REPORT TO THE PENNSYLVANIA INSURANCE DEPARTMENT CONCERNING THE APPLICATIONS OF BLUE CROSS PLANS FOR THE APPROVAL OF RESERVES AND SURPLUS

Larry Kirsch
IMR Health Economics, LLC
Brookline, MA
(617) 731 2600
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REPORT

On August 6, 2004, the Pennsylvania Insurance Department (Department) invited public comment on the applications of Highmark Blue Cross Blue Shield (Highmark), Independence Blue Cross (IBC), Capital Blue Cross (CBC) and Blue Cross of Northeastern Pennsylvania (BCNEPA) for approval of their reserves and surplus pursuant to 40 Pa. C.S. Chapters 61, 63.[1]

Thirteen Pennsylvania not-for-profit organizations and trade unions and the national Consumers Union of the U.S., along with the City of Philadelphia,[2] concerned about the impact on policyholders, the uninsured and the general public of the buildup of $4 billion of surplus on the balance sheets of the nonprofit Blue Cross Plans (the Plans), retained IMR Health Economics, LLC, to conduct an independent analysis of the applications filed with the Department in this proceeding.[3]

What follows is IMR Health Economics' detailed (primarily technical) report containing analysis and recommendations addressed to the Department on the topics listed below:

* Minimum surplus
* Maximum surplus
* Impact of excess surplus on policyholders
* Expenditures in fulfillment of charitable obligations
* Implementation issues

These matters are central to the concerns articulated by the Department in its January 16, 2004 Notice:

> Therefore, to assure that the Blues Plans are maintaining properly stated reserve levels and appropriate but not excessive surplus to properly fulfill corporate obligations and social missions, the Department has determined that each Blues Plan must submit an application for approval of its reserve and surplus.[4]

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1 34 Pa.B. 4340, Doc. No. 04-1465

2 Consumers Union, City of Philadelphia, Citizens for Consumer Justice, Women's Law Project, PHILAPOSH, Service Employees International Union, District 1199 P, Jobs for Justice, Philadelphia Welfare Rights Organization, Schuylkill Alliance for Health Care Access, Philadelphia Citizens for Children and Youth, Pennsylvania Alliance for Retired Americans, Consumer Health Coalition, Philadelphia Unemployment Project, Action Alliance of Senior Citizens of Greater Philadelphia, Mon Valley Unemployed Committee.

3 This report was prepared by Larry Kirsch, Managing Partner of IMR Health Economics. My qualifications, experience, and background are listed in attached Appendix A.

4 Pa.B. 458, Doc. No. 04-122

I. PRELIMINARY MATTER: THE CONSOLIDATED COMPANY IS THE PROPER UNIT FOR THE DETERMINING CAPITAL ADEQUACY

At the outset I wish to draw the Department's attention to an extremely important threshold issue: the inconsistency between the Department's January notice and the applications filed by the four Blue Plans. The notice stated, in relevant part:

> In the application, each Blues Plan must, in a manner the Department deems necessary and proper: (a) state 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...[5]

This provision is clear evidence of the Department's recognition that the appropriate basis for this inquiry is the range of surplus needed by the applicants on a consolidated basis, i.e., the parent companies together with their insurance subsidiaries and affiliates. Since each of the Plans operates within a holding company structure and has a substantial and growing stake in subsidiaries and affiliates – for profit and not for profit – the Department's position was the correct one.[6] A financial analysis from the perspective of the Consolidated Company is the only way for the Department and the public to develop a comprehensive and accurate picture of the financial strength of the applicants. For instance while the basic Risk-Based Capital[7] framework relied upon by the Department to assess capital adequacy reflects the risks imposed on the parent company by subsidiaries and affiliates,[8] it does not fully capture the corresponding strengths that subsidiaries and affiliates may contribute to the parent company.[9] An individualized

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[5] Ibid.

[6] Percentage of Parent Companies' Admitted Assets Invested in Subsidiaries and Affiliates, 2002 and 2003.

PLAN	2002	2003
Highmark	15.5%	16.0%
Capital	2.4%	7.2%
BCNEPA	9.5%	9.8%
IBC	61.3%	64.8%

Source: 2003 Annual Statements, 5 Year Historical Data.

[7] Risk based capital (RBC) is a metric developed and adopted on a model law basis by the National Association of Insurance Commissioners (NAIC). Its purpose is to measure the adequacy of capital held by an insurer (including a Blue Cross-Blue Shield Plan) in light of its business operations, size and individualized risk profile. By far the largest component of risk incorporated in RBC is the chance that an insurer will under-estimate its claims' liability. Minimum RBC standards are used to trigger regulatory monitoring and financial compliance measures in the interest of protecting policyholders, vendors and the public against chances of insolvency. The Commonwealth has adopted the RBC framework. 40 P.S. §221.1-B et. seq.

[8] Subsidiary and affiliate risk is captured in the Asset Risk (H_o) component of Risk Based Capital. See, Overview and Instructions, Health Risk-Based Capital Forecasting. (Published and distributed by the NAIC, 2003

[9] As one example, Independence Blue Cross management reported that "The $133.8 million increase in Capital and Surplus is primarily attributable to unrealized gains from subsidiary operations. IBC's net gain before taxes excluding dividends from its subsidiaries was $9.8 million. The increase in Capital and Surplus reflects the continuing achievement of IBC's goals to strengthen the Company's financial position through these subsidiary operations." Management's Discussion and Analysis (2003 Annual Statement).

consideration of inter-company financial relationships and financial flows would greatly assist the Department making an accurate, balanced and inclusive analysis of surplus requirements.

Unfortunately, each of the Plans has basically chosen to respond to the Department's Notice by presenting financial data on a parent company-only rather than a consolidated basis. Thus, for instance, while CBC reported surplus (December 31, 2003) on a Consolidated Company basis in the amount of $788 million,[10] the thrust of its analysis was predicated on a year-end surplus of only $515 million – the surplus of the parent company standing alone. Considering this unit of analysis, in isolation, fully a third of the consolidated company's surplus would be disregarded.[11] Similarly, in its application, IBC reported paying out $620 million in claims monthly ($7.44 billion a year).[12] Using that figure, it calculated that its surplus account could only pay 41 days of claims. Yet the company's annual financial statement reported annual claims and expenses valued at only $366 million.[13] On that basis, IBC's surplus would cover more than two year's worth of claims and expenses.[14]

For all of these reasons, I conclude that the parent company-only financial format presented by the applicants provides an incomplete and potentially misleading picture of their capital adequacy. The consolidated company format would offer a more comprehensive view. Having identified this concern and brought the matter to the Department's attention, I will now proceed to an analysis of the applications filed by the Blue Plans.

