above.*

The percentage change was calculated by taking the average monthly SNF payment of a later period and subtracting from it the average monthly SNF payment of an earlier period. This difference was then divided by the earlier period's average monthly SNF payment.

The box below shows the lowest and highest percentage change in each period.

Percentage Change

	RANGE		
Pre-guideline to post-guideline	-28.8%	to	115.6%
Post-guideline to MCCA	-4.1%	to	596.2%
MCCA to post-MCCA	-18.3%	to	109.6%

FISCAL INTERMEDIARY	PRE-GUIDE	POST GUIDE	MCCA	POST MCCA
BLUE CROSS OF ALABAMA	$211,179	$150,380 -28 8%	$1,046,998 596.2%	$855,066 -18.3%
BLUE CROSS OF ARIZONA	$414,673	$590,500 42.4%	$2,355,279 298.9%	$2,747,563 16.7%
BLUE CROSS OF ARKANSAS	$530,867	$630,375 18.7%	$654,414 3.8%	$616,065 -5.9%
BLUE CROSS OF CALIFORNIA	$6,777,740	$7,240,019 6.8%	$14,284,444 97.3%	$15,592,446 9.2%
BLUE CROSS OF FLORIDA	$869,497	$1,208,013 38.9%	$2,743,227 127.1%	$3,956,291 44.2%
BLUE CROSS OF GEORGIA	$148,966	$236,978 59.1%	$648,003 173.4%	$766,912 18.4%
HEALTH CARE SERVICES ILLINOIS	$2,394,245	$3,046,749 27.3%	$6,533,240 114.4%	$8680663 32.9%
ASSOCIATED INSURANCE INDIANA	$1,326,312	$1,767,164 33.2%	$5,160,192 192.0%	$5,990,398 16.1%
IASD HEALTH SERVICES	$1,466,026	$1,528,349 4.3%	$2,619,650 71.4%	$3,028,748 15.6%
BLUE CROSS OF KANSAS	$658,350	$574,895 -12.7%	$1,064,076 85.1%	$1,311,893 23.3%
BLUE CROSS OF KENTUCKY	$654,984	$768,767 17.4%	$2,152,175 180.0%	$1,796,293 -16.5%
BLUE CROSS OF LOUISIANA	$1,594,996	$1,740,192 9.1%	$3,224,166 85.3%	$4,034,460 25.1%
HAWAII MEDICAL	$203,666	$218,299 7.2%	$551,261 152.5%	$613,908 11.4%
BLUE CROSS OF MAINE	$196,006	$350,697 78.9%	$676,937 93.0%	$494,760 -26.9%

BLUE CROSS OF MASSACHUSETTS	$630,712 15.3%	$727,430	$1,321,986 81.7%	$1,455,373 10.1%
BLUE CROSS OF MICHIGAN	$684,726	$777,685 13.6%	$1,410,410 81.4%	$1,275,590 -9.6%
BLUE CROSS OF MINNESOTA	$747,651	$1,396,780 86.8%	$6,717,137 380.9%	$7,003,025 4.3%
BLUE CROSS OF MISSISSIPPI	$180,956	$227,582 25.8%	$406,573 78.6%	$556,253 36.8%
BLUE CROSS OF MISSOURI	$2,697,873	$3,066,547 13.7%	$7,196,201 134.7%	$7,741,371 7.8%
BLUE CROSS OF MONTANA	$246,585	$239,868 -2.7%	$821,241 242.4%	$658,555 -19.8%
BLUE CROSS OF NEBRASKA	$11,347	$14,153 24.7%	$94,062 564.6%	$149,015 58.4%
BLUE CROSS OF NEW HAMPSHIRE-VERMONT	$122,849	$264,884 115.6%	$301,338 13.8%	$375,090 24.5%
BLUE CROSS OF NEW MEXICO	$164,309	$271,847 65.4%	$1,851,545 581.1%	$3,767,860 103.5%
EMPIRE BLUE CROSS NEW YORK	$4,649,860	$5,158,328 10.9%	$10,732,640 108.1%	$13,284,002 23.7%
BLUE CROSS OF NORTH CAROLINA	$418,062	$433,449 3.7%	$1,525,485 251.9%	$1,836,555 20.4%
BLUE CROSS OF NORTH DAKOTA	$161,865	$204,052 26.1%	$600,504 194.3%	$602,553 .3%
COMMUNITY MUTUAL INSURANCE OHIO	$2,184,684	$2,421,110 10.8%	$7,800,447 222.2%	$8,195,512 5.1%
BLUE CROSS OF OKLAHOMA	$912,560	$1,026,987 12.5%	$985,070 -4.1%	$832,871 -15.5%
BLUE CROSS OF OREGON	$643,401	$983,401 52.8%	$2,740,901 178.7%	$2,604,584 -5.0%

BLUE CROSS OF PHILADELPHIA, PA	$966,754	$1,186,745 22.8%	$2,611,751 120.1%	$2,834,427 8.5%
COOPERATIVA PUERTO RICO	$86,523	$74,995 -13.3%	$109,305 45.6%	$229,141 109.6%
BLUE CROSS OF RHODE ISLAND	$189,220	$256,954 35.8%	$1,279,789 398.1%	$1,139,088 -11.0%
BLUE CROSS OF SOUTH CAROLINA	$382,787	$353,002 -7.8%	$960,588 172.1%	$949,288 -1.2%
BLUE CROSS OF TENNESSEE	$1,110,672	$1,224,131 10.2%	$3,619,678 195.7%	$3,016,784 -16.7%
BLUE CROSS OF TEXAS	$2,304,866	$2,524,985 9.5%	$2,590,484 2.6%	$3,485,399 34.5%
BLUE CROSS OF UTAH	$416,283	$508,591 22.8%	$1,485,970 192.2%	$1,105,014 -25.6%
BLUE CROSS OF VIRGINIA	$517,577	$641,153 23.9%	$1,646,043 156.7%	$1,620,768 -1.5%
BLUE CROSS OF WEST VIRGINIA	$233,530	$243,951 4.5%	$759,773 211.4%	$887,130 16.7%
BLUE CROSS OF WISCONSIN	$870,318	$1,081,803 24.3%	$3,090,320 185.7%	$3,368,907 9.0%
BLUE CROSS OF WYOMING	$34,507	$30,135 -12.7%	$99,205 229.2%	$146,984 48.2%
TRAVELERS	$2,617,042	$3,809,356 45.6%	$12,772,469 235.3%	$13,205,106 3.4%
MUTUAL OF OMAHA	$7,309,716	$8,556,090 17.1%	$25,816,096 201.7%	$24,575,832 -4.8%
AETNA TOTAL A	$12,043,225	$14,320,023 18.9%	$56,863,843 297.1%	$63,689,235 12.0%