BEFORE THE PENNSYLVANIA INSURANCE DEPARTMENT

In Re: Reserve and Surplus Levels of Hospital Plan and Professional Health Services Plan Corporations, Notice 2004-01

COMMENTS ON THE APPLICATIONS OF THE FOUR BLUE CLASS PLANS

OF

PHILADELPHIA UNEMPLOYMENT PROJECT, CONSUMER HEALTH COALITION, MON VALLEY UNEMPLOYED COMMITTEE, SERVICE EMPLOYEES INTERNATIONAL UNION, PENNSYLVANIA STATE COUNCIL, PENNPIRG EDUCATION FUND, PHILADELPHIA CITIZENS FOR CHILDREN AND YOUTH, PENNSYLVANIA ALLIANCE FOR RETIRED AMERICANS, ACTION ALLIANCE OF SENIOR CITIZENS OF GREATER PHILADELPHIA, PHILAPOSH, PHILADELPHIA WELFARE RIGHTS ORGANIZATION, CITIZENS FOR CONSUMER JUSTICE, JOBS WITH JUSTICE, AND WOMEN'S LAW PROJECT

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DESCRIPTION OF STATE-WIDE AND NATIONAL PUBLIC INTEREST ORGANIZATIONS FILING THIS JOINT COMMENT

Thirteen Pennsylvania groups are filing these Comments with attached Report of consultant Lawrence Kirsch and IMR Health Economics, LLC, with the Pennsylvania Insurance Department in response to the applications of the state's four Blue Cross Plans to approve reserve and surplus levels. These are non-profit organizations and unions committed to improving the health of all Pennsylvanians and reducing mortality and morbidity in the Commonwealth by insuring access to needed health care and affordable health insurance for the well over one million Pennsylvania residents who are currently uninsured or underinsured.

These public interest organizations share a common interest in utilizing the considerable excess surplus of the four Blue Cross Plans across the Commonwealth to provide health insurance for the uninsured and related goals. They also believe that the Pennsylvania Insurance Department has an as yet unmet responsibility to specifically define and enforce the legally mandated charitable mission of the Blue Cross Plans and apply such policy in this proceeding by having excess surplus directed to these charitable purposes. The groups co-filing these Comments along with the appended Report of Mr. Kirsch are as follows:

Philadelphia Citizens for Children and Youth has worked for two decades on increasing the access and availability of health care and health insurance for children and families. Often, PCCY has found families with children covered by insurance programs, but their parents excluded from coverage, as well as families with incomes rendering both children and parents unable to afford coverage. Other families have had children with health needs exceeding services covered by the Children's Health Insurance Program (CHIP). Blue Cross surplus funds could provide better and more affordable health insurance to children and adults in

these families.

Pennsylvania Alliance for Retired Americans is comprised largely of labor union retirees, many of whom, under age 65, are not yet eligible for Medicare and are thus without coverage. The Alliance believes that Blue Cross surpluses could help union members who have lost health benefits from retirement, layoffs and job closings and who cannot now secure health insurance.

Consumer Health Coalition, based in Pittsburgh, is a health policy and advocacy organization that has scrutinized the charitable status and contributions, and reserve policies of Highmark Blue Cross/Blue Shield in Western Pennsylvania. Highmark, has amassed the largest dollar surplus of the four Plans. The Coalition believes that the Pennsylvania Insurance Department has failed to define and enforce the charitable obligations of Highmark, including its own 1996 Highmark merger Order requiring 1.25% of total premiums dedicated to charitable mission, as well as obligations of other Blue Cross organizations in the state, letting enormous surpluses be amassed that could be used to provide insurance to the uninsured.

Philadelphia Unemployment Project, established in 1975, is a membership organization of unemployed and low-wage workers that successfully advocated for the establishment of the new adultBasic Care ("ABC") health insurance program funded by tobacco settlement money in state hands. In light of the approximately 100,000 Pennsylvania uninsured now on the adultBasic waiting list, PUP maintains that the Department must enforce the charitable mandate of Independence Blue Cross and other Blues by ordering that excess surplus be directed for such measures as expanding the adultBasic program for these uninsured.

Action Alliance of Senior Citizens of Greater Philadelphia has struggled to provide

access to health care for retirees and others in the 55-64 age range who are too young to qualify for Medicare. Very few of these individuals are able to afford to pay Blue Cross premiums, even in those Plans that would accept them. Moreover, even Medicare insured senior citizens cannot pay for prescribed medications. IBC excess surplus, and surplus from other Blues, could be spent on extending medical and prescription coverage to these retirees and seniors.

Mon Valley Unemployed Committee of unemployed and underemployed workers in western Pennsylvania has found lack of access to affordable healthcare one of the most pressing problems facing its members, and often gets calls from those desperate for health care and with no health insurance. The Highmark Blue Cross "Special Care" insurance package for low income and unemployed is unaffordable; costing more than three times the premium set for adultBasic established with Tobacco Settlement monies. The Mon Valley Unemployed Committee testified at the "informational hearing" on excess surplus held by the Insurance Department on Sept. 4, 2002. MVUC urges the use of excess funds to expand the "Special Care" program by reducing its premium to the adultBasic level and ending its prohibition on covering pre-existing conditions, and by expanding openings for and the medical coverage of adultBasic.

Service Employees International Union, Pennsylvania State Council, Pennsylvania's largest union of health care workers, has a strong interest in ensuring all citizens enjoy access to quality, affordable health care. SEIU believes that the low staffing levels at many hospitals, especially of nurses, and the growing number of uninsured Pennsylvanians, raise significant public policy questions about the prudence of allowing the various Pennsylvania Blue Cross organizations to amass excess surpluses and fail to implement a charitable mission that could

ameliorate these problems.

PennPIRG Education Fund pursues public interest reforms by conducting research, formulating policy change and educating citizens. The Fund has worked to promote quality, affordable health care and patient safety in Pennsylvania, and thus is concerned about the adverse impact the excessive surplus of the Blue Cross Plans will have on access to quality health care for the uninsured and health consumers of Pennsylvania.

PHILAPOSH is a coalition of 100 unions in the Greater Philadelphia area concerned with job safety and workers health matters, and assisting those injured on the job. When Worker's Compensation claims are contested by insurance companies, workers and their dependents are often without health insurance or access to health care, creating a nightmare of anguish for the injured worker and his or her entire family. PHILAPOSH believes that the Insurance Department has an obligation to establish the criteria for and enforcement of a Blue Cross charitable mission that would assure that excess surplus be used for coverage of injured workers and families without health insurance.

Philadelphia Welfare Rights Organization is the oldest such group in the nation, advocating for the basic income and health needs of the impoverished in Pennsylvania. The unaffordability of private health insurance provided by Blue Cross, and the rising number of uninsured in the Commonwealth, has put undue pressures on the state's Medical Assistance (Medicaid), CHIP and adultBasic programs. This has led to threatened or adopted cutbacks in services or eligibility in Pennsylvania, which could be avoided if the surplus funds of Blue Cross were directed to expanding health insurance for the uninsured and making it more affordable for employers and employees.

Citizens for Consumer Justice is the Pennsylvania affiliate of USAction that represents three million members in 23 states. CCJ has worked on many community health care and health access issues, including testifying before the Insurance Department on Blue Cross surplus, and working to expand the CHIP and adultBasic programs. CCJ maintains that the Department needs to assure that Blue Cross charitable health assets be used to expand access to health care, instead of their being allowed to accumulate as excess surplus, as if these were for-profit health organizations.

Women's Law Project, based in Philadelphia and Pittsburgh, is a non-profit public interest legal center dedicated to improving the legal and economic status of women and their families. Since its founding in 1974, it has made insurance equity and accessibility for women a high priority. WLP is concerned about the so-called "gender treatment gap" in which uninsured women receive markedly lower levels of treatment and fail to receive critical health screenings compared to those with insurance. Blue Cross switching from community to demographic rating worsens discrimination against women. Blue Cross surpluses could be directed to meet the health insurance needs of these women, if the Department were to define and enforce the charitable obligations of Blue Cross with regard to these surpluses.

Schuylkill Alliance for Health Care Access, based in Pottsville, has as its mission creating a healthier community for residents of Schuylkill County by increasing the availability of and access to primary and preventive medical, dental and behavioral services. In pursuing its mission, the Alliance has addressed Blue Cross surplus and has sought to expand health insurance coverage of the uninsured, including those many eligible for adultBasic health insurance.

Jobs With Justice is an coalition of labor unions, community groups, faith organizations and student associations advocating for working families, increasing numbers of whom have found themselves lacking health insurance because of the unaffordable and inadequate health insurance products of the Blue Cross Plans and because of the failure of the Blues to meet their charitable obligations to uninsured workers.

PROCEDURAL HISTORY AND A PROCEEDING DENYING FUNDAMENTAL FAIRNESS TO CONSUMERS

By Notice 2004-01 of Jan. 17, 2004, 34 Pa.Bull. 458, the Insurance Commissioner directed the four Blue Cross Plans ("the Plans") to file applications in 90 days for approval of their reserves and surpluses maintained under 40 Pa.C.S. Chapter 61. After an abortive effort by a Plan to enjoin this proceeding in the Commonwealth Court, and the filing of these applications, by additional Notice, the Pennsylvania Insurance Department ("the Department") gave the public 30 days from August 16, 2004 to respond to these applications. The public was then given a ten day extension to Sept. 24, 2004 to file comments.

This is an unprecedented proceeding and initiative of the Department which, like other state Insurance Departments, have never set maxima for reserve and surplus levels despite the legal authority to do so. With a combined surplus of well over $4 billion and excess surplus in the billions of dollars, coupled with a compelling crisis of the uninsured in Pennsylvania, see infra, it is incumbent on the Department to abide by the highest standards of fairness and objectivity for consumer policyholders and the 1.4 million uninsured in the state.

The commenters, via their counsel, filed a Motion to the Department, dated September 3, 2004, to obtain basic procedural safeguards. A brief 10 day extension was granted the public, well short of the preparation time allocated to the Plans and also sought by movants here. The Department did not flatly reject the Motion's request for public, adversarial hearings, stating that the proposal was being taken under advisement.

The Department's failure to grant the relief requested in the Motion has meant that due process procedural fairness is currently lacking in this reserve and surplus proceeding and is in immediate need of remedying. The following due process procedural safeguards were requested

in the September 3, 2004 Motion, and are now further substantiated by a national health finance consultant, Lawrence Kirsch, in his Report ("Kirsch Report"), attached to these comments:

(1) Right to Pursue Discovery and Cross-Examination: This proceeding has no provision for discovery directed to the four Blue Cross Plans, and no access to essential, but redacted data, which could be accessed via a confidentiality agreement preserving any justified confidentiality. Mr. Kirsch, although clearly showing the inadequacy of the proffered surplus levels of the Blues was unable to offer specific upper level limits beyond adherence to the NAIC minimum 200% RBC level, because, he wrote,

> [L]ack of access to essential Plan data precludes my doing so. Examples of essential non-public data include each Plan's Risk Based Capital Report to the Department, redacted portions of their applications in this proceeding, business and financial plans and the risk assessment models generated by consultants and relied upon by the Plans. I have also been stymied by the presentation of the financial data on a parent company-only basis instead of on a consolidated basis....[P]arent-only financial presentations now before the Department provide an incomplete and misleading picture of the financial strengths and risks of the applicants.

Kirsch Report at 8-9. The lack of access to essential data remarkably extends also to the Insurance Department, which, according to Mr. Kirsch, also lacks access to each Plan's risk assessment model, and thus "the Department cannot independently validate the estimates provided or critically assess their underlying assumptions." Id. at 9.

Similar issues extend to assessing the charitable mission commitments of the Blue Cross Plans. For example, the Plans assert that they subsidize and support such programs as CHIP and adultBasic but, according to Mr. Kirsch, "None of them...has furnished data to back up their subsidy claims. There is no way of knowing what proportion of the total support they claimed was, in fact, charitable in nature." Kirsch Report at 15-16. It is highly apparent that the Blue

Cross Plans have been inconsistently and loosely attributing varying expenditures to charitable mission, yet no one has interrogated them to obtain a truthful accounting of what would clearly meet a charitable mission. Id.

Without a right of discovery and cross-examination, the uninsured and policyholders cannot fully and fairly comment on the applications. Because the Department similarly lacks much of this data as well, this procedural deficiency impedes the very ability of the Department to achieve its own stated regulatory goal here.

(2) Adversarial Public Hearings: The Department has written to counsel for the commenters that it is "continuing to monitor the need for or propriety of hearings as this process progresses." Such hearings are essential if fundamental fairness is to be assured and also essential to accurately assess how much of the accumulated surpluses are excessive. Mr. Kirsch has proposed an alternative approach to evaluate Plan-specific upper bound values providing for the Department asking each Plan to prepare models incorporating basic risk assumptions and specifications set forth by the Department. Kirsch Report at.9 et seq. With this alternative process, Mr. Kirsch recommends that the Department notice,

> [C]ontested case proceedings to the four Blue Cross Plans for the purposes of evaluating the reasonableness of maximum surplus levels...in light of estimates of the underlying risks.

Id. at 11. This proceeding embraces the most important and largest health insurance policy issue ever to come before the Department. It is one of major national interest because of the precedent setting impact for the rest of the country. For this proceeding to be done right, public and adversarial hearings are necessary. Under the Hospital Plans Corporation Act the agency has ample authority to schedule such hearings as its authority to seek application from and approval

of Plan reserve levels, 40 Pa.C.S.A.§6124, incorporates the procedural provisions of Sec. 6102(c)–(f) providing that the Department "shall afford reasonable opportunity for hearing which shall be public...." 40 Pa.C.S.A. §6102(e).