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10 CBC Application at 36.

11 Approximately a quarter of Highmark's surplus (consolidated basis) is held by affiliates and subsidiaries. By analyzing the parent company alone, the Department would effectively disregard $667 million in subsidiary/affiliate surplus.

12 IBC Application at 2. I assume this reflects net claims and expenses for IBC and its subsidiaries and affiliates. If so, it is inconsistent with the basis used in the application to present the other financial data of interest, e.g. surplus. Those data are presented on a parent company basis.

13 IBC Annual Statement 2003, Income Statement (lines 18 plus 21).

14 The trend in all of the companies has been to move business from the Parent Company into the subsidiaries. Between 2001 and 2002, claims in NEPA, the Parent Company, declined by 44%; at Highmark, claims fell 45% and at IBC, they decreased 43%. The same phenomenon occurred at CBC between 2002 and 2003. There, claims declined by 69% in a single year. This plainly makes analysis of capital adequacy at the Parent Company level much less meaningful.

II. PURPOSES OF THIS PROCEEDING

Consistent with the notices published in the Pennsylvania Bulletin on January 14, 2004 and August 6, 2004, I would summarize the essential objectives of this proceeding as being:

* To determine the exact level of surplus of each of the Plans.

* To set a range of surplus levels which:

  – at the lower end, should give a well-managed Blue Plan sufficient time and capital to plan, initiate and implement financial recovery measures and regain financial health over some reasonable time period;

  – at the upper end, should generate sufficient surplus (from all sources – operating margins, capital gains and investment income) to provide a high and sustainable probability of insolvency protection under realistic (but not extreme) threat scenarios; and

  – at all points along the spectrum, to make certain that surplus will never be so high as to promote an environment of managerial slack in which financial vigilance and risk management efforts are relaxed.

* To avoid the potentially adverse, inefficient and inequitable impact on policyholders of excess surplus accumulation.

* To provide sufficient funding for charitable mission-related initiatives.

* To set forth further steps for implementing the conclusions and recommendations developed in this report.

This proceeding also provides a much needed opportunity (1) for the Plans to thoroughly document their sources and uses of capital and surplus, (2) for a full public discussion of the amounts needed in today's health insurance environment to meet legitimate solvency, business and charitable obligations, (3) for the Department to strike a balance between the concerns that policyholders and the public have for reasonable premiums and adequate coverage against valid interests in insolvency protection and access to sources of business capital, and (4) for there to be a clearly defined plan and expeditious timeline established for implementing the findings of this proceeding.

III. ISSUES

This report addresses the following questions and provides Plan-specific analyses, answers and recommendations:[15]

A. What are the realistic threats to Plan solvency in the current environment and the foreseeable future? Given these threats what is an appropriate range of surplus for Plans to maintain?

B. Recognizing that greater amounts of capital and surplus funds can help reduce, but not fully eliminate, the chances of Plan insolvency, how much insolvency risk is prudent and acceptable to the public? In other words, what is the appropriate maximum surplus range?

C. What assumptions and specifications should the Department require the Plans to incorporate into the financial ruin-type models used to determine maximum surplus levels?

D. What methodologies should the Department employ, if any, to authorize the accumulation of additional capital and surplus on a stand-by (as-needed) basis in lieu of higher levels of surplus build-up on a routine basis?

E. How are policyholders, the uninsured, the underinsured and the public impacted by excessive surplus?

F. Are the Plans meeting their charitable obligations? If not, what steps should the Department take to assure their compliance?

[15] My contribution, however, will of necessity be limited by lack of access to essential data categorized as proprietary or otherwise confidential.

IV. COMMENTS

A. Minimum Surplus Requirement

It is my understanding that each of the Plans has recommended a minimum threshold target of 375% ACL consistent with the Blue Cross Blue Shield Association membership and trademark standard.[16] None has provided specific justification for that level of surplus.[17] A 375% ACL minimum standard is excessive.

The 200% ACL (NAIC) standard adopted by the NAIC and the Commonwealth[18] provides a more than adequate level of "early warning" protection in today's environment. In fact, it probably provides considerably more protection than its designers and the NAIC had anticipated when the model was first developed and adopted in the early 1990's. In large measure, this comes about as a result of significant changes in the health insurance business and financial environment which have caused the baseline modeling assumptions to become overly conservative. These changes include:

* The consolidation of many smaller, financially weaker BCBS Plans into larger more secure business units. The BCBS sector being modeled in the early 1990's was at far greater risk of instability than the sector we have today.

* The significant increase in risk transfer since the early 1990 period. The important point is that the BCBS Plans originally modeled bore far more risk than those that survive today. In the interval, more risk has been shifted downstream to providers (through capitation and other risk-sharing mechanisms), upstream to policyholders (through high deductible and other benefit designs requiring significant cost-sharing) and forward to reinsurers and other pooling mechanisms (such as the consortium established by all of the Blue Plans in Pennsylvania).

* Far greater regulatory and management attention to the threat of insolvency. The fact that insurers now operate in a carefully monitored environment under capital and surplus guidelines has plainly altered their financial behavior. I would submit that the attenuation of previously large swings in underwriting results–-the single largest risk factor targeted by RBC-- reflects the impact of better risk management practices and more pricing discipline brought about by the advent of RBC regulation.

If the 200% ACL threshold standard adopted and retained by the NAIC for more than 10 years[19] is fully adequate, and I believe it is, then by definition, the 375% ACL standard adopted

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[16] ACL stands for "authorized control level". It is the level of surplus below which state insurance departments are authorized to take whatever action is necessary to protect the interests of policyholders and creditors including liquidation or rehabilitation of the insurer. At 200% ACL or greater, surplus is deemed sufficient to permit insurance companies to operate without special regulatory monitoring or supervision.

[17] Because some portions of each of the applications have been redacted, I cannot be absolutely certain about the Plans' positions on this matter.

[18] I wish to acknowledge the very helpful discussion of Pennsylvania's Risk Based Capital Requirements, 40 P.S. §221.1-B, contained in the written comments submitted in this proceeding on behalf of Lawrence S. Herman et. al. beginning at page 13.

