ConsumersUnion

POLICY & ACTION FROM CONSUMER REPORTS

Surplus Report Update

JUNE 2015

How Much is Too Much: Nonprofit Insurer Surplus After the ACA

EXECUTIVE SUMMARY

Since enactment of the landmark Patient Protection and Affordable Care Act (ACA) five years ago, the landscape of insurance pricing and underwriting has changed enormously. In light of these changes, Consumers Union re-visits our examination of nonprofit insurance carriers' surplus previously undertaken in our 2010 report. Our re-examination finds that although the upward trajectory of surplus growth has slowed, many nonprofit carriers continue to hold surplus many times in excess of benchmarks set by regulators and the Blue Cross Blue Shield Association. While the current terrain of health insurance involves some new risks, it also includes government support and an expanded customer base. As we explain in this report, there is a place for surplus for each nonprofit health insurance carrier; however, policymakers should use the rate review process to protect consumers from excessive rates built on a presumed need for outsized surplus holdings, well beyond what is needed for solvency.

In this update, we:

- Review trends in nonprofit surplus growth since the ACA.
- Evaluate the criteria for rate review in light of non-profit carrier surplus.
- Consider how calculation for known risks should be incorporated in rate review.

Overview: surplus in the dawn of the ACA

In every state, regulators require all insurance carriers[i] to hold surplus in order to protect policyholders against the risk of default due to unforeseen contingencies. This purpose—hedging against unanticipated claims and other expenses—is commonly called solvency protection.[ii] The National Association of Insurance Commissioners (NAIC) has established and promoted model laws[iii] that set minimum surplus requirements and a system for regulating them. Currently, all states have adopted such laws. Separately, the BCBS Association sets a floor for its members' surpluses. However, although there is consensus around the need to set a minimum that carriers should have for solvency purposes, there is no guidance on maximum surplus levels. Because surplus is primarily amassed through premiums, and inflated surplus can be achieved by inflating premiums, ensuring that carriers do not overcharge is as important to regulators and consumers as ensuring that they don't undercharge.

When Consumers Union reviewed non-profit health insurance carrier surplus in a 2010 report,[iv] we determined that Blue Cross and Blue Shield (BSBS) carriers, including charitable plans and mutual plans, held over $9 billion in surplus by 2009. In our 2010 report, we reviewed the surplus and "risk-based capital" (RBC) percentages (that is, surplus relative to estimated risk exposure)[v], maintained by ten BCBS carriers and found that actual surplus greatly exceeded required RBC levels. In our analysis for this report, we determined that nine of those carriers,[vi] held over $12 billion in surplus in 2014; the concerns we expressed about the size of surplus holdings in 2010 therefore remain today. The result of our survey is shown in Table 1, on the following page, with the far-right columns showing how much each carrier's RBC ratio changed over the past five years, as well as in the first two years of the ACA.

For the most part, carriers' surpluses continued to grow over the past five years while in many cases their RBC ratios declined. This dichotomy likely results from business expansion. Because RBC value is based on exposure to risk, as a carrier's number of policyholders grows, so too does the amount of risk to which it is exposed. Therefore, as a carrier insures more people under the ACA, its RBC ratio might decrease because the calculation of surplus needed for solvency protection will increase. For most of the nine carriers reviewed, however, the amount of surplus still held in 2014 far exceeded industry or regulatory benchmarks.