(3) Appointment of an Insurance Public Advocate in This Proceeding: For the most significant health insurance proceeding in the Department's history, the appointment of a Public Advocate may be the most important procedural measure to establish an equal playing field with four Blue Cross Plans. These Plans have repeatedly demonstrated that they have virtually unlimited funds for actuaries, lawyers, consultants, lobbyists, public relations, support staff and contributions to garner public support to press their self-serving claims upon the Department. The Utility Public Advocate in Pennsylvania has demonstrated the extraordinary efficacy of having such an Advocate in similar proceedings before the Public Utility Commission.

As appointment an Advocate now would be a new initiative for the Department, a special effort would be required to direct funding for this position; an Insurance Department assessment of the Plans is a logical source of funding to parallel the funding for the Utility Public Advocate coming from PUC regulated industries. The Governor's Office also has authority to appoint a special counsel who could serve as an Advocate in this proceeding as the Office had done prior to the establishment of the Utility Public Advocate.

The 1.4 million uninsured and millions of others who are underinsured and are Blue Cross subscribers in Pennsylvania currently have no Advocate, and with the richly resourced and free-spending Plans, the current highly unequal playing field will continue unless the Department acts now.

(4) Appointment of an Independent Hearing Examiner and Recusal of the Insurance Commissioner and Staff: On January 16, 2004 when the Commissioner published her Notice 2004-01 setting up a regulatory inquiry to ascertain and establish maxima for accumulated surplus, whether intentionally or unintentionally, she gave the distinct and lasting impression of already having the answer to this key adjudicative issue. The Department, without any apparent legitimate regulatory need to do so, set forth in this Notice its answer to this pivotal question by asserting that the "appropriate RBC [Risk Based Capital] ratio range for the Blues Plans is most likely [sic] between 350% and 650%. [Those]...in excess of 650% are likely [sic] excessive."

Although, after the fact, the Department now claims that this was not an "adjudication" or "finding" or "prejudged determination," the Commonwealth Court nevertheless stated that this Notice did in fact represent the Department's "position on RBC" and was "a statement of the Department's policy." Capital Blue Cross v. Koken, No. 172 M.D. 2004 (March 23, 2004) (Pellegrini, J.) (by holding that this statement did not embody a "binding norm" it rejected the claim that formal rule-making was a required prerequisite; rule making is an issue clearly distinct from the need to appear fair and independent). If the purpose of the initiated proceeding was to objectively, fairly and independently assess what surpluses were excessive, what regulatory purpose was served by rendering at the very outset any judgment, even a non-binding one?

Reasonable skepticism about the pre-judgment of the issue, or appearance of pre-judgment, was generated not only by the Notice's lack of any accompanying studies, hearings, filings or apparent rational analysis to support these numbers, but also by the fact that the only two specific sources cited by the Department and supportive of these RBC numbers came from the Blue Cross Plan industry and had no legal or governmental policy support: one was the Blue

Cross Blue Shield Trade Association supporting a questionable 375% minimum.[1] The second was a reference to the Blue Cross industry wide average of 628%, interestingly just under the 650% level, which the Commissioner's Notice said would be her "likely excessive" threshold. Of course this 628% average has been allowed to float in a regulatory environment where no Insurance Department, including Pennsylvania's, has ever set a maximum

Extraordinarily, the Commissioner did not acknowledge or reference the much lower 200% RBC standard measure for surplus of her own National Association of Insurance Commissioners. Kirsch Report at 6 et seq. There was no justification or even apparent need to set forth a very high threshold, "likely excessive" number in the Department's Notice that was above the Blue Cross trade association and industry average numbers, except perhaps to send a pre-adjudicatory message to the Plans not to be overly worried about where this proceeding would be leading in setting surplus maxima for them.

An adjudicative or quasi-adjudicative body that on the first day of a seemingly independent and public inquiry states so baldly its public "position," Capital Blue Cross, supra, on the seminal issue to be elucidated by the proceeding, and where this "position" so clearly tilts toward one set of parties to the proceeding who have a long history of having their way before this agency, forfeits its position in the public eye as a fair and independent decision-maker, whatever the protestations that this was not a prejudged determination.

The Pennsylvania Constitution due process protections guarantee not only fairness in fact but also the "appearance of fairness." As our Pennsylvania Supreme Court has held,

[1] This standard receives multiple criticisms in the Kirsch Report, including the fact that the trade association has not offered a documented rationale for it, creating a "classic 'black box' [that] should not be relied upon by the Department." Kirsch Report at 6-7.

> There is a strong notion in Pennsylvania that even an appearance of bias or partiality must be viewed with deep skepticism in a system that guarantees due process to each citizen....'actual bias' is not the watchword in ferreting out violations of due process under the Pennsylvania Constitution.

Lyness v. State Board of Medicine, 529 Pa. 535, 542-43, 605 A.2d 1204, 1207-08 (1992).

It is irrelevant whether the Department's official "position" or "policy" on RBC ratios and what would be a "likely excessive" surplus was or was not an "adjudicative fact" or "finding." Much more critical is whether an appearance of pre-judgment of the issue was generated by the Commissioner proffering her opinion or as the Commonwealth Court termed it, her "position" on the issue most central to the adjudication or quasi-adjudication she would soon be deciding. There can be no doubt that the Commissioner, even inadvertently, has established an appearance of pre-judgment and should recuse herself and her senior staff who prepared the Notice 2004-01 and the RBC numbers in it.

Aside from this recusal issue, the Commissioner should appoint an independent hearing examiner to review the filings, conduct discovery, hear evidence and preside over the cross-examination of Blue Cross witnesses so that an unbiased decision, based on pertinent facts only of public record, can be rendered in this proceeding.

In conclusion, until these procedural safeguards are established for consumer policyholders and the uninsured in need of health insurance, there can be no due process or justice in this proceeding.

COMMENTS

I. THERE IS A HEALTH CARE COVERAGE CRISIS IN PENNSYLVANIA: THE UNINSURED GET SICKER AND DIE EARLIER, WHILE PENNSYLVANIA'S BLUES PLANS INCREASE THEIR EXCESSIVE SURPLUSES INSTEAD OF HEALTH CARE.

Pennsylvania is in the midst of a health insurance coverage crisis. By 2003, the proportion of Pennsylvanians who lacked any form of health insurance had reached 11.4%[2] - over one million Commonwealth residents. This figure includes the elderly, who are almost all covered by Medicare;[3] the uninsured rate among the non-elderly was about 12%.[4] Other recent regional data confirms the health crisis. Even in Southeastern Pennsylvania,[5] home to some of Pennsylvania's wealthiest counties, a 2002 survey found the uninsured rate for adults to be 8.9%.[6] The number is as high as 3.9% for children,[7] despite their eligibility for a wider variety of publicly funded programs.[8]

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[2] "Income, Poverty, and Health Insurance Coverage in the United States, 2003," U.S. Census Bureau, available at http://ferret.bls.census.gov/macro/032004/health/toc.htm.

[3] Less than 1% of the elderly were uninsured for the entire year in 2002. See "Health Insurance Coverage in the United States: 2002," U.S. Census Bureau, 2002, ("Health Insurance Coverage") available at: http://www.census.gov/prod/2003pubs/p60-223.pdf. Ex. 8.

[4] "Kaiser Family Foundation State Health Facts Online," Kaiser Family Foundation, 2003, available at: http://www.statehealthfacts.kff.org/cgi-bin/healthfacts.cgi. ("Kaiser 2003").

[5] Southeastern Pennsylvania defined as Bucks, Chester, Delaware, Montgomery, and Philadelphia counties. "Community Voices: Health, Wellness and Quality of Life In Southeastern Pennsylvania," Philadelphia Health Management Corporation's Community Health Data Base 2002 Southeastern Pennsylvania Household Health Survey. ("PHMC 2002"). Ex. 2.

[6] PHMC 2002.

[7] PHMC 2002.

[8] Medicaid provides coverage for all children from families under 100% of the Federal Poverty Income Guidelines, and covers young children from families up to 185% of the Federal Poverty Income Guideline depending upon age. 55 Pa. Code §§140.1(b), 140.3. Disabled children are covered by Medicaid regardless of their parental income. Medical Assistance Eligibility Handbook §355.4. Ex. 27. The CHIP program covers children from families up to 235% of the Federal Poverty Income Guideline. 40 Pa. Stat. Ann. § 991.2311(e)(1).

The data show a consistent increase in the number and percent of uninsured in recent years, as the Plans, like Independence Blue Cross ("IBC") in the southeast, built their surpluses to enormous levels[9] – the percentage of non-elderly Pennsylvanians without health insurance has risen from 9.2% in 1999-2000[10] to 11.9% in 2003.[11] Since then, the problem has only continued to worsen. Nationwide, in 2004, health insurance premiums have risen so high that employers have been unable to hire new workers due to the unsustainable cost of their benefits. In the second quarter alone, the cost of health benefits rose at an annual rate of 8.1 percent - more than three times the inflation rate.[12] At least some Pennsylvania insurers report that they expect to impose double-digit premium increases between 2004 and 2005, outpacing the rest of the country – including an increase in the mid-teens for Blue Cross of Northeastern Pennsylvania ("BCNEPA").[13]

By mid-August 2004, a poll revealed that a quarter of Pennsylvanians had postponed treatment for an illness or injury due to cost, or had had difficulty affording necessary medical care, while 13% had been dropped from a health insurance plan or denied coverage entirely.[14] One in four respondents said that a family member had gone without health insurance at some

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[9] PHMC 2002.

[10] "Health Insurance Coverage in America: 2000 Data Update," Kaiser Family Foundation, February 2002, available at http://www.kff.org/uninsured/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14103.

[11] Kaiser 2003.

[12] Eduardo Porter, "Rising Cost of Health Benefits Cited As Factor in Slump of Jobs," New York Times, August 19, 2004.

[13] Jeff Sonderman, "Health insurers talking double-digit hikes," The Scranton Sunday Times, August 29, 2004.

[14]The Pennsylvania Economy League, "Issues PA/Pew Poll: 44% of Pennsylvanians Say Health Care Is Getting Worse," September 2004, available at http://www.issuespa.net/articles/10262/.

point in the past year.[15] Unsurprisingly, the proportion of Pennsylvanians ranking health care costs as a big problem rose to 50% in 2004.[16]

The implications for living without health insurance are serious and severe. The uninsured "receive less preventive care, are diagnosed at more advanced disease stages, and once diagnosed, tend to receive less therapeutic care (drugs and surgical interventions)."[17] The uninsured get reduced access to care, poorer medical outcomes, tend to live sicker and die earlier, die from preventable diseases at higher rates, and have much higher utilization rates for emergency services, according to The American College of Physicians.[18]

Uninsured persons often do not get health care treatment. A 2003 national study showed that the uninsured are three times more likely to postpone seeking medical care because of cost, four times more likely to not get needed care, three times more likely to not get prescription coverage because of cost, and almost three times more likely to skip recommended treatment because of cost.[19] A 2002 survey indicates that uninsured children are 70% more likely to go untreated for common conditions, and 30% more likely to go untreated for injuries.[20] The

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[15] Id.

[16] Pennsylvania Economy League, "Pennsylvanians Increasingly Concerned About Economic Conditions in the Commonwealth," press release, May 11, 2004.

[17] "Sicker and Poorer: The Consequences of Being Uninsured," Executive Summary, Kaiser Family Foundation 2003 Commission on Medicaid and the Uninsured, Kaiser Family Foundation, 2003 ("Kaiser 2003"), available at: http://www.kff.org/content/2002/20020510/4051.pdf. Ex. 40.

[18] "Fact Sheet: The Cost of The Uninsured," available at: http://www.acponline.org/uninsured/cost_factsheet.pdf. Ex. 6.

[19] "Access to Care For the Uninsured: An Update," Kaiser 2003 Commission on Medicaid and the Uninsured. ("Kaiser Update 2003") Available at http://www.kff.org/content/2003/4142/4142.pdf. Ex. 1.

[20] Kaiser Update 2003.

treatment the uninsured do receive is often late, meaning they are hospitalized for preventable conditions or detected with virulent diseases, such as cancer, at later stages.[21]

Data for Southeast Pennsylvania, IBC's coverage area, confirms the gap separating the uninsured from treatment. The uninsured are four times more likely to have no regular care, three times more likely to have no prescriptions or dental treatment, and over half of uninsured patients visited an Emergency Room instead of a doctor's office.[22] The treatment gap is particularly pronounced for demographic subpopulations, such as women, who receive dramatically lower levels of treatment when uninsured. The percentage of women who did not receive critical health screenings is far greater for women without insurance than women with private insurance: 46.7% to 18.2% for mammograms, 47.9% to 22.1% for breast exams, and 50.8% to 24.9% for PAP tests.[23]

Not surprisingly, the gap in treatment translates into debilitated health status for the uninsured. Nationally, it is estimated that insuring the uninsured would reduce their mortality rate (i.e., the rate at which they die) by 10-15%.[24] The non-elderly uninsured are 70% more likely to die from diagnosed colorectal cancer, 29% more likely to die in hospitals after heart attacks, and 115% more likely to die in hospitals after traumatic injuries.[25] Most troubling is the dramatically increased rate of infant mortality for uninsured mothers: their babies are 60% more

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[21] Kaiser Update 2003.

[22] PHMC 2002, supra note 5.

[23] PHMC 2002.

[24] Kaiser Update 2003.