[19] While the NAIC has refined the RBC formula applicable to Blue Plans, it has not changed the basic 200% ACL minimum threshold standard since its adoption. Inasmuch as the Health RBC formula has been under active

by the Blue Cross Blue Shield Association (BCBSA), as its lower bound membership requirement, provides an excessive degree of early warning protection.[20]

The only justification offered by applicants in support of the BCBSA 375 % ACL threshold value is that it constitutes a trade association licensing and trademark standard.[21] A national trade association's licensing and trademark standard is irrelevant to a financial inquiry about the Commonwealth's standards for excess surplus and availability for charitable obligations. Neither the Plans nor the BCBSA have documented the assumptions, data and methodologies inherent in the 375% ACL standard. Therefore, I am unable to analyze the inherent degree of conservative bias or compare it directly with the NAIC and Pennsylvania minimum standard. The BCBSA standard is thus a classic analytic "black box", and should not be relied upon by the Department.

B. Maximum Surplus Targets

The Department's authority for approving surpluses and determining whether excess surplus funds have been accumulated is firmly grounded in its obligation to disapprove rates which it finds to be excessive, inadequate or unfairly discriminatory. Subscriber rates are continuously subject to the prior approval of the Department and may be subsequently disapproved.[22]

At the upper bound, capital and surplus funds should contribute to a high and sustainable degree of protection for policyholders, providers, vendors and the general public against realistic but not exaggerated threats to solvency. Surplus is one of a number of risk stabilization and management tools available for this purpose.

1. Plans' proposed maximum surplus range.

The Plans report that as of December 31, 2003 they held (on a parent company-only basis) accumulated capital and surplus totaling $3.96 billion, up $500 million from the prior year. Highmark's 2003 surplus of $2.2 billion was equivalent to 645% ACL; IBC's surplus of $841 million represented 391% ACL; BCNEPA's surplus, $405 million was equal to 1006% ACL and CBC's surplus of $515 million represented 929% ACL.

The upper bound surplus targets *proposed* by the Plans are as follows: IBC, 25% of claims and expenses (the equivalent in 2003 of 865% ACL);[23] Highmark, a range of 650-950% ACL;

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and continuing review, one can safely conclude that if experience had demonstrated the inadequacy of 200% floor, it would have been lifted.

[20] Since its adoption in Pennsylvania, the 200% ACL standard has remained constant.

[21] I fear, however, that the Department's decision to cite the 375% ACL minimum threshold value in its Notice (in lieu of the state's own standard of 200% ACL) may have given applicants some comfort and created an impression of official deference to the BCBS Association guideline.

[22] 40 P.S. §6124-6125 make it plain that the rates and reserves of Blue Plans are at all times subject to the prior approval of the Department and that the Department has the authority to examine into the financial affairs of each Plan as it deems necessary. Jules Ciamaichelo & Rob Stevens, Inc. v. IBC, 814 A2d 800.

[23] To be calculated on the basis of consolidated company claims. See, section I *supra* for a discussion of IBC's confusing presentation of its financial position.

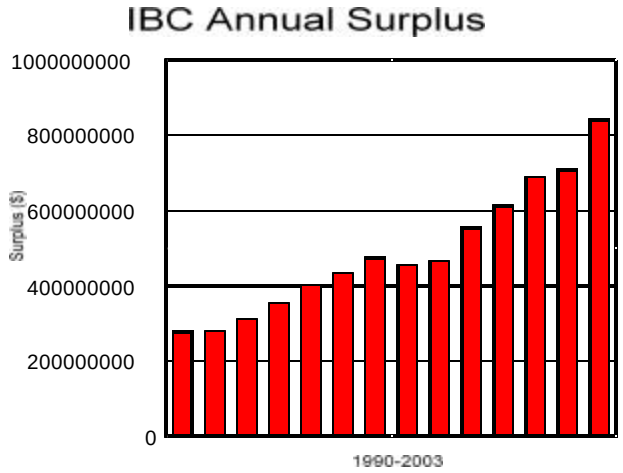
BCNEPA, 750-850% ACL; and CBC, no specific recommendation.[24] Accordingly, two Plans, Highmark and IBC, considered themselves to fall short of the top end of the acceptable range; one Plan, CBC, deemed itself to be at precisely the appropriate level; and one Plan, BCNEPA considered its current surplus to be above the top of the range. If, as of December 31, 2003, each of the Plans had held surplus equal to their respective upper bound targets, aggregate capital and surplus *would have* totaled $5.94 billion – 50% in excess of today's levels.

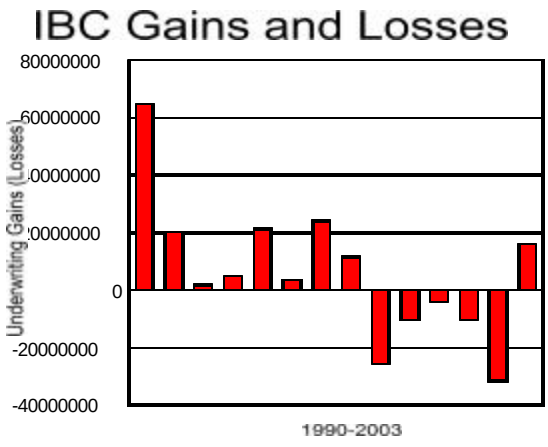
2. Analysis of Plans' proposed maximum surplus range.

An analysis of the Plans' historical experience (1990-2003) demonstrates that each Plan currently holds surplus far in excess of its realistic needs. The principal source of financial risk to a Plan derives from the potential to underestimate its actual claims' liability. Surplus is earned and maintained in order to protect the Plan – its policyholders, vendors, creditors and the public – against adverse claims' experience. Each Plan attempts to provide a sufficient cushion against the possibility that a string of annual losses will use up accumulated surplus.

Annual underwriting experience is captured in the set of charts (below). These charts labeled "Gains and Losses" show the amount of money gained or lost by each Plan from the writing of health insurance business. The amount of money held in surplus is depicted in the corresponding charts labeled "Annual Surplus."

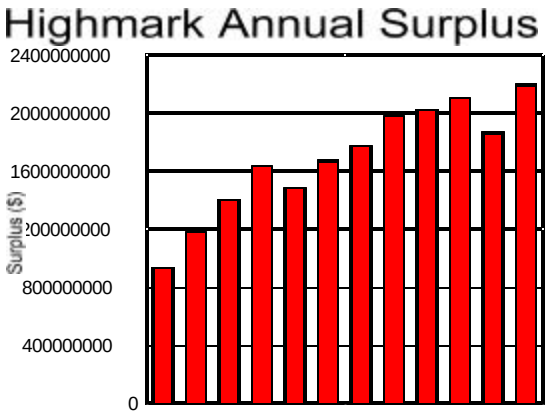
The charts demonstrate that for virtually all of the Plans, surplus has increased steadily over the period 1990-2003 with only a few momentary and minor declines. Even when Plans experienced substantial *annual* losses (e.g. Highmark, $311 million in 1996) and/or *multi-year losses (*e.g. Highmark, $568 million of underwriting losses from 1995-1999), surplus has not been eroded. Indeed, in the case of Highmark, surplus grew by $341 million (1995-1999) notwithstanding the substantial, concurrent five-year loss.[25] Similarly, in the instance of CBC, the company experienced a cumulative loss over the six-year period, 1997-2002, of $161 million; during the same period, surplus increased by $51 million. These data do not support the thesis that surplus (currently on the order of $4 billion in the aggregate) is justified as protection against reasonably projected risks.