TABLE 1 - TOTAL SURPLUS ($ MILLIONS) AND RBC SCORES OF NONPROFIT BCBS CARRIERS									
BCBS Plan		**2001**	**2010**	**2011**	**2012**	**2013**	**2014**	**% Change 2013-2014**	**% Change 2010-2014**
Wyoming	S	68.4	168.1	179.	199.9	242.3	251.3	4%	49%
	R	***1154%***	***1462%***	***1619%***	***1473%***	***1430%***	***1402%***	-2%	-4%
Tennessee	S	614.1	1243.2	1313.5	1514.9	1651.4	1733.5	5%	39%
	R	***1098%***	***1023%***	***1092%***	***1240%***	***1267%***	***1191%***	-6%	16%
Arizona	S	159.9	790.	891.	908.5	1036.3	1030.1	-1%	30%
	R	904%	***1493%***	***1488%***	***1223%***	***1226%***	***1114%***	-9%	-25%
Oregon (Regence)	S	266.3	544.5	522.3	565.2	627.7	635.6	1%	17%
	R	446%	970%	901%	996%	983%	***1004%***	2%	3%
Alabama	S	433.7	855.8	991.1	1118.9	1243.9	1077.4	-13%	26%
	R	754%	708%	946%	***1070%***	***1165%***	872%	-25%	23%
North Carolina	S	439.1	1751.6	1816.2	2081.	2388.5	2298.3	-4%	31%
	R	580%	***1098%***	***1065%***	***1045%***	***1033%***	788%	-24%	-28%
Michigan	S	1300.6	2759.5	2789.7	3060.6	3288.7	3340.8	2%	21%
	R	493%	698%	673%	711%	719%	677%	-6%	-3%
Massachusetts	S	525.7	732.7	711.2	740.8	820.1	671.2	-18%	-8%
	R	481%	685%	643%	634%	645%	544%	-16%	-21%
New York (Excellus)	S	393.9	1089.7	1267.3	1287.7	1359.	1165.	-14%	7%
	R	361%	576%	631%	602%	566%	520%	-8%	-10%
Average RBC Score (unweighted)		697%	968%	***1006%***	999%	***1004%***	901%	-10%	7%

Key: S = Surplus R = RBC Score
RBC scores 1000% and greater shown in bold italic, shaded cells reflect the highest RBC scores for each carrier.

Other factors might also explain why RBC ratio growth slowed, and in many cases reversed, over the past five years. All are attributable to the ACA. These causes may operate either independently or jointly:

1. The Medical Loss Ratio (MLR) establishes the minimum amount an insurer must spend on medical care and quality improvement equal to 80 cents of every net premium dollar (for individuals and small groups) and 85 cents of every net premium dollar for large groups.[vii] This provision reins in how much carriers can collect in premium dollars in excess of what they anticipate spending on health care; carriers that run afoul of the MLR must issue refunds to policyholders.
2. In tandem with mandating health insurance coverage for all Americans, the ACA makes it easier for consumers to compare insurance options. The ACA created more uniform market rules—for example, by eliminating most underwriting, requiring every health plan to cover essential health benefits without annual or lifetime limits, and establishing tiers within which all health plans have similar

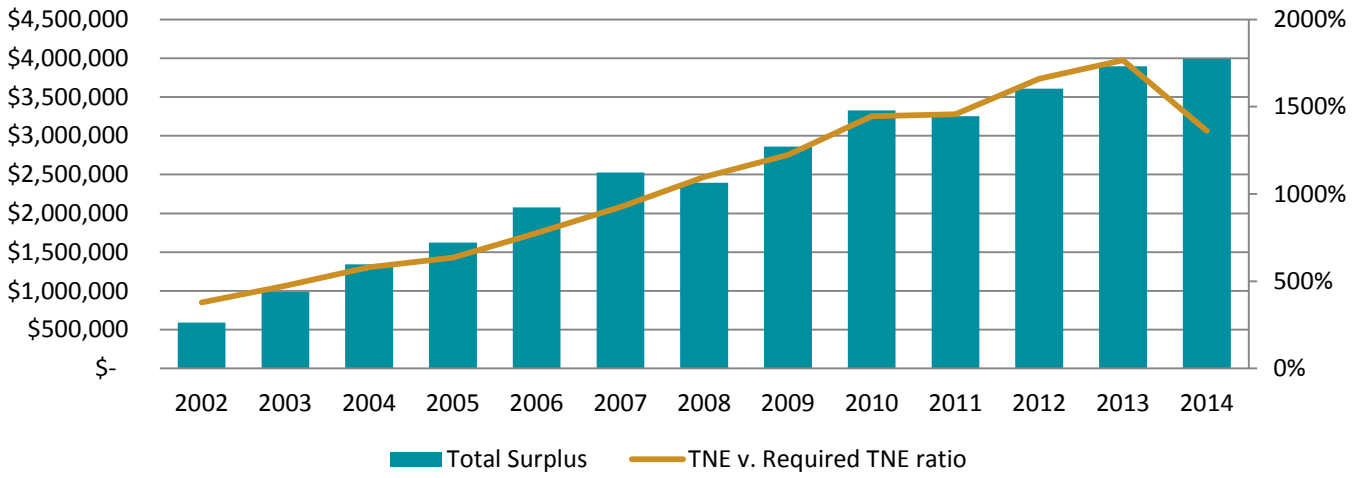
actuarial value. Carriers in such a market are forced to compete on price, as well as networks and services, hampering their ability to charge excessive premiums and amass unnecessary surplus. Some carriers may intend to draw down unnecessary surplus in order to offer more competitively priced plans.[viii]

In addition to regulatory and competitive causes for slower growth of surplus[ix], there is also the possibility that surpluses were used for purposes that benefit the carriers more than policy holders or the greater community. For example: for business expansion via large acquisitions, capital investments, or prefunding increases in executive compensation.