[25] Kaiser Update 2003.

likely to die in the first month after birth, and 50% more likely to die in the remaining months before their first birthday.[26]

Throughout Pennsylvania, the inferior health status of the uninsured is clear. Uninsured non-elderly adults are 34% more likely to suffer from fair or poor health (as opposed to good or excellent health) than their insured counterparts.[27] Uninsured children are 73% more likely to suffer from fair or poor health than insured children.[28] Although the elderly are largely covered by Medicare, those elderly who are uninsured are 53% more likely to suffer from depression.[29]

Ironically, the uninsured overpay for the treatment they do receive. Insurance companies and programs negotiate with hospitals and doctors for reduced rates, and the hospitals make up at least part of the shortfall by raising rates on the uninsured.[30] Far from minimal, the differences can be staggering.[31]

Lacking health insurance also leads to the cycling of the uninsured. First, virtually all insurance plans have exclusions (or prohibitive premiums) for pre-existing conditions, such that

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[26] Kaiser Update 2003.

[27] Lucette Lagnado, "One Critical Appendectomy Later, Young Woman Has a $19,000 Debt" Wall Street Journal On-Line, March 17, 2003. The percentages are 25.3% for the uninsured compared to 18.9% for the insured. Ex. 26

[28] 10.4% for the uninsured compared to 6.0% for the insured. PHMC 2002.

[29] 19.3% for the uninsured compared to 12.6% for the insured. PHMC 2002.

[30] See supra note 20.

[31] A study of charges for routine mammogram service showed the price differences at several hospitals around the country. UCLA Medical Center in Los Angeles charges $460 to individual payers, but only $90-242 for HMOs, health plans, Medicaid, and Medicare. Jamaica Hospital in Queens, NY, charges $351 for individual payers, but only $40-96 for HMOs, health plans, Medicaid, and Medicare. Other hospitals showed similar trends: $240 versus $59-128 at Oregon Health and Science University in Portland, $261 versus $156-186 at Johns Hopkins Hospital and Health System in Baltimore, and $285 versus $73-190 at Grinnell Regional Medical Center in Grinnell, Iowa. Supra note 20.

once a person becomes uninsured, it may be impossible to get back into an insured status.[32] Second, because insurance correlates to good health, the uninsured are more likely to have sickness that interferes with employment – which is the primary source of insurance. Finally, when an uninsured individual attempts to become insured, they face the highest level of expense, because studies have shown that cost reduces with enrollment time.[33] All of these factors pull the uninsured away from possible sources of coverage, and propagate the cyclical uninsured status.

The uninsured crisis has overwhelmed the under-funded programs run through the Insurance Department. In July of 2002, the Department began the adultBasic program, which was contracted through the Plans throughout Pennsylvania with Tobacco Settlement monies paying the cost, and which provides low-cost insurance to low-income eligible adults.[34] By February 2003, only 8 months after adultBasic began, it had reached its maximum capacity of 50,258 enrollees,[35] but, due to declining tobacco funds, the number of enrollees has decreased since then.[36] In March 2003 a waiting list was created, and by June 2004 the waiting list had

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[32] Taking IBC as an example, in its materials on Individual Health Plans, it notes that IBC's only plans that are not subject to pre-existing conditions exclusions are two (federally-mandated) HIPAA plans, as well as the publically funded adultBasic and CHIP programs. See "IBC Personal Choice PPO – Creditable Coverage FAQ," available at http://www.ibx.com/jsps/article.jsp?id=/plan_info/individual/personal_choice_ppo/credible_coverage_faq.html. Ex. 9.

[33] "Staying Covered: The Importance of Retaining Health Insurance For Low-Income Families," Center on Budget and Policy Priorities, December 2002, p 8-9, available at http://www.cmwf.org/programs/insurance/ku_stayingcovered_586.pdf. Ex. 44.

[34] Legislative Update to Blue Cross of NE Pennsylvania by adultBasic program director Patricia Stromberg, 5/9/03. ("Legislative Update"), available at http://www.bcnepa.com/legislative_info/leg_update_5.9.03.htm. See also, "Facts About adultBasic," Pennsylvania Insurance Department Report to CHIP Advisory Committee, July 29, 2003. ("Facts About adultBasic"). Ex. 23.

[35] Legislative Update; Facts About adultBasic.

[36] Facts About adultBasic.

grown to over 100,000 applicants.[37] The need for health care is so great that, in under a year, the adultBasic program more than double over-enrolled. In fact, the Department has estimated that there are upwards of 350,000 Pennsylvanians eligible for adultBasic,[38] although actual enrollment has fallen to 37,087 in August 2004.[39]

The filings currently before the Department should be viewed within the context of Pennsylvania's health insurance coverage crisis. As the Blues plans increased their already excessive surplus and excessive reserves instead of using the excess to meet their charitable obligations and mission, the numbers of Pennsylvania's uninsured and underinsured increased. The Department has the authority and responsibility to redress this situation.

[37] Marian Uhlman, "Waiting list for health care surges in Pa.," The Philadelphia Inquirer, September 17, 2004.

[38] Legislative Update.

[39] Pennsylvania Insurance Department, "adultBasic Enrollment By County," August 20, 2004, available at http://www.ins.state.pa.us/ins/cwp/view.asp?a=1278&q=527061&tx=0.

II. BY FAILING TO REPORT THE RESERVE AND SURPLUS LEVELS OF THE CONSOLIDATED COMPANY, THE PLANS HAVE SEVERELY UNDERSTATED THEIR RESERVE AND SURPLUS LEVELS AND FAILED TO COMPLY WITH THE DEPARTMENT'S DIRECTIVE.

According to the January 16, 2004 Notice upon which this proceeding is based, the Plans were required to submit applications which:

> [S]tate what reserve levels it and all of its insurance subsidiaries are holding and what surplus levels it and all of its insurance subsidiaries are currently maintaining…

Notice 2004-1(a)(emphasis added). Despite the explicit requirement that the Plans' applications state reserve and surplus levels of the Plan and "all of its insurance subsidiaries," all four Plans' analysis of surplus levels focused upon the parent company-only surplus and not the consolidated company surplus. This flouting of the clear instructions of the Department greatly undercounts the true surplus addressed by the four Plans' applications.

As explained in the Kirsch Report, the Capitol Blue Cross ("CBC") application reveals the extent to which the failure to include subsidiaries impacts any determination of surplus levels. CBC's application reported a parent-only surplus as of December 31, 2003 of $515 million, compared to the consolidated company surplus of $788 million (it appears that CBC was the only Plan to report a consolidated company surplus, but its analysis lay with the parent company-only surplus). Kirsch Report at 3. The disparity between parent and consolidated company is likely largest for IBC. As of 2003, 64.8% of IBC's parent company's admitted assets were invested in subsidiaries and affiliates. Id. at 3. Thus IBC's asserted parent company-only surplus of $841 million (representing 391% ACL), is likely an extraordinary undercounting of their true surplus.

This entire proceeding must be premised, as the Department's initiating Notice laid forth, upon an accounting of all the reserve and surplus of the Plans and all their subsidiaries. By

ignoring the plain mandate and clear instructions of the Department in the agency's January 16, 2004 Notice, the Plans have filed inadequate and deceptive applications for approval by the Department. The Insurance Department should take immediate steps to remedy this flouting of its directive.

III. THE PLANS HAVE NOT MET THEIR BURDEN OF JUSTIFYING EITHER LOWER OR UPPER RANGE SURPLUS LEVELS.

Under the Notice, the Plans were required to submit applications which:

> [S]tate the maximum RBC ratio within the 350% to 650% range that is appropriate, and explain the rationale for that maximum ratio…

Notice 2004-1(b). The Department's Notice clearly put the burdens of proof and persuasion upon the four Plans to both "state" and "explain the rationale for" their company's maximum Risk Based Capital standard. After a detailed analysis by Lawrence Kirsch, Managing Partner of IMR Health Economics, a nationally recognized health finance consulting firm, of the four Plan applications filed and open to the public, it is apparent that all four Plans have totally failed to justify either their lower range level proposed – 375% ACL – or their proposed upper range surplus levels – up to 950% ACL or greater.[40]

A. The Department has the Authority to establish acceptable minimum and maximum reserve levels.

Preliminarily it should be noted that the Department has ample authority to establish both minimum and maximum levels of reserves of the Plans. As hospital plan corporations, the Plans are subject to the requirements of the Hospital Plan Corporations Act ("the Act"). The Act grants the Department the explicit authority to approve the rates and reserves of the Plans.

> The rates charged to subscribers by hospital plan corporations, all rates of payments to hospitals made by such corporations pursuant to the contracts provided for in this chapter, all acquisition costs in connection with the solicitation of subscribers to such hospital plans, *the reserves to be maintained by such corporations*, the certificates issued by such corporations representing their agreements with subscribers, and any and all contracts entered into by any such corporation with any hospital, shall, at all times, be subject to the prior approval of the department. 40 Pa.C.S. § 6124 (a) (emphasis added).

[40] ACL or "authorize control level" is the level of surplus below which state insurance agencies are authorized to take protective action on behalf of policyholders and creditors. Surplus is deemed sufficient at 200% ACL or greater to permit insurance comp any operations without regulatory intervention or supervision.

The authority granted the Department by the Act was confirmed by the Pennsylvania courts in Ciamachelo v. Independence Blue Cross, 814 A.2d 800; 2002 Pa. Commw. The Court recognized that the Plans, as hospital plan corporations authorized by the Act, are a special class of insurers and therefore, "subject to regulation **[**5]** by the Insurance Department, which must approve its rates, reserves, and surplus, as well as the investment of its reserves and surplus." Id., at 4-5, 802.[41]

Most relevant to this proceeding, Pennsylvania courts have directly confirmed the authority of the Department to conduct this specific review of the Plans' reserves and surplus. CBC v. Koken, No. 172 M.D. 2004 (Cmwth. Ct. March 23, 2004) (Pellegrini, J.) (denying preliminary injunction to enjoin this proceeding).

The authority of the PID to review and approve surplus is in no way limited to reviewing and approving a minimum amount of reserves. The statute which expressly grants the PID authority over the reserve amounts, 40 Pa.C.S. § 6124 (a) contains no language limiting Department authority to reserve minimums. Instead the Department is vested with a broad authority of prior approval of the reserves maintained by the Plans – including the maximum level of those reserves.

B. A 200% ACL Minimum Threshold is Fully Adequate; the Trade Associations Self-Serving 375% ACL is an Excessive Minimum.

The Kirsch Report shows that the minimum threshold of 375% ACL, the Blue Cross trade association (BCBSA) standard, is excessive and has been simply asserted, *ex cathedra,* by

[41] Ciamachelo, of course, reverses a Common Pleas Court decision to deny a motion to dismiss on jurisdictional grounds by Independence Blue Cross (IBC). In their appeal, to the Commonwealth Court, IBC argued vigorously that the Department did in fact have the authority to review and approve the reserves and surplus of the Plans. Other Plans have made this argument both as Amici in the Carmichelo case and in other proceedings in an attempt to escape the jurisdiction of Pennsylvania courts as described by the Memorandum of Law of the PA Insurance Department and Commissioner M. Diane Koken in Opposition to Petitioner's Application for Preliminary Injunction, filed in CBC v. Koken.

the Plans as a number without any documented of record, specific justification. The National Association of Insurance Commissioners (NAIC) adopted a 200% ACL, "early warning" minimum standard in the early 1990's which, in retrospect, was an overly conservative and cautious minimum. Kirsch Report at 6. Since that time the health insurance industry has shown considerable growth and has substantially reduced the risks of insolvency through consolidations of weaker Plans into large, more secure corporate structures; and since that earlier time, the Plans have shifted risk off them to providers, policyholders, reinsurers, and mechanisms like the consortium established by the Plans in Pennsylvania. Id.

The Plans' refusal or inability to detail the data and assumptions in their BCBSA standard of 375%, which would allow the number to be subjected to independent analysis and criticism, renders the self-serving standard of the industry unreliable and unsupported within this record, and bearing no legal authority.

C. Current Plan Capital and Surplus, and Proposed Maxima, are Far in Excess of Those Needed for Reasonably Projected Risks.

The Plans' combined, application filed surplus–but only for the parent companies–has now climbed to $3.96 billion, an increase of $500 million just in the prior year. Kirsch Report at 7. The consolidated companies combined surplus could well be a third or more higher than this total, when the true numbers are demanded, obtained and reviewed by the Department. Id. at 3. Even with this undercount, percentages of ACL range from 391% to 1006% (the latter for BCNEPA). Upper thresholds proposed by three of the Plans (CBC had no specific recommendation) would range from 650% to 950% ACL (the latter Highmark's upper range). Thus the Plans make the extraordinary assertion that they could have capital and surplus of just under $6 billion, 50% more than their undercounted reported levels, and still not have "excess"

surplus. Id. at 7-8.

Typical of the far fetched and facially defective analysis proffered by the Plans, is the Highmark Blue Cross Clue Shield, Inc ("Highmark") suggestion of a target surplus that would include three components: (1) the base BCBSA minimum threshold of 375% ACL; and (2) an operating component to cover claims fluctuations and corporate commitments; and (3) a contingencies component to address unforeseen events like market changes. The Kirsch Report properly finds these components "overlapping and duplicative." Id. at 13, n.43

The Kirsch Report's analysis of the Plans' historical experience over thirteen years, 1990-2003, shows that even their current, underreported surplus, much less the Plans' proposed maxima, are "far in excess of [their] realistic needs." Id. Surplus serves a valid function in protecting against adverse claims' experience, but the Kirsch Report shows that over a decade of operations there has been a marked and largely steady increase in each Plan's surplus even when Plans like Highmark and CBC showed substantial annual or multi-year losses. Id. Based on the information made available to the public, the magnitude of the surplus cannot now be viewed as either necessary or reasonable to protect against projected risk.