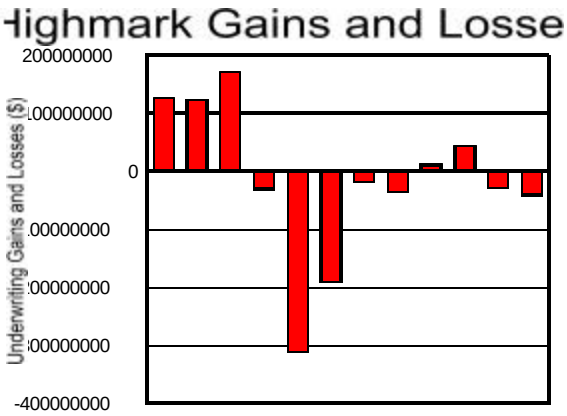


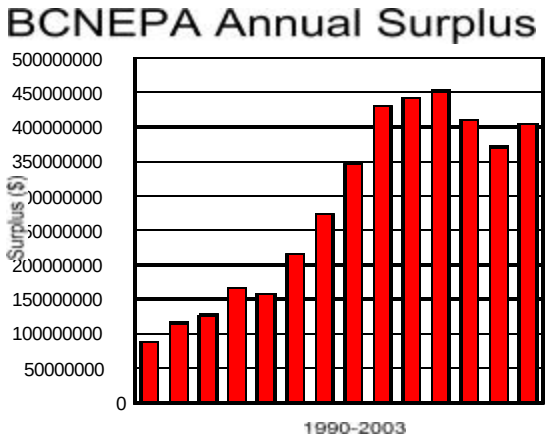


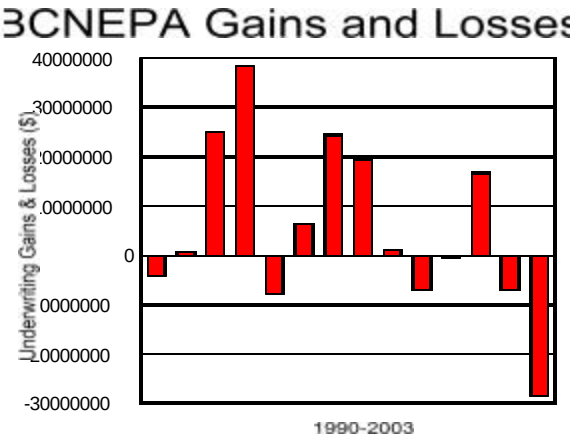
[24] The company indicated, however, that its current surplus (929% ACL) was appropriate and not excessive. For purposes of this report, I will assume that the current level of surplus represents the upper end of the spectrum deemed proper by CBC. See the CBC application at 45.

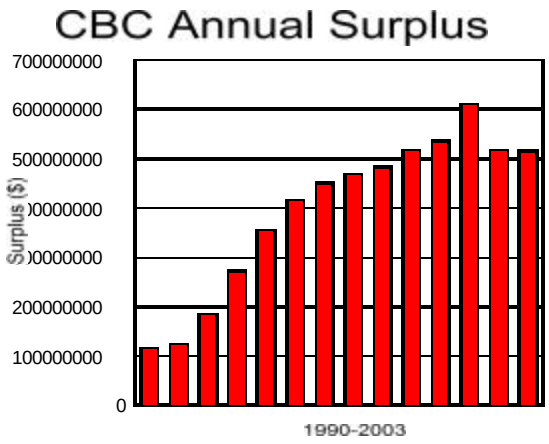
[25] Over the same period of time, Highmark report investment gains totaling $2.8 billion.

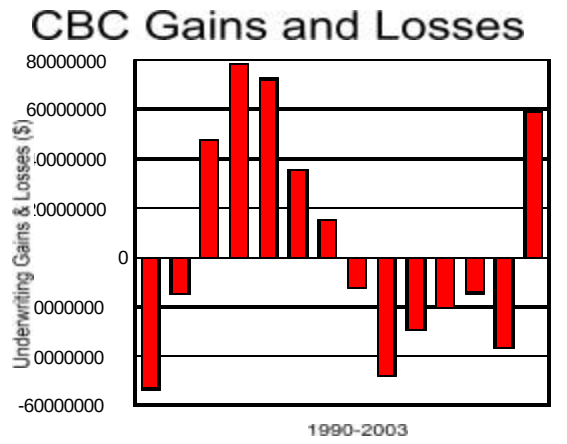












On the strength of the available data currently before the Department and the public, I cannot agree with applicants' assertion that current levels of surplus are reasonable, not excessive and even short of appropriate upper limits.

3. Lack of Information.

Instead of simply critiquing the Plans' proposals, I would have preferred to provide the Department with my own, specific, upper-bound recommendations. Regrettably, lack 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, the unredacted 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.

Perhaps even more important, the Department – despite its greater access to Plan-specific data – is not currently in a position to make a reliable factual finding of whether the upper bound surplus recommendations submitted by the Plans are reasonable and not excessive. For instance, without access to each Plan's risk assessment model, the Department cannot independently validate the estimates provided or critically assess their underlying assumptions. Nor would it be in a position to ask crucial "what-if" questions as a means of testing the sensitivity of the models to alternatives assumptions. Finally, as stated above, the parent-only financial presentations now before the Department provide an incomplete and misleading picture of the financial strengths and risks of the applicants.

In conclusion, despite the great volume of material generated by the Plans in response to the January notice, the Department does not have a sufficient basis for either establishing a reasonable upper level of capital and surplus, or, in the alternative, for critically reviewing and making a sound determination of what a reasonable range of surplus would be, based on the information currently before it.

C. Alternative Approach

Under these circumstances it would be constructive to propose an alternative approach for calculating suitable upper bound surplus requirements with the objective of overcoming the shortcomings indicated.