The average RBC scores of these nine BCBS carriers peaked in 2011 but the trend was not uniform. For example, Blue Cross and Blue Shield of Alabama continued to build surplus through 2013, when it reached an RBC score of 1156%, or nearly six times the NAIC-standard threshold for intervention, then dropped its surplus to 872% in 2014. In contrast, Regence BlueCross BlueShield of Oregon continued to accumulate surplus, reaching 1004% RBC in 2014. One hypothesis is that implementation of the ACA was less likely to affect Oregon's longstanding rate review processes and, therefore, the trajectory of issuers' surpluses.

Finally, in addition to the nine carriers reviewed above, the California Physicians' Service (dba Blue Shield of California), a plan Consumers Union had not reported on in 2010[x], stands out for its relentless surplus growth despite changes under the ACA and its own "2% Pledge" to limit profit-taking, declared in 2011.[xi] That upward trend is shown in Table 2, below. In 2014, the California Franchise Tax Board revoked the company's state tax- exempt status. Although the grounds for this revocation are currently unknown, Consumers Union and reporters had questioned Blue Shield's surplus in excess of $4 billion surplus and planned increase in contribution to surplus in the 2015 plan year.[xii] Blue Shield is reportedly appealing the revocation.

TABLE 2 - BLUE SHIELD OF CALIFORNIA
TANGIBLE NET EQUITY AND RATIO OF TNE v. REQUIRED TNE



Criteria for rate review in light of carrier surplus

There is little uniformity in the process and the extent to which rate review is conducted across the country, or in how surplus factors into each jurisdiction's rate review process. Further, governmental agencies that review rates have limited ability to restrict the growth of nonprofit surplus; in most jurisdictions, they do not have the authority to order spend down of existing surplus. After years of largely unchecked health insurance rate increases, the Affordable Care Act instituted rate review requirements, including that carriers submit information on their capital, surplus, and reserve needs.[xiii, xiv] In states where insurance regulators review rates, this information serves as a critical tool for regulators to discourage excessive surplus by rejecting proposed increases that are unjustified on the basis of needs for additional capital, surplus and reserves, in light of the carrier's anticipated MLR and other factors. Simply stated, although most regulators cannot tell carriers what to do with premiums, they can reject a carrier's proposal to collect excessive premiums in the first place.

Even prior to the ACA, the Commissioner of the Commonwealth of Pennsylvania provided an example for how to review rates in light of surplus and other financial data, stating, "[p]articularly where a Blue Plan has sufficient surplus, forward-looking rate relief would assure that additional surplus is not cumulatively derived from premium income. Thus, for example, it would be appropriate to charge rates that do not include a risk and contingency factor when a Plan has a sufficient level of surplus."[xvi] That Commissioner categorized each carrier's surplus into three tiers based on the recognition of the diminishing returns from each successive dollar of surplus as well as balancing the "marginal reduction in risk" against the benefits of using the funds for other purposes.[xvii] Importantly, the Commissioner tailored RBC ratios to each individual plan, stating "acceptable ranges might vary based on a Plan's particular circumstances."[xviii]

Outside of Pennsylvania, however, it appears some regulators do not use the rate review process to protect consumers from unjustified rate increases.

- In Colorado, Rocky Mountain HMO, Inc. failed to achieve the MLR target *every year* since the ACA was enacted. See Table 3. In all that time, the carrier maintained a robust surplus of more than 1500% RBC, more than seven times the regulatory minimum. Reviewing surplus alongside MLR in this case illuminates the fact that this carrier, despite holding significant resources to protect its solvency, maximized how much it could charge consumers, and

Table 3 - Rocky Mountain HMO, Inc.[xv]

Year	MLR	RBC %
2009	80.25%	1657%
2010	79.11%	1743%
2011	79.54%	1655%
2012	77.45%	1831%
2013	78.78%	1553%
5-Year Average	79.03%	1688%

consumers paid the price. With its prior approval authority and the ACA's rate review standards, the Colorado Division of Insurance was empowered to deny rate increases but did not.[xix] It is unclear whether or to what extent the Colorado Division of Insurance factors carrier surplus into its analysis of proposed rates.