D. An Adjusted 200% ACL Threshold Surplus Provides Reasonable and Adequate Risk Protection for the Blue Cross Plans.

It is apparent that the Plans' proposed minima and maxima have no substantiated support in this record. The Kirsch Report recommends a minimum capital and surplus requirement of 200% ACL--the amount proposed by the NAIC and embodied in Pennsylvania law. If desired by the Department as extra protection, Kirsch would also support a a time-limited increase in minimum surplus that would take effect if and when a Plan experienced a negative surplus

trend and was in substantial danger of triggering regulatory insolvency-avoidance measures (The standby provision is similar to one in Maine, Rev. Stat. Ann., Title 24-A §6453(1)(A)(2)).

E. A Further Contested, Public Hearing Proceeding to Determine Maxima is Alternatively Recommended.

The Kirsch Report, as noted earlier, both shows that the lack of access to essential data precludes a more thorough upper limit recommendation,[42] and that the Department itself is stymied to determine upper bound limits because it, too, has been given incomplete data by the Plans (e.g. parent-only data), and it lacks access to the Plan risk assessment models to independently and critically validate estimates and underlying risk assumptions. Id. at 8-9.

The Kirsch Report sets forth an alternative modeling exercise in which the Department would detail particular assumptions and specifications to assess reasonable underlying risks for each Plan. Instead of utilizing the original RBC model developed by the firm currently known as Milliman USA, and later adopted by the NAIC, which embraced a number of overly conservative biases, such as an evaluation of a pattern of underwriting gains and losses during a historical period of considerably higher volatility, the Kirsch Report proposes an alternative model that would incorporate the record of Blue Cross improvements in managing less volatile underwriting. Id. at 10-11. These reflect, as well, the recommendations of other consultants, Ernst and Young, and Nova Rest Consulting, to the North Carolina Insurance Department and Washington Insurance Commissioner, respectively. Id. at p. 11.

F. Excess Surplus Harms the Uninsured and Underinsured and Policyholders.

Excess surplus is highly deleterious to the public interest when it exceeds, as with all the

[42]This includes filing of parent company-only financial data; the Plans' Risk Based Capital Reports to the Department; redacted portions of their applications in this proceeding; and business and financial plans and the risk assessment models generated by consultants for the Plans' use here. Kirsch Report at 8-9.

four Plans here, what is reasonably required to protect against realistic risks of insolvency.

The Kirsch Report, perhaps for the first time in a proceeding before the Department, suggests that "the higher the overall dollar contribution to margin"-- the premium contributions earmarked for Plan surplus (or profits)–"the more unequal will be the burden imposed on the least favored policyholders." Id. at 13-14. Individual and small group subscribers make a disproportionately higher contribution to margin than large employer groups and self-funded accounts, as shown in the Capital Blue Cross example utilized by Kirsch. Id. at 14, n.47. Thus the excess surplus problem has a heretofore unexamined, fundamental inequity which calls for remedying, and adds yet another public policy reason for departmental action.

Other adverse effects of excess surplus need little exposition as it is uncontroverted that the high premiums that fuel excess surplus contribute to the increasing rate of uninsurance, as subscribers and employers drop coverage. And high premiums force policyholders to "buy down" coverage, e.g. reducing benefits or increasing deductibles, which eviscerates adequate levels of protection for the escalating costs of medical services. Id. at 14.

IV. THE PLANS HAVE MADE GROSSLY INSUFFICIENT, TRULY CHARITABLE CONTRIBUTIONS IN PART BECAUSE THE DEPARTMENT HAS FAILED TO DEFINE AND ENFORCE THE LEGAL CHARITABLE OBLIGATION OF THE PLANS,

Under the Notice, the Plans were required to:

> [I]dentify the Plan's funds dedicated, allocated or expended for charitable purposes in 2002 and 2003, and those planned for 2004 through 2006;

Notice 2004-1(c). The information submitted by the Plans reveals that a lack of departmental regulation of the charitable obligations has discouraged the Plans from taking their charitable obligation seriously and has allowed them to skirt their legal responsibilities.

A. The Plans have a statutory obligation to dedicate resources to charitable purposes.

Corporations holding certificates under the Act are required to function as "charitable and benevolent institutions." 40 Pa.C.S.§ 6103(b). As charitable institutions, all "funds and investments" of the corporation are exempt from "taxation by the Commonwealth and its political subdivisions." Id. As corporations which hold certificates pursuant to the Act, the Plans have all been declared "charitable and benevolent institutions" and are eligible for state tax exemptions.[43]

1. In order to qualify for this tax exemption, the Plans must operate as institutions of purely public charity.

The Plans' grant of tax exemption came from the General Assembly, pursuant to the authority granted by the Pennsylvania Constitution, Article VIII, §§ 2(a)(i), (a)(vi). The Plans cannot qualify for this exemption unless they are "institutions of purely public charity," because

[43] The Blue Plans are not-for-profit corporations engaged in the business of maintaining and operating nonprofit hospital plans, i.e. plans whereby for prepayment, periodical or lump sum payment hospitalization or related health benefits may be provided to subscribers to such plans. Thus, they are hospital plan corporations within the meaning of 40 Pa.C.S. chapter 61, as defined in § 6101. See Ciamaichelo v. Independence Blue Cross, 814 A.2d 800, 802-803 (Pa.Cmwlth. 2002).

"the legislature is constitutionally limited to exempt only those charitable organizations which are institutions of purely public charity[.]" Hospital Utilization Project v. Commonwealth of Pennsylvania, 507 Pa. 1, 12, 487 A.2d 1306, 1312 (1987).[44]

The Pennsylvania Supreme Court has explained that a corporation cannot qualify as a purely public charity unless, at a minimum, it serves a charitable purpose and benefits a class of persons who are legitimate subjects of charity. Hospital Utilization Project ["H.U.P."], 507 Pa. at 18, 487 A.2d 1315; St. Margaret Seneca Place v. Board of Property Assessment, Appeals and Review, County of Allegheny, 536 Pa. 478, 483-486, 640 A.2d 380, 383-384 (1994). In so doing, such a corporation must render a substantial portion of its services freely or at a greatly reduced, subsidized price, and relieve the government of some of its burden. HUP, 507 Pa. at 18, 487 A.2d 1315; St. Margaret Seneca Place, 536 Pa. at 483-486, 640 A.2d at 383-384. If a nonprofit corporation serves clients who are already receiving a government-subsidized benefit, such as adultBasic or CHIP, then in order to fulfill the requirements of the HUP test and qualify as a purely public charity, the corporation must, at least, use its own resources to subsidize and absorb part of the cost of caring for those receiving the public subsidy. St. Margaret Seneca Place, 536 Pa. at 483-486, 640 A.2d at 383-394. Hence, under the H.U.P. test, the Plans must relieve some of the Commonwealth's burden of providing for the health and welfare of the uninsured, by rendering a substantial portion of their product freely or at a greatly reduced price, subsidized with the Plans' own resources.

[44] "It is, of course, well settled that when the Constitution enumerates the kind of property that may be exempted from taxation, it by implication excludes all other taxable property." Clearfield Bituminous Coal Corporation v. Thomas et al., 336 Pa. 572, 577, 9 A.2d 727, 729 (1939). Aside from institutions of purely public charity, the only other types of private property which may be exempted are places of religious worship, burial grounds, and "that portion of the property owned and occupied by any branch, post or camp of honorably discharged servicemen or servicewomen which is actually and regularly used for benevolent, charitable or patriotic purposes." Pa. Const. Art. VIII, § 2(a)(i), (ii), (iv).

B. The Department has the authority to define the specific charitable obligation of the Plans.

While the Act and Pennsylvania's courts require that the Plans have a charitable purpose, the Department has the authority to determine how the Plans may legitimately fulfill that obligation.

1. The Department has a broad regulatory authority over the insurance laws of the Commonwealth, including provisions of the Act.

The Department was established for the express purpose of regulating the insurance industry and was given broad supervisory powers. In establishing the Department, the General Assembly charged the Department, "with the execution of the laws of this Commonwealth in relation to insurance." 40 P.S. § 41. The authority of the Department was reiterated by the Pennsylvania courts in Foster v. Mutual Fire, Marine and Inland Insurance Company, 531 Pa. 598, 608, 614 A.2d 1086, 1091 (1992), cert. denied, 113 S. Ct. 1047 (1993),

> The General Assembly, in recognition of the specialized complexities involved in insurance generally, and in the regulation of this industry in particular, assigned the task of overseeing the management of that industry, in this Commonwealth, to the Insurance Department, the agency having expertise in that field. 40 P.S. § 41, et seq. The Insurance Commissioner, an appointed position pursuant to 40 P.S. § 42 is, therefore, afforded broad supervisory powers to regulate the insurance business in this Commonwealth….

The Plans' obligation to serve as charitable institutions is a statutory obligation arising out of the Act. 40 Pa.C.S.§ 6103(b). As a law pertaining to insurance, the Department retains regulatory authority over all of the Act and its provisions. 40 P.S. § 41. Under this broad authority, the Department should develop definitions upon which Plan compliance with the charitable mandate of the Act can be evaluated. Unfortunately, historically, little has been done to enforce the

charitable mission. This proceeding offers the Department and the Commonwealth a unique and most appropriate opportunity to remedy this history.

2. The Department has a distinct, unique authority over the operations of the Plans.

In addition to the Department's broad authority over the insurance industry, the Act grants the Department a unique authority over hospital plan corporations, including the Plans. The Act charges the Department with the power to issue certificates of authority. As part of this power, the Department is expressly authorized to 1) promulgate regulations regarding the standards plans certified under the act must meet and 2) evaluate whether or not plans meet those standards. 40 Pa.C.S.§ 6102(d). The Department is also expressly authorized to "impose such conditions as it may deem to be just and reasonable" upon corporations authorized to operate as hospital plan corporations. 40 Pa.C.S. §6102(e).

In addition to these express authorities to promulgate regulations, impose conditions and evaluate the eligibility of corporations to operate under the Act, the Department has the implied authority to define the charitable obligation of the Plans. The Pennsylvania Supreme Court has declared that:

> [T]he rule requiring express legislative delegation is tempered by the recognition that an administrative agency is invested with the implied authority necessary to the effectuation of its express mandates.

Pennyslvania Dep't of Transp. V. Beam, 567 Pa. 492, 496, 788 A.2d 357, 360 (2002)(emphasis added). The Act expressly authorizes the Department to determine which plans will be allowed to operate as hospital plan corporations and to develop regulations or impose conditions as part of the determination process. 40 Pa.C.S.§ 6102.

The Act also requires hospital plan corporations to function as charitable and benevolent institutions. In order for the Department to carry out its express mandate to certify plans as hospital plan corporations it must have the authority to define the charitable obligation required under the Act. If the Department is not authorized to define the charitable obligation, there would be no way for the Department to determine whether or not a plan complies with the provisions of the Act. Therefore, the Department has the implied authority to define the charitable obligation in order to accomplish its express mandate to regulate compliance with the Act. The Department may define the charitable obligation of the Plans as either a regulation pursuant to 40 Pa.C.S.§ 6102(d), or as a condition pursuant to 40 Pa.C.S.§ 6102(e), or both.

3. The Department properly used this authority in the 1996 consolidation and change in control case of Highmark, Inc.

The Department has set a clear, definitive standard for charitable giving in the past. In 1996, the Department approved a consolidation and change in control of a number of subsidiaries of the predecessors of what became and is now, Highmark, Inc. In Re: Application of Medical Service Association of Pennsylvania, et. al., Docket No. MS96-04-098 at 47. In the final Order ("the Order"), then Commissioner Kaiser specifically directed Highmark, Inc. to commit "to social or charitable endeavors 1.25% of its direct written premium as reported in its most recent Annual Statement…" Id. at 47-48. The Order also listed the programs to which Highmark could contribute in fulfillment of its required charitable obligation. This standing and unchallenged Order, establishes a precedent for the Department's authority and provides a starting point for the Department's efforts to create a state-wide concrete and enforceable standard definition for the charitable obligations of the Plans.[45]

[45] **The Department needs to enforce this standard against Highmark.** (See Kirsch at pp. 15-18) The requirements in the order have been enforceable against Highmark since November 27, 1996 and, absent any

Just as in the Highmark Order, the Department has the authority to create a two-tiered definition of charitable obligation. The first tier defines the amount all Plans must contribute to fulfill their charitable obligation, and the second defines appropriate ways to spend that money.

C. The Department must define the amount that all Plans are required to contribute in fulfillment of their charitable obligation.

Pursuant to the authorities described in section IV.B. above, the Department should create a single, definitive standard for the amount that all Plans must contribute to charitable expenditures. Without a standard definition, or indeed any definition, the Plans have been left to define their own charitable obligation. The result has been less overall charitable spending (despite inflated premiums and surpluses), inconsistent spending between plans,[46] and inconsistent spending within Plans.[47] Establishing a single, state-wide requirement would standardize and stabilize the Plans' charitable contributions. Plans would become reliable charitable institutions, easily accountable to the Department and the public.

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indication that Highmark ever objected or appealed the Order, remain enforceable against Highmark today. Given Highmark's choice to only report on the parent company's operations and its suspect charitable expenditure claims it is likely that Highmark has fallen well short of this standard over the last eight years.

The Department needs to audit Highmark's filings dating back to the date of the order to determine how much money was contributed to sources identified by the Order as charitable. Any difference between the amount Highmark was required to contribute and the amount it actually contributed should be recouped and set aside for future charitable expenditures.