1. Further proceedings are needed.

Perhaps the most pragmatic approach to evaluating Plan-specific upper-bound values would be for the Department to initiate further proceeding(s) – in the form of a contested case proceeding – to consider the standard financial ruin-type models, scenario testing and pro forma projections used by the Plans to estimate their capital and surplus requirements.[26] A contested case proceeding would be in the public interest and could be designed to provide each Plan with the requisite amount of confidentiality.[27] Under the scenario detailed below, the Department would ask each Plan to prepare model(s) which, at a minimum, incorporated certain basic assumptions and specifications set forth by the Department. Each Plan would be free, of course,

[26] Some examples of these risk assessment models can be found in (1) the original RBC development work presented to the NAIC by the American Academy of Actuaries, and (2) the modeling referenced in the Milliman USA report to Highmark and incorporated in the Highmark application.

[27] I believe a contested case (adjudicatory) proceeding would be appropriate and would allow for full public intervention with the right to inspect documents, present and cross-examine witnesses, etc. A contested case format would also be proper for purposes of granting relief upon a determination that a given Plan's accumulated surpluses were excessive.

to present additional model specifications and sensitivity tests so that the Department would have a sound basis for evaluating the impact of the various assumptions and specifications on a "what if" basis.

2. A Framework for Analysis

In the following sections, I summarize the key assumptions and specifications I believe to be incorporated in the financial ruin-type models alluded to by some of the Plans in their applications. Since these models are only presented in highly general terms (and are not in the public domain) I have had to piece together information from a variety of sources[28] and, of course, have been unable to independently test them. After summarizing the assumptions and specifications believed to be in the Plans' models, I will comment on these assumptions and specifications and suggest alternatives the Department should ask the Plans to present in the proposed contested case proceedings.

a. Summary and comments of models used by the Plans

To the best of my knowledge, the original RBC model developed by Milliman and Robertson (now, Milliman USA) for the American Academy of Actuaries (as later adopted by the NAIC) attempted to calculate the starting level of surplus that would be required by a carrier in order to weather an adverse underwriting cycle lasting 5 years at the 95th percentile level of certainty.[29] I believe the original model was estimated before adjustment for covariance.[30] One consequence of the failure to adjust for covariance is the resulting tendency to understate the degree of certainty implicit in the estimate.[31] This tendency is especially prevalent in cases where a Blue Plan's book of business, including its subsidiaries, is exposed to long-tailed claims (as in life insurance, medical malpractice and other lines).[32] This has become an increasingly prominent feature of Blue Plan business, today, where Plans have ownership interests in life insurance, property and casualty insurance and other lines with long-tailed claims.

To test the model, Milliman evaluated the pattern of cumulative underwriting gains and losses during an historical period quite different from more recent experience. The major differences were that during prior underwriting cycles, periods of gain and periods of loss tended to be shorter but considerably more volatile. In fact, Milliman reports average annual underwriting losses during the period 1980-1983 of 5%, 1986-1989 of 4.5% and 1995-2000 of

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[28] Sources include consultants' reports, NAIC publications, personal interviews with health actuaries, professional literature, etc.

[29] It is not clear precisely how the concept of "weathering" an adverse loss cycle is modeled. By one definition it means that surplus would never dip below the 100% ACL level. (See Milliman USA Report to Premera BCBS in the Matter of the Proposed Conversion of the Premera BCBS Health Plan on the Washington Insurance Department website at 18). By another definition it means that surplus would not fall below 375% of ACL even after a Plan has experienced adverse results. (See Ernst and Young Report to the NC Insurance Department in the Matter of the Proposed Conversion of the NC BCBS Plan at VI-5). Inasmuch as this definition (and specification) goes to the heart of the surplus calculation, it is vital that the issue be clarified.

[30] The covariance adjustment recognizes and statistically takes into account the low probability that all of the multiple risk factors built into RBC model will occur simultaneously.

[31] By way of example (hypothetical), in the absence of taking covariance into account, it may appear that a Plan would accumulate $XXX surplus to "weather" a 5-year adverse underwriting cycle with 95% certainty; if covariance had been factored in, the degree of certainty might have risen to, e.g. 98%.

[32] Private communication between Julia Philips, actuary for the Minnesota Insurance Department and chair of the NAIC Risk Based Capital Working Group and Larry Kirsch, September 2004.

3.6%. (Highmark Application at 660). A longer but less volatile cycle is far more tractable in the sense of prediction and management than a shorter but more erratic one.

b. Suggestions for an alternative model

For purposes of the proposed contested case proceeding, the Department should require the Plans to present modified models or scenarios which incorporate the following suggestions.

To begin with, these modified models or scenarios should be based on more recent but less volatile underwriting cycles. The model should capture the impact of less volatile swings in gains/losses, and should, at a minimum, test alternative durations of cumulative losses (e.g. 2-5 years) to reflect the impact of improvements in the management of less volatile underwriting cycles. I would note that related points were made in the report to the North Carolina Insurance Department by James Roberts of Ernst and Young (consultant in this proceeding to Independence Blue Cross-Blue Shield)[33] and to the Washington Insurance Commissioner's Office in a report on behalf of Premera Blue Cross by Donna Novak, Nova Rest Consulting (Report on Capital Requirements and Sources of Capital).[34]

Second, for purposes of modeling, it should define "weathering" adverse underwriting cycles to mean that surplus should not dip below 200% ACL (i.e. the low end of the acceptable spectrum) and should be rebuilt over some reasonable period of time, e.g. 2-4 years.

Third, the degree of certainty of the estimate (i.e. the probability that surplus will fall below the minimum threshold) should be tested in the range of 75%-95%.[35] I would point out that surplus requirements are extremely sensitive to differences in the degree of certainty of the estimate. In the Matter of the Conversion of Premera Blue Cross, Milliman USA calculated that surplus requirements at the 95th percentile of certainty would exceed requirements at the 75th percentile by 52%.[36]

Finally, each Plan should be modeled on a consolidated basis.

To recap, I recommend that the Department notice contested case proceedings to the four Blue Plans for the purposes of evaluating the reasonableness of maximum surplus levels (funded through premiums, investment income and capital gains) in light of estimates of the underlying risks. The Department should ask each of the Plans to incorporate certain assumptions and

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[33] "BCBSNC modeled such losses based on results from their selection of a market-basket of BCBS Plans during the last three historical underwriting loss cycles. I believe these historical low points are likely to be overstated in terms of a projection of future loss cycles. Their calculation of a potential loss cycle is heavily weighted by losses from the downturn shown in 1986-89...The last decade has seem more sophisticated pricing of provider networks and managed care impacts." (2003)

[34] "Actuarial models are used along with company specific and general market data to determine the probability of loss in a period of time. The period of time may be *one year* or some number of consecutive years. Depending on the company's risk tolerance and ability to recover from loss, a percentile and level of loss is determined and a surplus level needed to cover the loss is targeted." (Emphasis added) (2003)

[35] Milliman USA (consultants to Highmark in this proceeding and Premera in the Washington conversion proceeding) stated that "...we believe that the 75th percentile represents a minimum safety threshold.." Report to Premera BC and the Washington Insurance Commissioner's Office at 20. Yet, in this proceeding, and without explaining the basis for their choice, they illustrate safety thresholds in the range of 90-98% (requiring considerably more capital and surplus).