- Blue Cross Blue Shield of Arizona, Inc. significantly increased its health insurance rates in 2007, 2008, and 2009, while growing its surplus to more than seven times the regulatory minimum.[xx] BCBS of Arizona failed to meet MLR standards in both the small group and individual markets in 2011, and continued to fail to meet standards in the small group market in 2012 and 2013, while drawing down surplus. These factors are each available in the rate filings and relevant to a finding of whether any proposed increase is justified. However, not until recently did Arizona conduct rate review, let alone require carriers to submit rates at all; the state became an *Effective Rate Review* state for individual rates only in January, 2013, and for small group rates in January, 2014.[xxi]

Table 4 - Blue Cross Blue Shield of Arizona

Year	MLR Refund	RBC %
2011	$7,097,415 (indiv.) $4,380,469 (sm. grp.)	1488%
2012	$2,261,658 (sm. grp.)	1223%
2013	$2,752,922 (sm. grp.)	1226%

- Blue Shield of California held a surplus in excess of $4 billion, well above the amount required by the state and the BCBS Association.[xxii] It added to that surplus in 2014, and raised insurance premiums in 2015 with a clearly stated intent to grow additional surplus.[xxiii] California's rate regulators[xxiv] were not empowered to require Blue Shield of California to use its robust surplus to stabilize rates, provide community benefits, or invest in quality improvement or cost containment initiatives. But they could have determined that the proposed rate increase was unjustified and did not, despite the carriers' failure to adequately justify its decision to increase surplus.[xxv]

Finally, as suggested by the Colorado and Arizona examples above, although a critical component of rate review, MLR is an imperfect tool for keeping rate increases in check. Regulators that use the MLR in lieu of aggressively executed rate review will discover two major shortcomings. First, the current ratio—or how it is applied uniformly across all carriers—may be inadequate, as demonstrated by carriers building surplus regardless of the MLR minimum.[xxvi] Second, because the MLR may correct egregious overcharging *after the fact*—that is, after consumers have paid excessive premiums—competing carriers may be encouraged to charge higher premiums while still remaining competitive with the high premiums established by a carrier in the initial year, further impacting consumers.

Calculating for known risks

The ACA abolished many of the underwriting practices for which health insurance carriers were criticized. Prior to the ACA, carriers limited their risk exposure by denying policies to consumers with potentially expensive health conditions or systematically charging higher premiums to some consumers—such as women of childbearing age.

Starting in 2014, carriers were required to sell plans to all consumers without regard to health status or gender, and in general vary premiums (within limits) only by age, region, and/or tobacco use.[xxvii] To address carriers' risk exposure in the absence of underwriting, the ACA established three programs: state-level *risk adjustment, federal reinsurance, and federal risk corridors*, known as the "3 Rs".[xxviii] To address market-wide risk, the ACA offers premium subsidies to low- and middle-income individuals and families and also requires all consumers, with narrow exceptions, to have health coverage. These provisions pool risk broadly while encouraging younger and healthier individuals to buy coverage.

Despite these important counterweights to potential market disruption in the early years of health care reform, carriers frequently have cited unknown risk due to the ACA as justification for maintaining very high surpluses, and in many cases adding to surplus. However, the 3 Rs were explicitly designed to shield carriers from unknown risk, providing a cushion for carriers in the early years, while giving them time to develop effective quality and cost controls and a more accurate understanding of their consumer base for calculating premiums. In advance of the first payout from the reinsurance and risk corridor programs—scheduled for July through September, 2015—there is concern that the programs will fall short of carriers' expectations when they set rates the previous year. As of this publication there is no information to assess whether these concerns are valid.

Two of the 3 R programs are set to expire in 2017, which was known from the outset. The expectation was that when the two programs expired, the carriers would have had three years to strengthen their quality and cost controls, and then will continue to be helped by the permanent risk adjustment program. Stockpiling surplus is not the solution anticipated by the ACA or HHS.