While Highmark's obligation exists independent of the surplus issue, excess reserves present a potential and viable resource from which Highmark can pay any unfulfilled obligations. Using the surplus for this purpose would actually be quite appropriate considering that Highmark has built such massive surplus while failing to fulfill the reasonable and relatively minimal charitable obligation mandated by the Commissioner's orders (See Kirsch report on Plans' reserves and surplus).

[46] For 2003, IBC reported spending $25.5 million, Highmark reported $96.1 million and CBC reported $99.6 million plus underwriting losses in the indivudal market which were redacted. (IBC Application at p. 8; Highmark Application at p. 23; CBC Application at p.78) BCNEPA redacted the amount of all contributions except those to charitable organizations – $1.2 million. (BCNEPA Application at p. 13)

[47] BCNEPA's decreases are particularly egregious. Between 2002 and 2003 BCNEPA's contributions to charitable organizations fell from $7.8 million to $1.2 million. In 2004 it intends to contribute only $40,000, in 2005 $400,000 and in 2006 only $500,000. BCNEPA Application at 13.

1. The Department should require the Plans to contribute 3.75% of direct written premiums to truly charitable health insurance related purposes.

Just as in the 1996 Highmark Order, the Department should define the charitable obligation as a percentage of direct written premium. There is no indication that Highmark ever objected to basing its required charitable expenditure on a percentage of direct written premium. Furthermore, Kirsch accepts this as an appropriate measure of a Plans' charitable obligation and recommends that the standard adopted by the Department be a percentage of direct written premium. Kirsch Report at 17. The Department should follow its own precedent and Kirsch's recommendation to define the charitable obligation as a percentage of direct written premium.

In 1996, the Department adopted a standard which set the charitable obligation of the Highmark Plan at 1.25% of direct written premium. Order at 47-48. As a previously enacted and currently enforceable charitable giving standard, 1.25% of direct written premium establishes a de minimus definition of the charitable obligation of the Plans. Kirsch Report at 17. While the 1.25% standard may have been appropriate in 1996, improvements in the finances of the Plans as well as changes in the health insurance landscape in Pennsylvania require the Department to take this opportunity to reevaluate the appropriateness of that standard.

Since 1996, Plan surplus levels have increased significantly. Highmark's surplus is at an all time high while IBC and BCNEPA surpluses have nearly doubled since 1996. Kirsch Report at 8-9. During the time that this surplus was accumulating, the Department established the adultBasic health insurance program. This program, which did not even exist in 1996, had developed a waiting list of over 100,000 individuals by June 2004.[48] Given these changes (increased resources combined with the clearly demonstrated need of Pennsylvania's uninsured),

[48] See Uhlman, Footnote 37, Supra

it is appropriate for the Department to establish a higher percentage as the standard for charitable giving.

The commenters recommend the Department adopt a standard which would require Plans to contribute 3.75% of direct written premium to appropriate charitable expenditures. This number generates sufficient income to fund an effective and sincere charitable obligation while not over-burdening the Plans.

If the Department examines the Plans filings, insures that deficiencies and inaccuracies are corrected, and determines that there are indeed excess reserves, the Department should increase the charitable obligation to a higher percentage of direct written premium, particularly as a method of paying down the excess surplus.

2. The Department must apply the standard to the direct written premiums of the Plans' insurance subsidiaries and affiliates.

a. Pennsylvania courts have determined that subsidiaries and affiliates must contribute to the charitable obligation of the Parent company.

Hospital Utilization Project v. Commonwealth of Pennsylvania, 507 Pa. 1, 487 A.2d 1306 (1987) instructs that, in order to qualify as a "purely public charity" (and thus be eligible for tax-exemption) under Article VIII, § 2(a)(v) of the Pennsylvania Constitution, an organization must operate freely from a private profit motive. The court held that, to be free of a private profit motive, an organization that owns or invests in for-profit subsidiaries must utilize the surplus revenue generated from that activity toward its charitable purpose. Wilson Area School District v. Easton Hospital, 561 Pa. 1 (2000). The Court's consistent focus on the way revenues from the for-profit subsidiaries of non-profit organizations are utilized reflects a strong policy determination that all monies related to the parent company must contribute to its

charitable goal. See e.g., Wilson at 10; Hahn Home v. York County Board of Assessment Appeals, 778 A.2d 755, 763-64 (Pa. 2000). Exempting any of the for-profit subsidiaries from contributing to the Plans' charitable mission would directly contradict this policy and the ruling in Wilson. Thus, the 3.75% direct written premium standard, and increases in the percentage, must apply to all of the subsidiaries and affiliates of the Plans.

These cases require the 3.75% direct written premium charitable spending requirement to be applied to the Plans as well as their for-profit insurance subsidiaries and affiliates. These for-profit subsidiaries were established or purchased with funds raised by the non-profit parent companies. Since these companies were borne out of the non-profit, charitable Plans, their activities and profits must be used to help fulfill the charitable obligations of the Plans.

The Plans themselves also recognize that their charitable obligation extends to their for-profit affiliates and subsidiaries. In their filings to the Department, the Plans characterized the contributions made by these subsidiaries and affiliates as charitable activities in fulfillment of their charitable mission. CBC Application at 74; IBC Application at 7, 168, 172. Since these affiliates and subsidiaries share the burden of the charitable mission, the 3.75% direct written premium standard should be applied to them as well.

b. Failing to apply the standard to for-profit insurance subsidiaries and affiliates will increase the incentive for Plans to engage in de facto for-profit conversion.

If the standard only applies to the premiums of the non-profit parent company it will not generate enough funding to support an effective and sincere charitable program. Exempting subsidiaries and affiliates from the percentage of direct written payment charitable spending standard, would encourage the Plans to continue to shift enrollment from the non-profit parent to a wholly-owned subsidiary in order to avoid charitable obligations. This would accelerate the de facto conversion of the Plans to for-profit corporations by providing yet another incentive to shift the operations of the parent non-profits to for-profit subsidiaries while allowing the parent to maintain the benefits of operating as a non-profit charitable organization – tax exemption and favored status in the community. In order to ensure that the Plans do not accelerate any de facto conversion and that enough revenue remains available to support an effective charitable obligation per the General Assembly's intent, it is necessary that the standard be applied to the parent and all subsidiaries and affiliates.

c. The standard as originally created was meant to apply to insurance subsidiaries and affiliates.

Application of the standard to all subsidiaries and affiliates is implied by the context of the Order which originally set a standard. The 1996 Highmark case was a request for consolidation and change of control. See Order generally. The Commissioner approved the consolidation of a number of subsidiaries and affiliates into one health plan corporation – Highmark, Inc. Id. at 47-52. One of the conditions of that consolidation was that Highmark, as the remaining parent entity, would be responsible for dedicating the standard amount of funds towards the charitable obligation. Id. at 47-48. As a condition of consolidation, the requirement

appears to have been intended to apply to the whole company including the subsidiaries and affiliates

D. The Department must also use its authority to also create a clear, understandable, and enforceable definition of charitable expenditure.

Once the Department has defined the amount of money which Plans must donate to meet the charitable obligation, the Department must clarify the definition of "charitable expenditure." The Department currently provides no guidance to the Plans on what spending qualifies as charitable. The Plans have understandably exploited the lack of a Department definition to claim a wide variety of activities qualify as charitable. The result has been 1) a decrease in the amount of truly charitable spending, and 2) a complete inconsistency between Plans in the way they spend charitable resources. In order to establish consistency among the Plans and the regions they serve and to ensure that Plan resources are used to fulfill the charitable obligation envisioned by the General Assembly, the Department must create a definition of charitable expenditure.

1. The Plans' charitable expenditure claims are wildly inconsistent.

The Plans have defined charitable expenditure as widely as possible in their filings in an attempt to increase their apparent charitable contributions and mask their insufficient compliance.

IBC claims as charitable the following: direct and undefined in-direct subsidies to non group benefits plans and Personal Choice products; alleged, but undocumented subsidies of the CHIP and adultBasic government funded programs; year round enrollment for non-group products; administrative subsidies of the CHIP and adultBasic programs; contributions to charitable, fund-raising and wellness activities of local health care, education and civic

organizations; direct financial support to free medical clinics; and the creation of a nursing scholars program. IBC Application at 6-8, 168-172.

Highmark claims as charitable the following: offering coverage to everyone; subsidies to its Special Care program; open enrollment of its guarantee issue direct pay products; group conversion programs; offering coverage to small business employers; serving individuals in the CHIP and adultBasic programs; contributions to community organizations; funding health education and awareness program; subsidizing the administrative costs of adultBasic; subsidizing a Medicare supplement product; CHIP and adultBasic losses (despite a cost based contract with the Commonwealth to administer these programs); and employee volunteerism. Highmark Application at 21-30.

After vehemently denying that it has any charitable obligation, CBC, the Plan that unsuccessfully tried to enjoin this entire proceeding, claims as charitable the following: voluntarily offering coverage in the non-group market that is community-rated; offering a non-group program that is not medically underwritten; losses in its underwriting business; products offered in the non-group market; offering Special Care as an option for low income families; losses from the adultBasic program; administering the CHIP program; providing financial assistance to charitable organizations that promote health; providing financial assistance to organizations that work to relieve poverty, advance education and otherwise benefit the community; sponsoring events, theater and fundraisers; voluntary payments to the county in lieu of real estate tax; and taxes paid by CBC's subsidiaries. CBC Application at 74-79.

BCNEPA claims as charitable the following: reserve appreciation credit; surplus funded initiatives such as information technology investments and other one-time extraordinary charges; investment income credit; subsidies to the Medicare supplement; non-group indemnity and non-

group major medical products; contributions to the Blue Ribbon Foundation; contributions to the Caring Foundation which administers CHIP; premium tax forgiveness; and contributions to non-profit organizations in the community. BCNEPA Application at pp. 218-220.

This brief summary of the Plans charitable claims reveals the inconsistency and bogus claims that result from failing to provide a specific, enforceable definition of charitable expenditure. Each Plan has invented a definition which is designed to increase the appearance of charitable giving by claiming that numerous ordinary costs of doing business are charitable expenditures. This system makes it easy for the Plans to create the appearance of meeting the obligation without actually doing significant charitable work.

2. The Plans avoid their obligations by reporting considerable expenditures which are plainly not charitable.

As detailed above, absent Department intervention, the Plans have taken the liberty of defining "charitable expenditure" as broadly as possible. As a result, the Plans have included in their descriptions of charitable activities many activities and expenditures which, upon closer examination, are not charitable.[49]

a. Losses in the non-group market are not charitable expenditures.

Each of the Plans claims losses in the non-group market as a charitable expense. Some of the Plans claim these losses as a direct subsidy. Others claim them as an indirect subsidy. IBC claims them as both. IBC reports in a letter to Commissioner Koken dated March 22, 2004 that it provided a direct rate subsidy to non group programs of $3.7 million in 2003. IBC Application at 168. It also claims an indirect rate subsidy to non-group programs of $2.8 million in 2003.

[49] The bogus charitable claims detailed in this section are not an exhaustive list of the non-charitable expenditures the Plans claim to be charitable.

An attached balance sheet demonstrates the application of these subsidies. (IBC Application at 171. A close look at the balance sheet shows that the direct and indirect subsidies were actually applied to the administrative costs of the product, not the product itself. For 2003, IBC collected $88.1 million in premiums from non-group products, but only paid $83.3 million in claims. Therefore, before administrative expenses and medical management costs, IBC was actually reporting profits of $4.8 million from non-group products. Once IBC added inflated and unaudited administrative expenses ($7.7 million)[50] and medical management costs, it was reporting a loss of $5.2 million. IBC then provided a $3.7 million direct subsidy and a $1.4 million indirect subsidy (the source of the $2.8 million reported in the letter is unclear) to the non-group products.

IBC's filing demonstrates the danger of allowing Plans to write off losses as charitable expenses. For IBC the loss was a result of administrative costs, not greatly reduced premiums or disproportionately high claims. Allowing administrative costs to be effectively written off as a charitable expenditure will only encourage Plans to be less efficient.

b. Taxes are not a charitable expenditure.

CBC and IBC both make reference to payment of taxes as fulfilling their charitable missions. CBC Application at 58; IBC Application at 170, 174. Both Plans remind the Department that the tax exemption afforded by the Act is limited and that they and their subsidiaries are still subject to a variety of taxes. Taxes paid by the Plans in accordance with federal, state or local laws or agreements should not be counted as charitable. All corporations are required to pay taxes. The state would never consider taxes paid by a private corporation to

[50] High relative to QCC, IBC's for profit subsidiary, which only incurred costs of $4.2 million to administer non-group programs which collected comparable premiums. It is also interesting to note that QCC paid considerably higher claims than IBC on its non-group products in 2003. (IBC Application at p. 171)

be charitable. The mere fact that these payments are made by a charitable institution should not change this. Taxes made in compliance with the tax laws of the Commonwealth are not charitable contributions.

c. Donations to non-profit organizations not pursuing a safety-net health insurance mission are not charitable expenditures.

While the Plans deserve praise for contributing to non-profit community organizations in their regions, these types of contributions should not be counted towards the Plans' charitable obligations. All four Plans claim donations to 501(c)(3) non-profit organizations as an element of their charitable work. BCNEPA Application at 13; CBC Application at 77; IBC Application at 168-69, 174; Highmark Application at 22, 29-30. The Plans claim expenditures ranging from $1.2 million to $7.8 million to organizations like the United Way, the Orchestra, the Boys and Girls Club, and others. These types of donations are no different than the donations that for-profit companies make regularly. Donations to non-profit organizations serve a dual purpose to all corporations, including the Plans. The donations are tax deductible and they provide good publicity in the community. The Plans should not be allowed to also use the donations to fulfill their charitable health care and health insurance mission.