[36] Ibid. at 18

specifications in their modeling (leaving them the option to develop and recommend additional model outputs). The specifications and assumptions set forth above are now summarized in Table 1 with Highmark serving as an illustration.

TABLE 1. Recommended Model Assumptions and Specifications

	PROPOSED	HIGHMARK
Underwriting Cycles: Period Studied	1990-Present	1980's-Present[37]
Safety Threshold	Test 75%; 85%; 95%	90-98%[38]
Length of Loss Cycle	Test 2 years; 3 years...5 years	The full duration of historical loss cycles
"Weathering" Adverse Loss Cycles: Minimum Surplus at Trough of Cycle	200% ACL	Not clearly defined
Recovery Period	Test 2-4 years	Not clearly defined
Financial Format	Consolidated Company	Parent Company

D. Stand-by authority

I believe that capital and surplus in the range of 200% ACL (lower bound) and such amounts as may be determined (consistent with the recommendations for contested case proceedings) will provide reasonable and adequate protection and will meet the several objectives defined in section II, supra. If, however, the Department believes that additional protection would be in the public interest e.g. as a means of deterring a looming company action level event, I would recommend a procedure which could serve as an effective alternative to a permanent and across-the-board increase in minimum and maximum RBC ratios.[39]

I would recommend that, in the interest of avoiding an impending company action level event, the Department could trigger a time-limited increase in a Plan's threshold surplus (200% ACL) at any time (1) the account fell below some trigger point, e.g. 250% ACL, and (2) the Plan

[37] Since we do not have access to a full description of the model(s) Highmark relied upon, we infer from other sources, that the period studied extends back to 1980 or even earlier.

[38] This is the range Highmark's consultant proposed in the Premera conversion case.

[39] This could address, for example, the situation in which an underwriting cycle turned out to be more volatile than had been predicted in a Plan's risk assessment modeling.

was experiencing negative surplus trends (i.e. was drawing down surplus too rapidly)[40] At such time as surplus trends returned to more stable levels, the minimum ratio would revert to 200% ACL.

E. The Adverse Impact of Excess Surplus on Policyholders, the Uninsured, the Underinsured and the Public

I have reviewed the public version of each Plan's application in full. My review leads me to the regrettable conclusion that none of the Plans has really begun to address the range of legitimate policyholder and public interests and concerns – including concerns regarding Pennsylvania's uninsured crisis – implicit in this matter.[41] Indeed, it would not be an overstatement to say that the policyholder is virtually missing-in-action in most of the applications.

In this respect, I find myself in total agreement with the Department's statement on this issue.

> CBC's status requires a unique analysis of solvency that encompasses not only a minimum solvency threshold (below which the ability to pay present and future health claims could be threatened) but also a maximum threshold (above which inefficiently high levels of reserves and surplus may work to the detriment of CBC's subscribers.[42]

While it is beyond debate that policyholders have a strong interest in assuring reasonable protection against the realistic risks of insolvency, it is equally true that they are ill-served by the accumulation and retention of inefficiently high levels of surplus based on extreme and/or duplicative risk assumptions.[43]

The applications fail to make it clear that policyholders contribute to surplus through their premiums. Policyholder dollars fund surplus accounts in two ways: (1) directly, through "margin" assessments,[44] that is, monthly or quarterly premium contributions earmarked for Plan profits (surplus), and (2) indirectly, through their regular premium payments which are in turn invested in income-generating funds (stocks, bonds, and other approved assets) that ultimately contribute to surplus.

To the extent that Plans charge premiums which are higher than necessary to maintain reasonable (but not excessive) amounts of surplus, policyholder premiums are, by definition,

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[40] There is precedent for a provision somewhat like this. See Maine Revised Statutes Annotated, Title 24-A §6453(1)(A)(2).

[41] Policyholders may also be referred to as subscribers, members or certificate holders.

[42] Memorandum of Law of the Pennsylvania Insurance Department and Commissioner M. Diane Koken in Opposition to Petitioner's Application for Preliminary Injunctive Relief at 11 (Commonwealth Court, Docket No. 172 MD 2004, March 16, 2004).

[43] Highmark suggests that target surplus should consist of three components: (1) a base component to meet the BCBSA Early Warning threshold requirement of 375% ACL, (2) an operating component to cover claims fluctuations and corporate commitments, and (3) a contingencies components to cover unforeseen events such as market changes (Highmark Application at 12). I would submit that the three components are overlapping and duplicative. Each piece ultimately is meant to serve as protection against unforeseen underwriting risk.

[44] Margin is also referred to sometimes as contingency and profit loadings.

excessive. The Department has a continuing obligation to prevent excessive rates and the build-up of excess reserve and surplus funds.

From a public policy perspective, high premiums (in this case, driven by excess surplus accumulation targets) have indisputable adverse effects that will be familiar to the Department:

* High premiums contribute, significantly, to the rising rate of uninsurance. People drop their coverage and employers find it increasingly difficult to offer health insurance as an employee benefit. The latest Pennsylvania Pew Poll, for instance, reported that one in four families had at least one member without insurance sometime in the last 12 months.[45]

* High premiums lead policyholders (individuals and employers) to "buy down" their coverage, i.e. to reduce benefits, increase deductibles and other cost sharing. "Bare Bones" (minimum benefit) policies are, in some areas, the only affordable choice available to subscribers in the individual and small group markets. More and more insurers are now offering limited benefit plans (e.g. dread disease policies) and there have been reports of consumers being misled into believing they have comprehensive protection. Rising premiums have also led some state legislatures to consider mandated benefit rollbacks and similar measures aimed at public programs. At some point this raises the important question whether insurance is providing a meaningful level of financial protection against the growing cost of medical care.