When carriers calculate health insurance premiums, they consider a number of factors such as medical and pharmaceutical trends, assumptions about the morbidity of their consumers, and projected administrative expenses and fees; it is an educated calculus based on known risks and historical data. Despite the amount of information available, not all risk is predictable. Therefore, the need for surplus remains in the post-ACA landscape. However, we urge regulators to reject the presumption that the regulatory and market changes brought about by the ACA justify the stockpiling of excessive surplus.

Rather, much of the risk surrounding the first years of the ACA—cushioned by the 3 Rs programs—was known, especially for the largest companies that historically had dominated the individual market. These companies knew the risk profiles of applicants they had denied prior to the ACA and, therefore, the highest-risk new applicants they

were likely to encounter under the ACA. Further, the NAIC's decision in 2014 to maintain its formula for calculating the minimum benchmark for necessary surplus (the "RBC-ACL" calculation) and adopt a separate ACA Risk Adjustment and Risk Corridor Sensitivity Test[xxix] suggests that it does not encourage carriers, as a blanket rule, to increase their surplus in response to ACA-induced market changes. Instead, government regulators should analyze whether rates are adequate in light of the Risk Adjustment, Reinsurance, and Risk Corridor programs.

As carriers gain experience under the ACA, uncertainty about the implications of market changes and the value of the 3Rs will decrease. Carriers had three years to anticipate market changes under the ACA. They now have a full year of experience, another two years of protection under the Reinsurance and Risk Corridor programs, and ongoing protection from risk adjustment. We reject the notion that they must insulate themselves from change by charging consumers more, rather than by improving efficiency, cost control, and quality.

Nonprofit health insurer surplus in the courts

- **Washington D.C.**: In a landmark, years-long case, the Insurance Commissioner found that the DC-domiciled Blue Cross Blue Shield company, Group Hospitalization and Medical Services, Inc., held excessive surplus at year-end 2011, built over many years. The exact calculation of the excess amount, to be reinvested in community health, is currently under review. The Commissioner set permissible surplus at 721% RBC (approximately $696 million), while the company is arguing permissible surplus should be at least its current surplus—almost $268 million higher, and a community advocate is arguing that it should be still lower (at $400-500 million) than the Commissioner had found. For more on these ongoing proceedings, see http://bit.ly/1FNJ7Qe.
- **Washington State**: the Court of Appeals remanded to the lower court claims that Premera, Premera Blue Cross, and LifeWise Health Plan of Washington (referred to by the courts collectively as "Premera")[xxx1] collected excessive, unnecessary, or unfair rates, which they alleged resulted in excessive surplus. (The Court dismissed a claim of selective underwriting.) The court held that because the Insurance Commissioner lacked the statutory authority to effectively address or control excessive surplus, and because awarding damages on the claim would not substitute for the rate review process, the case should be remanded to the lower court for further proceedings. The court's opinion is available at http://www.courts.wa.gov/opinions/pdf/698486.pdf. The Supreme Court of the State of Washington ultimately reversed the Court of Appeals' ruling, not on the basis of the legal claims, but because the specific damages requested by the policyholders would require the trial court to step into the rate review process. The court's opinion is available at http://www.courts.wa.gov/opinions/pdf/905339.pdf.

Conclusion and recommendations for action

For the most part, the growth of surplus funds held by nonprofit carriers has slowed, and in some cases surplus decreased. However, many of the largest carriers continue to hold very high surpluses—demonstrably far more than needed for solvency considerations. Carriers frequently cite the ACA's requirement that they accept risk, compete fairly, and provide certain benefits to policyholders as the basis for requiring

high surplus. Rate regulators have a responsibility to consumers to question that argument. We urge policymakers and regulators to:

- Adopt definitions and purposes that would guide standards for maximum surplus. New laws may be needed to ensure regulators have the authority to deny rate increases or require spend down of excessive surplus, when an insurer's surplus exceeds the amount necessary to reasonably address solvency concerns.
- Evaluate carriers' capital, surplus, reserve needs, and MLR history and projections in light of surplus and consider the appropriateness of approving rate increases, keeping in mind that the MLR is a *minimum ratio*.
- Recognize that nonprofit carriers, like for-profit health insurance carriers, benefit from a dramatically expanded customer base with government premium and cost-sharing subsidies under the ACA. While profits and margins varied nationwide, the experience of some carriers in the first year of ACA enrollment yielded hefty profits[xxxi]—evidence that carriers' sophisticated actuarial tools enable them to anticipate and respond to change without inflating premiums.