Instead, the Plans' mission should focus on the unique service they were created to provide – health care and health insurance. Having a charitable mission does not mean giving money to others to do generic charitable work. It means donating a significant amount of your own health insurance product or its equivalent to individuals who cannot otherwise afford it. In the case of the Plans, the Department should require that only those expenditures related to the provision of health care or health insurance be counted towards the charitable mission.

d. The administration or availability of a program alone is not a charitable expenditure.

All of the Plans commit significant proportions of their charitable mission reports to a discussion of various products they offer. While the Plans should be recognized for offering, and encouraged to continue offering, these products, the mere availability of these products is not a charitable expenditure. Instead, the Plans should be credited for the actual, quantifiable fiscal subsidy the Plans provide directly to subscribers who purchase those products. No accounting of these subsidies has been offered. The three products the Plans cite that fall under this category are adultBasic and CHIP, Special Care and Group Conversion.

adultBasic[51] and CHIP[52]

The Plans all cite their administration of the adultBasic and CHIP programs as an element of their charitable mission. BCNEPA Application at 219; CBC Application at 76-77; IBC Application at 6, 7, 168, 173; Highmark Application at 22, 24, 25-27. The mere administration of these programs should not be counted as a charitable expenditure. The adultBasic and CHIP programs are designed to be completely publicly funded (CHIP through a combination of state and federal contributions; adultBasic through the Tobacco Settlement Fund). The Commonwealth has contracted with the Plans to administer these programs, but these contracts require no financial contribution from the Plans. The Plans charge the Commonwealth a

[51] adultBasic is a state-funded low cost health insurance program. The program provides health care coverage to individuals whose income is below 200% of the federal poverty level ($1,152/month for a single individual; $3,142/month for a family of four) for the low price of $30 per month. The program is currently full. Individuals who are on the waiting list can choose to buy into the program at the Department's cost. The cost varies by region, but on average the "at cost" price is $260/month. See the Department website: http://www.ins.state.pa.us/ins/cwp/view.asp?a=1336&Q=543301&PM=1

[52] CHIP, or the Children's Health Insurance Program, offers free or low cost health insurance to low income children. Children from families below 200% of federal poverty level receive CHIP for free. Children from families between 200% and 250% of Federal Poverty Level receive CHIP at a subsidized rate.

premium for the services they provide and that premium includes allocations for administrative expenses – including outreach activities.[53] The programs are essentially designed to cover the Plans' expenses. To the extent that the programs cost the Plans nothing, the Plans should not be credited for a charitable expenditure. Indeed, the Plans recently successfully negotiated a much higher reimbursement rate for the program, thus directly contributing to the adultBasic crisis of decreasing enrollees and increasing waiting list.[54]

The Plans do claim actual financial contributions to the programs. IBC and Highmark claim direct subsidies to the program. IBC Application at 6,7; Highmark Application at 22. IBC, Highmark and CBC claim subsidies in the form of loses from the program. IBC Application at 6,7; Highmark Application at 22; CBC Application at 76. All four Plans claim administrative subsidies, in one form or another, to the program. IBC Application at 6,7; Highmark Application at 22; CBC Application at 76; BCNEPA Application at 219. While a portion of these subsidies should be counted towards the charitable mission, they need to be closely regulated.

Allowing the Plans to simply state the amount of direct or administrative subsidies without requiring them to document the subsidy will lead to inefficient administration of the programs if not abuse. For example, in the filings, Highmark claimed to contribute a $9.3 million administrative subsidy to the CHIP, Caring Program and adultBasic programs in 2003. Highmark Application at 23. IBC claimed an administrative subsidy of $1.3 million to its Caring Foundation (which administers CHIP, adultBasic and Special Care) in 2003. IBC Application at

[53] See adultBasic and CHIP Requests for Proposals

[54] Effective July 2004 the "at cost" price of adultBasic – the price paid by the Department and individuals who chose to buy-in off the waiting list – rose 16%. According to Department officials, the Plans requested an even larger increase.

7. Highmark admitted serves more individuals under these two programs, but the disparity between individuals served is nowhere near the disparity in alleged administrative subsidies.[55]

The Department must include in its definition of charitable expenditure guidelines for contributions to state funded health care programs like adultBasic and CHIP.

Special Care[56]

CBC and Highmark claim the Special Care program as a charitable expense. CBC Application at 76; Highmark Application at 21, 24, 26. Once again, the mere availability of the program should not, in itself, satisfy the charitable obligation of the Plans. The Department should only count towards the charitable obligation, actual subsidies the Plans provide to Special Care enrollees. To the extent that Special Care rates are subsidized it is worth noting that the program provides a very limited benefit at a price that is still unaffordable for many working families.

Group Conversion[57]

Highmark claims group conversion programs as an element of its charitable mission. Highmark Application at 22. This claim is deceiving. All insurance companies in the Commonwealth are required, by law, to provide group conversion to their subscribers. 40 P.S. § 756.2 (d). The cost of group conversion is factored into all group policy premiums. Kirsch Report at 16. Any expense that Highmark or other Plans incur from group conversion products

[55] Highmark serves over 43,000 children in in the CHIP program and over 21,000 individuals in the adultBasic program. (Highmark Application at p. 22) IBC serves over 27,000 children and over 12,000 adults. (Caring Foundation Newsletter August 2004)

[56] Special Care is a low cost, limited benefit health plan for individuals with incomes below 185% of the federal poverty level ($1,436/month for an individual; $2,907/month for a family of four). The coverage is very limited and excludes coverage of pre-existing conditions for a 12-month period. The program costs $107/month.

[57] Group conversion policies are policies offered to individuals whose insurance under a group policy has been terminated.

that are comparable to those that all insurers must offer is not a charitable expense. The charitable obligation requires the Plans to do things that private insurers are not required to do. Only those expenses that are unique to the Plans and, therefore, different than expenses incurred by private insurers should be counted as charitable expenditures.

The Plans do have some unique obligations relating to group conversion programs. The Plans are required to implement the "alternative mechanism" requirements of the federal Health Insurance Portability and Accountability Act (HIPAA).[58] 40 P.S. § 981-3. As a "designated insurer" responsible for offering the alternative mechanism to HIPAA eligible individuals, the Plans must offer year round enrollment and a choice of at least two individual health insurance policies to eligible individuals. 40 P.S. § 981-4(a). The policies issued by the Plans to eligible individuals may not contain a pre-existing condition limitation and must be subsidized. 40 P.S. § 981-4(b) and (c). The amount of the subsidy is not defined by the statute.

In its filing Highmark claimed group conversion expenses of $36.4 million in 2002. It is highly unlikely that this cost can be attributed solely to group conversion programs for HIPAA eligible individuals. Kirsch Report at 16 It is more likely that this high cost also includes group conversion programs that are comparable to the programs that all insurers are required, by law, to provide. Kirsch Report at 16. Only those losses associated with group conversion programs the Plans are required to offer under 40 P.S. § 981-3 should count as charitable expenditures.

[58] The Health Insurance Portability and Accountability Act of 1996, otherwise known as HIPAA, is a federal law which provides protections to HIPAA eligible workers and their families when they lose insurance as a result of losing or changing jobs. HIPAA limits the effects of pre-existing conditions, prohibits, in some situations, discrimination based on health status, and provides eligible individuals with the opportunity to buy coverage after all other continuation coverage has been exhausted.

e. Investments in infrastructure and capital improvement are not charitable.

BCNEPA claims "surplus funded initiatives" as charitable expenditures. BCNEPA Application at 218-19. These initiatives are one-time, extraordinary charges such as informational technology upgrades that BCNEPA has used surplus funds to pay for. While this may be an appropriate use of surplus funds, it is not a charitable expenditure. Investments in BCNEPA infrastructure and capital improvement increase BCNEPA's value and, therefore, indirectly, benefit all subscribers. Expenditures such as this which only tangentially benefit subscribers are not charitable.

3. The definition of charitable expenditure crafted by the Department must include the following elements.

In order to avoid inconsistent and inappropriate spending, the Department must develop a definition of charitable expenditure. Below are suggestions of elements that should be included in a definition of charitable expenditure.

a. All charitable expenditures should be directed towards health care.

The Department should require that charitable expenditures be directed towards programs which help individuals access health insurance coverage. The Plans are both health insurers and charitable institutions. 40 Pa.C.S. 6103(b).

b. Charitable expenditures should benefit a certain class of individual who can broadly be defined as the uninsured and underinsured.

The Department should require charitable expenditures to benefit "legitimate subjects of charity." The Institutions of Purely Public Charity Act (IPPCA), while not directly applicable to the Plans, provides the following definition which is relevant and important:

> "Legitimate subjects of charity": those individuals who are unable to provide themselves with that which the institution provides for them.

10 P.S. § 375(e)(2). Adopting this definition as an element of the charitable expenditure definition would ensure that the Plans are directing their charitable spending to those who are in the most need.

c. Charitable expenditures should provide significant assistance to these individuals.

The Department should require that charitable expenditures are directed in a way that actually makes health insurance coverage affordable for individuals. Giving small subsidies to a large number of individuals is not going to help those individuals who cannot currently afford health coverage access that coverage. Instead it is important that resources be directed to provide meaningful assistance to those who need it the most.

d. Charitable expenditures should relieve the government of some burden.

Charitable expenditures should be directed to government programs or activities that are or would be, but for the existence of the program, the government's responsibility. Under the IPPCA, an institution meets this requirement if it does any one of the following:

> (1) provides a service to the public that the government would otherwise be obliged to fund or to provide directly or indirectly or to assure that a similar institution exists to provide the service.
> (2) Provides services in furtherance of its charitable purpose which are either the responsibility of the government by law or which historically have been assumed or offered or funded by the government.
> (3) Receives on a regular basis payments for services rendered under a government program if the payments are less that the full costs incurred by the institution, as determined by generally accepted accounting principles.
> (4) Provides a service to the public which directly or indirectly reduces dependence on government programs or relieves or lessens the burden borne by government for the advancement of social, moral, educational or physical objectives…

10 P.S. § 375(f)(2). The Department should incorporate a similar concept into its definition of charitable expenditure. Expenditures which support a service which the government provides or would provide are charitable. Since the Plans are health insurers, the Department should require them to direct their efforts towards relieving the government's efforts to make health care widely available to all residents of the Commonwealth.

The two government programs that attempt to provide health insurance coverage to low income residents of the Commonwealth are adultBasic and CHIP. Any definition of charitable expenditure should include a requirement that the Plans make significant, direct, verifiable contributions to these government funded health insurance programs.

e. Charitable expenditures should be unique to the Plans.

Only those expenditures which are unique to the Plans should be defined as charitable. As indicated above, the Plans currently include in their own definition of charitable expenditure, costs that are assumed by all insurers throughout the state either by law or common practice. Charitable expenditures should be defined as those costs and obligations which are unique to the Plans.

f. The Plans should still be required to provide inclusive insurance programs: group conversion, community-rating for small businesses, Medicare supplement programs for persons with disabilities, etc.

The Plans currently provide many important programs designed to insure those who are not insurable in the for-profit market. This is an important service that the Plans should be required to continue to provide. However, as argued in Section IV, B, iv, c. only the quantifiable and verifiable financial contributions Plans make to these programs should count as charitable expenditures.

E. <u>In order to ensure that Plans fulfill their charitable obligation, the Department should adopt the commenters' recommended definition of charitable obligation and charitable expenditure.</u>

In light of the above discussion, commenters recommend the following definition for charitable obligation and charitable expenditure.

(1) All Plans operating with a certificate of authority under the Act must fulfill a charitable obligation pursuant to 40 Pa.C.S.§ 6103(b).

(2) In order to fulfill the charitable obligation the Plan must spend, at a minimum, an amount equal to 3.75% of the Plan's direct written premium on charitable expenditures as defined by (4).

(3) The standard stated in (2) applies to the direct written premium of the consolidated company.

(4) A charitable expenditure is a direct, quantifiable and verifiable financial contribution, beyond any contribution which the Plans are currently legally obligated to provide, to a program or product which provides health insurance coverage, at a substantially reduced rate, to individuals that would not otherwise be able to afford it.

(5) Direct, quantifiable and verifiable financial contributions to the following programs will be considered charitable expenditures:

(a) the Children's Health Insurance Program
(b) the adultBasic health insurance program
(c) with prior approval of the Department, other government or private programs which provide subsidized health insurance coverage to low income individuals and families.

F. <u>The Department must use its authority to create reporting and compliance procedures, and manifest enforcement through concrete and public remedial action.</u>

The benefits of defining the charitable obligation of the Plans will only be actuated if the Department establishes mechanisms for monitoring Plan compliance with that definition. In the 1996 Order, the Department merely required Highmark to provide a summary of its "charitable and benevolent endeavors." <u>Order</u> at 47-48. (Perhaps this is one reason that Highmark has been out of compliance). In adopting this new charitable giving standard the Department must

develop stringent reporting and compliance procedures. These procedures must include reporting requirements that force the Plans to document, quantify and verify every contribution they claim as charitable. Plans should not be given credit for any contribution they cannot or do not quantify and verify. The procedures must also include consequences for Plans that do not fulfill the defined charitable obligation. Failure to fulfill the obligation cannot go unnoticed by the Department. Only by developing strict reporting and compliance requirements will the Department be able to enforce and will the uninsured of Pennsylvania benefit from the charitable obligation standard.