Policyholders do not make uniform contributions to surplus through their premium dollars. Although none of the applicants quantified the direct premium contributions (margin) required to fund the range of surpluses proposed, Highmark's consulting actuary, Milliman USA, did generate an estimate in a case not terribly dissimilar from the Highmark situation. In the recent Premera Blue Cross (Washington and Alaska) conversion proceeding, Milliman concluded that an average contribution on the order of 4% (in addition to investment income) would be needed to fund adequate levels of surplus.[46] A related fact, however, has received virtually no attention: some policyholders are likely to make no contributions to margin (due to their preferred competitive position and perceived risk characteristics) while others will pay far more than their fair share. For example, individual subscribers and small group members almost always make a disproportionate contribution to margin while some large employer groups and self-funded accounts receive preferred rates as low as 0%.[47] One abundantly clear implication is that the higher the overall dollar contribution to margin, the more unequal will be the burden imposed on the least favored policyholders.[48]

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[45] Results of the Pew Poll were reported in the Pittsburgh Post-Gazette, September 8, 2004, "Consumer Groups Want Deeper Probe into Blues' Surplus" by Pamela Gaynor.

[46] Milliman USA, Premera Comparative Premium Analysis at 20. Washington Office of the Insurance Commissioner, November 10, 2003.

[47] The margin contributions assessed by Capital Blue Cross to their basic experience rated groups ranged from 8% for groups with fewer than 200 covered lives to 3.6% for groups with between 7,500-12,000 lives. The largest groups are set on an "individual consideration" basis. (Letter from Nabila Audi, Senior Actuary CBC to Bharat Patel, Actuary, The Department, April 4, 2003, "Experience Rated Basic Blue Cross: Rating Factors and Formula Update-Filing No. 03-B.)

[48] A curious example can be found in the BCNEPA application. NEPA's strategy has been to provide premium rebates funded out of investment income earnings to group underwritten and self-funded members–but not non-group accounts and (perhaps not small groups, either). (Application at 15). Although the Plan touts the fact that it has not

F. The Charitable Obligation of the Plans

The Plans have charitable obligations stemming from their preferred tax status as non-profit entities. The January notice issued by the Department asked the Plans to enumerate past and anticipated future charitable expenditures. The responses made by the respective Plans make it abundantly clear that:

* There is no common understanding of the types of activities or cost allocations that are consistent with the discharge of their charitable obligations.

* There has been no consistency across Plans in terms of the proportion of revenue dedicated to the charitable mission.

* While the Department and the Attorney General have created an incipient legal framework for the definition, measurement and monitoring of charitable obligations, it needs to be extended, refined and tightened-up.

* The single Plan which has been subject to this framework (since 1996) appears to be out of compliance with aspects of the Order.[49]

* There is no indication that the Department has enforced the charitable obligation provisions of the 1996 Order.

The type of charitable activities funded varies widely from Plan to Plan. Each of the Plans reported support for Caring Foundations and routine community fund raising activities. Less typical – and meriting more careful scrutiny – are expenditures such as the following:

* One Plan reported that 60% of its charitable contributions in 2002 ($36.4 million) were earmarked for "group conversion subsidies."[50] Inasmuch as all group carriers in Pennsylvania are required by law to offer group conversion coverage, it is not clear why a state-mandate should be characterized as a charitable contribution.[51] Nor is it at all obvious from the data provided that such coverage is subsidized by the Plan – or subsidized to the degree reported. (It is my understanding that group accounts contribute toward conversion coverage, in effect prepaying it.) Similarly, if the group conversion referred to is limited to the state's HIPAA arrangement, I would question whether one Plan has subsidized HIPAA conversions to the extent shown.

* Other Plans reported support for CHIP, adultBasic and similar programs. None of them, however, 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

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put a margin contribution into non-group premiums, it also appears that it has not credited non-group accounts with a share of investment earnings.

[49] If the 1.25% charitable obligation had been earmarked against Highmark on a parent-only basis (not as recommended, on a consolidated basis), the cumulative obligation since 1996 would have been in excess of $350 million.

[50] Highmark Application at 22.

[51] 40 P.S. §756.2

nature.[52]

* Finally, some Plans claimed that taxes paid to federal, state and local governments (including premium taxes) were in the nature of charitable and benevolent contributions![53]

1. The 1996 Highmark Order.

In conjunction with the consolidation of Blue Cross and Blue Shield of Western Pennsylvania to form Highmark (1996) the Department issued an order which provides in relevant part:

> Highmark shall annually dedicate to social or charitable health care endeavors 1.25% of its direct written premium as reported in its most recent Annual Statement, and shall, on or before March 1 of each calendar year, provide to the Department a summary...of its charitable or benevolent endeavors...Highmark may consider contributions to programs including the following:
>
> a. HealthPlace...
> b. Special Care...
> c. Caring Program for Children...
> d. 65 Plus, Security Blue...
> e. Any other similar programs as Highmark determines suitable to consider in fulfillment of its charitable and benevolent purposes.[54]

The 1996 Highmark order creates a good starting point for defining the charitable mission, quantifying the obligation, establishing a viable monitoring mechanism and providing effective enforcement tools. It also demonstrates that the Department has the authority to define, set standards and enforce each Plan's social mission.

2. Charitable obligation recommendations

With regard to charitable obligation I recommend that:

* The Department improve and tighten the basic framework created in the 1996 Highmark Order to establish minimum, annual charitable obligations, applicable to each of the Plans.

* At a minimum, the 1.25% annual standard established in Highmark be extended to the other Plans.

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[52] The most recently completed financial examination of Highmark by the Department noted that CHIP is operated by the Department with funding provided by state and federal cigarette taxes and adultBasic is funded from an allocation of the Commonwealth's share of Tobacco Settlement moneys. (Examination Report, January 8, 2004 at 13).

[53] Capital Blue Cross Application at 58; Independence Blue Cross, Letters from John Foos, CFO to Commissioner Diane Koken (March 22, 2004, May 15, 2003, April 30, 2202, Aril 20, 2001).

[54] Decision and Order in Docket No. MS96-04-098 (November 27, 1996).

* The 1.25% minimum standard be calculated against revenues on a Consolidated Company rather than Parent Company basis.[55]

* The Department specifically define which expenditures will qualify as "charitable." The definition should require plans to direct quantifiable and verifiable contributions, beyond those they already have a legal obligation to provide, to programs which expand health insurance coverage to the uninsured and underinsured. The definition should be incorporated in whatever Order or Rules the Department promulgates to effectuate this recommendation.

* In the case of the 1996 Highmark Order, the Department audit the Plan's compliance with the charitable giving provisions. To the degree it determines that the Plan has not complied with the terms of that Order (e.g. the types of projects claimed to have met the definition of social mission) or the amount of the Plan's annual allocation, the Department should require Highmark to make up the shortfall prospectively.

[55] This is consistent with representations made by various Plans which characterized the contributions made by their subsidiaries and affiliates as charitable. See, CBC Application at 74; IBC Application at 7, 168, 172. It also appears to be in keeping with the terms of the original Highmark consolidation, approved by the Department (Docket No. MS96-04-098), see, pages 47-52.

V. SUMMARY OF MAJOR RECOMMENDATIONS

1. The lower range target surplus levels proposed by the Plans (375% ACL) are excessive and not justified by the evidence. A minimum surplus of 200% ACL, the statutory level adopted by the Commonwealth, is reasonable and sufficient. The Department should withhold its approval of the proposed 375% ACL minimum surplus level.

2. None of the Applications filed with the Department provides a valid basis for approving an upper range target surplus level. The Department should, therefore, withhold its approval of the proposed maximum surplus levels.

3. Although a considerable amount of material has already been filed in this proceeding, it does not give the Department a proper and adequate basis for reaching a sound determination regarding the key issues identified in the January Notice. The Department should, therefore, proceed, expeditiously, to notice contested case (adjudicatory) hearings for purposes of (a) determining reasonable upper and lower range surplus levels, (b) adopting measures, as necessary, to require Plans to come into compliance with maximum surplus limitations, including disgorgement and/or other remedial actions. The hearings, referenced above, should embody the detailed suggestions set forth in this report.

4. The Department should move promptly to tighten up and extend to all Plans the charitable mission obligation framework created by its 1996 Highmark Blue Cross Order. In so doing, the Department should be guided by the principles and specific recommendations set out in this report and in the separate comments submitted in this proceeding.

5. The Department should audit Highmark's compliance with the 1996 Order and require the Plan to fulfill any shortfall in the level and character of obligations defined therein.

Respectfully submitted,

IMR HEALTH ECONOMICS, LLC
Larry Kirsch, Managing Partner
1855 Beacon Street
Brookline, MA 02445
617-731-2600
larry@IMRHealth.com

September 24, 2004

RESUME

Lawrence Jay Kirsch

A.B., Cornell University (Economics and Government); M.A., University of Michigan (Economics)

Professional Positions

Economist and Staff Assistant to the Director, U.S. Office of Management and Budget

Deputy Commissioner and Chief Financial Officer, City of Boston Department of Health and Hospitals

Lecturer, Department of Social Medicine and Health Policy and Center for Community Health and Medical Care, Harvard Medical School

President and Executive Director, Consumer Health Advocates, Inc.

Vice President, Chief Health Economist and National Practice Leader (State Health Care Reform), The Segal Company

Managing Partner, IMR Health Economics, LLC (Current)

Consulting (Representative Clients)

Consumers Union D.C. Appleseed Law Center	Financial impact analysis of the conversion of nonprofit Blue Cross-Blue Shield Plans to for-profit status (N.Y. and D.C)
New Yorkers for Accessible Health Coverage	Estimate the cost of providing prescription drug coverage to disabled persons under N.Y. State Prescription Drug Assistance Program.
Hillquit-Smith Associates	Interactive consumer education to compare long term care insurance products

West Virginia Rural Health Networking Project	Study of risk and capital requirements and recommendations for licensing legislation for risk-bearing, provider-sponsored networks
New Jersey Office of the Public Advocate	Pilot proposal to finance health service for the uninsured; Blue Cross-Blue Shield rate cases (expert); hospital reimbursement reform (expert)
Connecticut Department on Aging	Consumer education strategy and training program for pilot long term care insurance initiative
Massachusetts Association of Older Americans	Analysis of Medicare Supplement rate filings. (Expert witness) Evaluation of state licensing application by Massachusetts first IPA. (Expert witness in licensing hearing).
Vermont Department of Banking and Insurance	Financial and actuarial analysis of continuing care retirement project (CCRC); expert witness on Blue Cross and AARP rates; statutory independent insurance rate analyst.
Partners Healthcare System	Expert witness (damages phase of arbitration proceeding with BCBS of Massachusetts)
University of Massachusetts	Studies of HMO risk contracts and Blue Cross mutualization.
City of Burlington, Vermont	Facilitate labor-management negotiation of municipal health plan.
Massachusetts Insurance Department	Study of regulatory issues in long-term care insurance market; examination of mail order life and health insurance market practices (market conduct examination).

Kentucky Attorney General, Kentucky Insurance Department and South Carolina Insurance Department	Develop legislative proposals for small group reform in Appalachia.
National Association of Insurance Commissioners	Funded Consumer Representative
	Medicare Supplement Standardization (OBRA-90)
	Chair of Long Term Care Insurance Rate Stabilization Advisory Committee
	Wellpoint Health Networks: Report to the NAIC on the Original IPO
Montana and North Dakota Insurance Departments	Insurance reform: special issues for rural states
Florida Agency for Health Care Administration	Financing issues applicable to Rural Health Networks
Kentucky Health Policy Board and Department of Insurance	Expert witness in case challenging constitutionality of state health insurance reform law
New Hampshire Insurance Department	Survey of insurance carriers and evaluation of Small Group and Individual Market Reforms (legislative-mandate)
Pomerantz, Haudek, Block, Grossman and Gross; Shapiro, Haber and Urmy; Milberg Weiss Bershad Hynes & Lerach Barrack, Rodos and Bacine Gianelli and Morris	Consulting expert for plaintiffs in unfair and deceptive insurance practices cases

Publications and Selected Presentations

"An Analysis of the Proposed Hill-Burton Regulations Governing "Medical Services for Persons Unable to Pay" Harvard Health Care Policy Discussion Paper, June 1972.

"Regulating Hospital Capacity: An Appraisal of the Certificate of Need Process and an Alternative", Harvard Medical School, March 1973.

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"Consumer Strategies for Affordable Health Care", National Consumers League, 1983.

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“Quasi-Group Associations and Health Insurance” IMR Working Paper 2002

"The Illusion of Group Health Insurance: Discretionary Associations", www.familiesusa.org
posted March 11, 2004.

Grants

Carnegie Foundation

Bruner Foundation

U.S. Department of Education

Villers Foundation

U.S. Department on Aging

Appalachian Regional Commission

Testifying and Consulting Expert

Qualified as an expert witness on health insurance ratemaking in Massachusetts, Rhode Island, New Jersey, Kentucky, Michigan and Vermont. Testified in more than 35 contested rate cases.

Testifying witness for Commonwealth of Kentucky (Health Policy Board and Insurance Department) in Golden Rule Insurance Co. v. Don W. Stephens, 912 F. Supp. 261 (E.D. Ky. 1995).

Consulting Expert for Plaintiff in Addison v. American Medical Security, No. CL 0001445-AB, 15th Judicial Circuit (Palm Beach County, Florida).

Consulting Expert for Plaintiff in Crichton v. Golden Rule Insurance Co. CA No. 02L202 3rd Cir. Court (Madison County, Illinois).