V. A SIGNIFICANT PORTION OF THE PLANS' EXCESS SURPLUS SHOULD BE DISGORGED AND DISTRIBUTED IN ACCORDANCE WITH THE ABOVE PROPOSED GUIDELINES FOR CHARITABLE MISSION.

The final element of the Notice required the Plans to:

> [P]rovide a proposed business plan explaining how any maintained surplus that results in an RBC ratio that is in excess of the maximum RBC ratio will be fairly and equitably distributed to benefit Plan participants and the Commonwealth's underinsured and uninsured citizens in a manner befitting charitable and benevolent institutions such as the Blues Plans.

Notice 2004-1(d). Given the Plans' failed commitment to their charitable obligation during the period in which it has accumulated record level surplus, the Department should disgorge the excess surplus and direct it to a true and uncontroverted charitable expenditure – the adultBasic health insurance program.

A. The Pennsylvania Insurance Department Has the Authority and Responsibility To Require the Plans To Disgorge and Distribute Excess Surplus for the Benefit of Subscribers and the Commonwealth's Uninsured and Underinsured, in Accordance with Their Charitable Mission.

The Plans have had excessive surplus of such magnitude, and for such duration, and in such disregard of their non-profit and charitable status, that policyholders in Pennsylvania have sued for disgorgement.[59] Policyholders and representatives in other states – for example, Alabama,[60] Maryland,[61] Minnesota,[62] and North Carolina,[63] as well as federal employees[64] – have

[59] Jules Ciamaichelo & Rob Stevens, Inc. v. Independence Blue Cross, 814 A.2d 800 (Pa. Commw. Ct., Dec. 20, 2002), appeal granted, 574 Pa. 749, 829 A.2d 1158 (Pa., Aug. 27, 2003); Independence Blue Cross v. Pennsylvania Ins. Dep't, 802 A.2d 715 (Pa. Commw. Ct., July 12, 2002) (action on behalf of subscribers, policyholders and members to disgorge $438 million in excess surplus and use it to provide coverage for uninsured citizens, expand benefits, or return premiums to policyholders); see also Capital Blue Cross v. Koken, Case No. 172 M.D. 2004 (Pa. Commw. Ct., Mar. 23, 2004) (opinion not reported).

[60] Ex parte Blue Cross and Blue Shield of Alabama (Sanderson v. Blue Cross and Blue Shield of Alabama), 582 So. 2d 469 (Ala., May 24, 1991) (action on behalf of all subscribers, seeking a declaratory judgment and order directing refunds of excess reserves, and identifying questions of fact remaining for trial court to determine).

[61] Blue Shield of Maryland, Inc. v. The Ward Machinery Co., 49 Md. App. 258, 431 A.2d 727 (Md. Ct. Spec. App., July 8, 1981) (affirming order of Insurance Commissioner of Maryland requiring plan to distribute excess surplus to subscribers).

sued the Blues Plans as well, reflecting nationwide concern that Blues Plans, applying the trade association's all too accommodating criteria, are accumulating excessive surplus to the detriment of paying subscribers and the public interest. Equally important, these cases reflect uniform consensus that insurance commissioners have the authority to order Blues Plans to disgorge excessive surplus. In other states – New Jersey,[65] Rhode Island,[66] and Tennessee,[67] for example – Blues Plans have voluntarily returned excess surplus before state insurance commissioners or departments might have ordered disgorgement. (See Appendix A for a comprehensive summary of the actions taken by insurance commissioners in other states in response to growing concerns regarding Blues Plans' operations.)

In Pennsylvania, the Plans concede that the Department has the authority to regulate a Plan's excessive reserves and surplus. Independence Blue Cross v. Pennsylvania Ins. Dep't, 802 A.2d 715 (Pa. Commw. Ct., July 12, 2002), began as a class action on behalf of subscribers,

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[62] In the Matter of the Excess Surplus Status of Blue Cross and Blue Shield of Minnesota, 624 N.W.2d 264, 275-77, 283 (Minn., Apr. 12, 2001) (affirming order by Department of Commerce disapproving Blues plan's proposal to distribute excess surplus because that proposal had the Blues plan retain control of the excess surplus and thus did not distribute the excess surplus within a reasonable period of time; the proposal did not well serve past, present and future subscribers because it did not provide proportional benefit to past subscribers who funded more of the surplus, and dissipated funds on duplicative programs and goods and services of uncertain value for present and future subscribers; and the proposal thus was not in the public interest).

[63] Lupton v. Blue Cross & Blue Shield of North Carolina, 139 N.C. App. 421, 533 S.E.2d 270 (N.C. Ct. App., Aug. 1, 2000) (in action to disgorge excessive reserves, holding that Commissioner of Insurance has jurisdiction to consider and distribute excessive reserves), review denied, 353 N.C. 266, 546 S.E.2d 105 (N.C., Dec. 20, 2000).

[64] Bolden v. Blue Cross and Blue Shield Ass'n, 669 F. Supp. 1096 (D.D.C., Oct. 28, 1986) (refunding excess contingency reserve funds to enrollees who were subscribers as of a certain date), aff'd, 848 F.2d 201 (D.C. Cir., May 17, 1988).

[65] Horizon Blue Cross Blue Shield of New Jersey distributed approximately $55 million in premiums back to policyholders.

[66] In October, 2003, Blue Cross and Blue Shield of Rhode Island announced that it would refund $21 million in premiums.

[67] In October, 2003, BlueCross BlueShield of Tennessee announced that it would refund $67 million in premiums beginning in December because of higher surpluses.

policyholders and members to disgorge $438 million in excess surplus and to use the excess surplus to provide coverage for uninsured citizens, expand benefits, or return premiums to policyholders. IBC pled "that IBC may not disgorge its reserves unless the Department rules otherwise".[68] In subsequent proceedings, the Commonwealth Court of Pennsylvania held that the Department had the authority to approve the rate, reserves, and surplus of the plans under its jurisdiction.[69] As the Court summarized:

> The complainants' claims . . . are all based first on their allegation that Blue Cross has accumulated excessive reserves (i.e., reserves higher than the industry standard, higher than in past years, higher than necessary to cover its claims and expenses and maintain solvency), and second, on their allegation that Blue Cross has accumulated the excessive reserves for impermissible purposes and has misused the reserve funds by transferring assets to subsidiaries. Approval of rates and reserves are matters with the exclusive jurisdiction of the Insurance Department . . . .[70]

The Court reached the same result under the filed-rate doctrine:

> The Insurance Department considers the amount of an insurer's reserves when approving rates, and the collection of premiums based on the rates must inevitably be a factor in the accumulation of excessive reserves. Any determination that Blue Cross has accumulated excessive reserves would necessarily require the recalculation of the approved rates.[71]

Lastly, in the case on the proceeding before us now, the Commonwealth Court upheld Commissioner Koken's authority in this proceeding to require the Plans to provide the information set forth in the Notice in order to measure the excessiveness of surplus and reserves and to determine how the excess "will be fairly and equitably distributed to benefit Plan

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[68] 802 A.2d at 715.

[69] Jules Ciamaichelo & Rob Stevens, Inc. v. Independence Blue Cross, 814 A.2d 800, 802-03 (Pa. Commw. Ct., Dec. 20, 2002), appeal granted, 574 Pa. 749, 829 A.2d 1158 (Pa., Aug. 27, 2003).

[70] 814 A.2d at 803.

[71] Id. at 805.

participants and the Commonwealth's underinsured and uninsured citizens in a manner befitting charitable and benevolent institutions such as the Blues Plans".[72]

As the cases above make clear, disgorgement of excessive reserves or surplus or profits is well within the Insurance Commissioner's responsibility and authority.[73]

B. The Department should exercise this authority to order a significant portion of the excess surplus to be committed to satisfy the as of yet unsatisfied charitable obligations of the Plans.

As described in section I above, the Commonwealth is facing an uninsured crisis. Over 1.4 million uninsured Pennsylvanians will die earlier and get much sicker than those with insurance, and increasing health care costs all but guarantee that this number will continue to rise. In the face of this crisis the Plans have accumulated record levels of surplus. Instead of using a portion of these surplus to provide much needed relief to the Commonwealth and its indigent and financially vulnerable citizens, in compliance with their charitable obligations, the Plans have effectively avoided their responsibility by creatively defining their charitable activities beyond legal bounds, and by proposing maxima that would astoundingly allow them to amass up to $2 billion more in surplus and not count any as excessive.

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[72] Slip Op. at 11-12, 14, Capital Blue Cross v. Koken, Case No. 172 M.D. 2004 (Pa. Commw. Ct., Mar. 23, 2004) (opinion not reported); Reserve and Surplus Levels of Hospital Plan and Professional Health Services Plan Corporations, Notice No. 2004-01, 34 Pa. Bull. 458 (Pa. Ins. Dep't, Jan. 16, 2004).

[73] The Department has experience with disgorgement in other contexts as well. In most lines of property and casualty insurance, 40 Pa. Stat. ' 1182, the Department has the mandate and authority to disallow excessive rates, id. '' 1181, 1183(d). The Commonwealth's courts have held, at least in the area of automobile insurance, that rollback of excessive rates are not unlawful. For example, disgorgement may be accomplished through rollback of rates. E.g., Ohio Casualty Ins. Co. v. Insurance Dep't, 137 Pa. Commw. 299, 308-09, 585 A.2d 1160 (Pa. Commw. Ct., Jan. 18, 1991) (Department shall not allow excessive rates, and even if rates are not excessive, Department need only allow rates which provide the bare minimum of a fair and adequate rate of return, and thus statute providing for rate decreases of at least 10%-22% was constitutional); Prudential Property & Casualty Ins. Co. v. Department of Ins., 141 Pa. Commw. 156, 182-84, 595 A.2d 649 (Pa. Commw. Ct., July 10, 1991) (same). By analogy, a Blues plan's excess surplus and excess reserves by definition exceed the minimally fair and adequate return.

This proceeding provides an unusual and timely opportunity for the Department to hold the Plans accountable to the Commonwealth by ensuring that Plans' resources, in the form of excess surplus, are used to expand the availability of heath care coverage to those who cannot afford it. The Department should use its above described authority to disgorge excess surplus and directly contribute a very significant portion of the excess funds into the state funded adultBasic health insurance coverage program.

The adultBasic program provides low cost health insurance coverage to individuals with incomes below 200% of federal poverty level. The program allows individuals, many of whom are working or are sick or disabled, to access coverage they would not otherwise be able to afford. While the Plans have been hoarding their surplus, the waiting list for adultBasic has grown to over 97,000 individuals. Program enrollment has fallen now to only 37,000 individuals, in part due to increased contract monetary demands made by the Plans in this, the third year of their adultBasic contracts with the state. Dedicating a significant portion of the Plans excess to the adultBasic program would enable the Department to extend health insurance coverage to tens of thousands of Pennsylvanians who are currently uninsured.

By disgorging the excess surplus and dedicating a sizable portion to the adultBasic program, the Department can remedy the harm caused by years of Plan noncompliance and ensure that the Plans do not continue to ignore their charitable obligation in the future.

VI. CONCLUSION

Commenters respectfully submit these comments and Appendix A (attached) to the Pennsylvania Insurance Department in compliance with Notice 2004-07; Reserve and Surplus Levels of Hospital Plan and Professional Health Services Plan Corporations; Application Update.

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APPENDIX A

NATIONAL TRENDS IN BLUE CROSS CHARITABLE ASSETS ENFORCEMENT

I. POLICYMAKERS AND COURTS IN MANY STATES HAVE DECIDED THAT BLUE CROSS AND BLUE SHIELD ORGANIZATIONS, INCLUDING THOSE ORGANIZED AND OPERATED LIKE PENNSYLVANIA'S BLUES PLANS, ARE CHARITABLE CORPORATIONS THAT MUST SET ASIDE OR DISTRIBUTE THEIR ASSETS FOR CHARITABLE PURPOSES WHEN THEY MERGE WITH OUT-OF-STATE PLANS OR CONVERT TO FOR-PROFIT CORPORATIONS.

Throughout most of its history, the national Blue Cross and Blue Shield Association ("BCBSA" or "Association") prohibited the use of its trademark for for-profit purposes. In 1994, however, the Association began allowing Blues plans to operate as for-profit companies. Blue Cross of California (BCC) was the first plan to attempt this conversion to for-profit activity. Although Blue Cross of California initially tried to deny it had charitable assets, regulators forced it to distribute $3.2 billion in charitable assets for the benefit of Californians (in the form of two nonprofit foundations, The California Endowment and the California HealthCare Foundation). Since then, over 25 charitable nonprofit Blues plans have proposed some type of conversion transaction.

Many plans originally tried to avoid their charitable obligations. Regulators, the courts, and legislators, however, have acted in the vast majority of states to prevent Blues plans from denying their charitable histories, to treat the Blues plans as charitable trusts, and to require them to disgorge and distribute significant portions of their charitable assets to serve their original, charitable mission. The Blue Cross and Blue Shield plans may have been established independently in each state but they all are tied to each other by a common trademark, historically representing to the public that they would meet certain guidelines and standards--the

most prominent being that they were nonprofit insurers created to serve the public good. This has been their slogan, their message, and their mode of operation for over half a century.

A. THE KANSAS COURTS RULED THAT THE BLUES PLAN OWED A CHARITABLE ASSET OBLIGATION TO THE PEOPLE OF KANSAS.

Blue Cross and Blue Shield of Kansas (BCBSK) denied that it had an obligation to set aside assets for the people of its state. In 1997, BCBSK filed a lawsuit against the Kansas Attorney General seeking a declaration that the plan had no charitable trust obligation to the people of Kansas. In January 1998, the court ruled in favor of the Kansas Attorney General. The court denied BCBSK's motion to dismiss, holding that the Attorney General had the right to enforce charitable obligations and seek damages against BCBSK if the Attorney General prevailed in the case. The Kansas Commissioner of Insurance intervened in the case in support of the Attorney General.

In January 2000, ruling on a summary judgment motion, the court found that BCBSK had possessed charitable assets from its inception in the early 1940s through 1969, the year the Kansas legislature repealed the enabling statutes that created Blue Cross and Blue Shield. Blue Cross and Blue Shield of Kansas v. Stovall, No. 97 CV 608 (Kan. Dist. Ct., Shawnee County, Jan. 7, 2000). See also Blue Cross and Blue Shield of Kansas v. Stovall, No. 97 CV 608 (Kan. Dist. Ct., Shawnee County, Apr. 5, 2000).

B. THE MISSOURI COURTS RULED THAT BLUES PLAN HAD CHARITABLE TRUST OBLIGATIONS.

Blue Cross and Blue Shield of Missouri (BCBSMO) emphatically denied that it was a charitable organization when it "restructured" in 1994. As part of its restructuring, BCBSMO moved approximately 80 percent of its business into a for-profit subsidiary called

RightCHOICE, but it neither set aside charitable assets nor acknowledged its obligation to do so. When the Department of Insurance sought to review this restructuring, BCBSMO sued the state. The court agreed with the state regulator and ruled that the Blues plan maintained a charitable trust obligation. Order and Judgment, Blue Cross and Blue Shield of Kansas City, Inc. v. Nixon, No. CV197-330CC (Mo. Cir. Ct., Cole County, Sept. 11, 1998). The court based its decision, in part, on the fact that for more than 50 years, BCBSKC "took advantage of tax considerations and status in the community based on its pledge to serve a public benefit mission." Id. The Court of Appeals of Missouri agreed with the trial court. Blue Cross and Blue Shield of Kansas City, Inc. v. Nixon, 26 S.W.3d 218 (Mo. Ct. App., W.D., June 20, 2000).

After the Missouri court of appeals ruled, the parties settled. The settlement called for the creation of the Missouri Foundation for Health Inc., which subsequently received approximately $13 million in start-up cash and 15 million shares of common stock in RightChoice. The foundation was valued at approximately $900 million when RightChoice was acquired in 2000 by California-based WellPoint.

C. BLUE CROSS AND BLUE SHIELD OF COLORADO PRESERVES ITS CHARITABLE ASSETS FOR THE BENEFIT OF COLORADANS.

Blue Cross and Blue Shield of Colorado (BCBSCO) was a social welfare organization, organized under federal law until 1987 as a section 501(c)(4) organization. Further, the plan charged premiums for health insurance coverage and covered an identified group of people.

When Blue Cross and Blue Shield of Colorado proposed conversion and sale to Anthem Insurance Companies, Inc. ("Anthem"), the Insurance Commissioner of Colorado preserved the nonprofit assets, which had accumulated in the nonprofit insurer, for the broader public. In November, 1999, Commissioner William Kirven III approved BCBSCO's proposed conversion

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and sale to Anthem. As part of the approval process, Commissioner Kirven ensured that the full fair-market value of BCBSCO would be preserved. A total of $155 million was placed in the Caring for Colorado Foundation, a health conversion foundation.

D. BLUE CROSS AND BLUE SHIELD OF NEW HAMPSHIRE MERGED WITH AN OUT-OF-STATE MUTUAL IN A TRANSACTION THAT PRESERVED ITS ASSETS FOR THE BENEFIT OF THE PEOPLE OF NEW HAMPSHIRE.

Blue Cross and Blue Shield of New Hampshire (BCBSNH) was also a social welfare organization organized under federal law until 1987 as a section 501(c)(4) organization. It had covered an identified group of people, had charged premiums, and had not been the insurer of "last resort".

In 1999, when Blue Cross and Blue Shield of New Hampshire and Anthem announced that Anthem would purchase BCBSNH, the Blues plan itself acknowledged that, upon a merger with an out-of-state mutual insurer, it had an obligation to set aside its assets to benefit the people of New Hampshire. Under the terms of the deal, the full fair-market value of BCBSNH, approximately $83 million in charitable assets, was set aside in the Endowment for Health, Inc., a foundation whose purpose is to improve the health of the people of New Hampshire.

E. MAINE'S ATTORNEY GENERAL AND BLUE CROSS AND BLUE SHIELD OF MAINE NEGOTIATE THE TERMS OF THE COMPANY'S CHARITABLE ASSET OBLIGATION TO THE PEOPLE OF MAINE.

In 1996, Blue Cross and Blue Shield of Maine (BCBSME) proposed joint ventures with two nonprofit hospitals in Maine in order to establish for-profit HMOs. Soon thereafter, BCBSME and the Attorney General announced that they had reached an "agreement in principle" on BCBSME's charitable status. Because of the longstanding common law charitable

trust doctrine, the agreement included provision for the passage of legislation that would require a charitable set-aside in the event of an outright sale to a for-profit corporation.

In 2002, Maine codified this long-standing common law charitable trust doctrine, requiring that a charitable asset be set aside. When BCBSME and Anthem Insurance Companies announced plans to "affiliate" in 1999, the companies were required to set aside assets for the people of Maine. Pursuant to the state law, Maine established a foundation with assets valued at approximately $81 million from the proceeds of the sale.

F. REGULATORS IN WISCONSIN SET ASIDE $250 MILLION AFTER WISCONSIN'S BLUE CROSS AND BLUE SHIELD PLAN CONVERTED TO FOR-PROFIT STATUS.

In 1999, Blue Cross Blue Shield United of Wisconsin (BCBSUW) announced its plans to convert from nonprofit to for-profit status. BCBSUW proposed to set aside $250 million in a foundation to support the state's two medical schools. The Insurance Commissioner approved the plan, but required that 35 percent of the funds be spent on public health projects.

Community organizations in Wisconsin thought that the full $250 million should be spent on public health projects, and filed a petition for judicial review challenging the Insurance Commissioner's decision. A trial judge heard the case in August 2000 and, in remarks from the bench, upheld the commissioner's decision, reasoning that he could only reverse the commissioner's decision if she exceeded her statutory authority. The Wisconsin court of appeals agreed, reasoning that, "[w]hile we are not bound by an agency's conclusions of law in the same manner as we are bound by its factual findings, we may nonetheless defer to an agency's legal conclusions." ABC for Health, Inc. v. Commissioner of Ins., 250 Wis. 2d 56, 67, 640 N.W.2d 510, 514 (Wis. Ct. App., Dec. 6, 2001) (stating that Wisconsin Statute ' 701.01(2) defined a

charitable trust as one in which the "income or principal presently or in the future must be used by the trustee exclusively for a charitable purpose").

G. AFTER YEARS OF NEW YORK'S EMPIRE BLUE CROSS AND BLUE SHIELD ACKNOWLEDGING ITS CHARITABLE OBLIGATION, NEW YORK'S LEGISLATURE TRIES TO RE-DEFINE CHARITABLE ASSET.

When Empire Blue Cross and Blue Shield (Empire), the largest Blues plan in New York, proposed to convert in 1997, it publicly acknowledged its nonprofit obligations and agreed to preserve 100 percent of its assets for nonprofit charitable purposes. Empire was a health insurance plan with paying subscribers, was organized as a nonprofit corporation and was categorized as a section 501(c)(4) social welfare organization, which exempted both plans from all federal taxes until 1987.

After the Attorney General issued an opinion that Empire could not convert to a for-profit corporation without a technical change in the nonprofit code, the New York legislature passed legislation seizing 95 percent of the charitable assets, and sending the remaining 5 percent to a foundation. (Chapter One of New York's Laws of 2002; Ins. L. ' 7317.) Although the legislature recognized that all of the assets belonged in the public realm and could not be diverted to private uses, the law passed allows the charitable assets to be used for a purpose other than Empire's original purpose. The Public Asset was allocated to fund salary increases for health care workers, many of whom are members of the union which supported the legislation.

In August 2002, Consumers Union, Disabled in Action, Housing Works, the New York Chapter of the National Multiple Sclerosis Society, the New York StateWide Senior Action Council, and several individual policyholders filed suit against the State of New York and Empire Blue Cross to block the conversion as proposed, on the grounds that the state legislation

that authorizes it is unconstitutional. Consumers Union of U.S., Inc. v. State of New York, No. 118699/02 (N.Y. Sup. Ct. filed Aug. 21, 2002). While the case is being litigated, the proceeds of Empire initial public offering are in escrow.

H. REGULATORS IN ILLINOIS AND NEW MEXICO REQUIRED SET-ASIDE OF ASSETS WHEN BLUES PLANS MERGED, AND A TEXAS CASE INVOLVING THE SAME COMPANY WILL DETERMINE THE DISPOSITION OF ASSETS FOR THE HEALTH OF TEXANS.

Texans established the first plan that initiated the Blue Cross and Blue Shield movement in 1939. Blue Cross and Blue Shield of Texas (BCBST) was organized as a charitable and benevolent organization and has a long history of helping otherwise uninsured patients obtain the health care they needed by providing low cost insurance initially on its own and later through government programs such as Medicare.

In 1996, Illinois Blue Cross and Blue Shield (BCBSIL) and Blue Cross and Blue Shield of Texas submitted proposals to merge. The Texas Attorney General immediately sued Blue Cross and Blue Shield of Texas and related entities, arguing that the assets of BCBST were impressed with a charitable trust for health-care purposes and that its net assets must continue to be used for similar charitable purposes in Texas. After the district court ruled against the Attorney General, the parties entered into an interim settlement allowing the merger to go forward while the charity issue was appealed. The parties agreed that if the Attorney General wins the charity issue on appeal, the merged entity will pay $560 million over 20 years to a foundation or other charitable entity providing health care assistance to Texans.

In 2003, the Court of Appeals for the Third Judicial District upheld the trial court=s ruling. Weeks later, the Attorney General discovered and shared with the Court of Appeals a written

history, which was authorized, underwritten, and published by Blue Cross and Blue Shield of Texas, entitled "Lone Star Legacy: The Birth of Group Hospitalization and the Story of Blue Cross and Blue Shield of Texas" (1999). In it, the author stated that BCBST had, in fact, solicited and received charitable donations over the years. Because of the new evidence, the Attorney General asked the Court of Appeals to reconsider its affirmation of the trial court's ruling, which the appellate court declined to do. In early 2004, the Attorney General filed a petition for review of this matter with the Supreme Court of Texas. The Supreme Court's decision is expected in late 2004.

While both the Blues plan in Illinois and the Blues plan in Texas have been arguing that the Texas plan has no charitable asset obligation, the holding company that controls both plans, Health Care Service Corporation (HCSC), acquired the Blues plan in New Mexico (Blue Cross and Blue Shield of New Mexico, or BCBSNM) and agreed in 2001 to set aside the full, fair-market value of the plan, $20 million, in a foundation dedicated to addressing the health needs of the people of New Mexico. Similarly, the parent company entered into a settlement agreement with the Attorney General of Illinois in 2002, under which it set aside $124.6 million in a health care foundation dedicated to the health needs of the children of Illinois. While the parties await the decision of the Supreme Court of Texas, it is clear that the parent company has admitted obligations to set aside assets for the other two plans it controls in Illinois and New Mexico.

I. REJECTIONS BY REGULATORS AND WITHDRAWALS BY BLUES PLANS.

Regulators in Washington, Alaska, Kansas and Maryland rejected proposals for their Blues plans to convert by deeming that the proposal in each state was not in the public interest. In North Carolina, a Blues plan withdrew its proposal to convert when it faced difficult questions

from regulators about the degree to which the Blues plan proposed to maintain authority over the foundation created to receive assets from the conversion. Similarly, the Regence Group, the Blues plans in Idaho, Oregon, Utah, and Washington, withdrew proposals to "affiliate" with Illinois-based Health Care Service Corporation after regulators began examining the degree of control that HCSC was proposing to exert over the charitable assets and the corporate governance of the four states' Blues plans. Regulators questioned whether the companies' proposals to affiliate could more accurately be described as a *merger*, with ultimate control over the plans' charitable assets being ceded to a company outside of the Northwest region.

J. THE SUPREME COURT OF SOUTH DAKOTA RULES UNEQUIVOCALLY THAT OUT-OF-STATE NONPROFIT HOSPITAL CHAIN MUST LEAVE SALE PROCEEDS IN SOUTH DAKOTA.

Charitable assets must be protected whenever a nonprofit corporation attempts to alter its mission or control of its assets. For example, Banner Health System, a nonprofit hospital chain, attempted to remove from South Dakota the proceeds from the sale of seven hospitals and nursing homes and to reinvest them in its nonprofit facilities in Arizona and Colorado. When the South Dakota Attorney General objected, Banner Health System sued him in federal court. The South Dakota Supreme Court took this case as a "certified question" from the United States District Court.

The South Dakota Supreme Court explicitly held that the assets of a nonprofit health care corporation, as well as the proceeds from the sale of those assets, are subject to the law of charitable trust. Banner Health System v. Long, 2003 S.D. 60, 663 N.W.2d 242 (S.D., May 21, 2003). The court also held that an out-of-state corporation must leave these proceeds with the local community upon divestiture.

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In summary, individually and collectively, the examples above demonstrate that Insurance Commissioners, like the Insurance Commissioner of Pennsylvania, have the authority and responsibility to treat the Blues plans as charitable trusts, and shall require Blues plans to disgorge and distribute significant portions of their charitable assets--such as excessive surplus and excessive reserves--to serve their original, charitable mission.

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