In addition to these new recommendations, our original surplus report from 2010, *How Much is Too Much*, includes suggestions for government regulators to create a process for comprehensive review of solvency and surplus. In that earlier report, we recommended that the agenda for a comprehensive review of solvency and surplus should address:

- Definitions and purposes that would guide minimum and upper-range surplus requirements in light of prevailing and projected patterns of risk and other appropriate factors, including affordability for consumers.
- Business practices that reduce the need to rely on surplus, including, when appropriate, participation in guaranty associations or other reciprocal risk-sharing arrangements.
- Feasibility of defining surplus as protection against insolvency, with other needs such as growth and development to be incorporated on a stand-alone basis.
- Methods and metrics that would break surplus and target surplus into its component parts (e.g. claims risk vs. growth and development) and would be transparent to consumers, regulators, and policymakers.
- Undertake modeling to determine the incremental value of surplus on the theory that policyholders should not be overburdened with additional contributions to surplus that actually provide declining levels of increased protection.
- Methods for fair and beneficial disposition of surplus in excess of upper bounds.

Author:

Dena Mendelsohn, JD, MPH
Health Policy Analyst
Consumers Union
West Coast Office

Acknowledgements: The author wishes to thank the following individuals for their assistance during the preparation of this report: Elizabeth Imholz, Deborah J. Chollet, Allan Schwartz, Jay Angoff. None of them is in any way responsible for the content of this document, but their willingness to share information and point out potential pitfalls and implications is gratefully acknowledged.

ConsumersUnion®
POLICY & ACTION FROM CONSUMER REPORTS

Consumers Union has a long history of advocating for improvements in the consumer marketplace. Since our creation in 1936, we have worked for safer, more affordable, and better quality products and services at both the state and federal levels. We are a non-profit, non-partisan organization with an overarching mission to test, inform and protect.

WWW.CONSUMERSUNION.ORG

HEADQUARTERS
101 Truman Avenue
Yonkers, NY 10703
Phone: (914) 378-2000

SOUTHWEST OFFICE
7020 Easy Wind Drive, Suite 250
Austin, TX 78752
Phone: (512) 477-4431

WASHINGTON DC OFFICE
1101 17th Street NW, Suite 500
Washington, DC 20036
Phone: (202) 462-6262

WEST COAST OFFICE
1535 Mission Street
San Francisco, CA 94103
Phone: (415) 431-6747

ENDNOTES

[i] In this report, "insurance carrier" or "carrier" refers to the insurance company while "insurance plan" or "plan" refers to product the carriers sell.

[ii] In addition to holding surplus, carriers hold reserves to finance anticipated claims as well as other funds to finance foreseen expenses, such as planned information technology upgrades.

[iii] Chart identifying the minimum capital and surplus requirements for each Uniform state is available at http://www.naic.org/documents/industry_ucaa_chart_min_capital_surplus.pdf.

[iv] Consumers Union, *How Much is Too Much*, July 2010, available at http://consumersunion.org/pdf/prescriptionforchange.org-surplus_report.pdf.

[v] If a company's RBC score falls to a minimum set RBC level, regulators are authorized to take control of the company; thus, the level is referred to as the "authorized control level" or RBC-ACL. The NAIC benchmark is currently 200% RBC-ACL.

[vi] For the purpose of consistency, Pennsylvania was left off this chart because the plan reviewed in our 2010 report, Northeastern Pennsylvania Blue Cross, merged with Highmark in 2014.

[vii] The federal MLR calculation is based on the following; when used in the rate filing, the calculation is based on projections. Numerator: incurred claims, risk adjustment, reinsurance, quality improvement. Denominator: premiums, insurer tax, exchange fee, federal income tax.

[viii] For the 2015 plan year, for example, the Kaiser Foundation Health Plan, Inc. offered rates its outside actuarial firm (Milliman) advised were "not adequate to provide for expected health benefit costs, settlement costs, marketing and administrative expenses, and cost of required capital". Actuarial Memorandum to the Kaiser Foundation Health Plan, Inc. – Individual Non-Grandfathered HMO Policy Filing, 31 July 2014. Implicitly, they may intend to draw down accumulated surplus funds to finance expected costs unrelated to claims.

[ix] See *How Much is Too Much*, page 11 et. seq. for more on how surplus may be used.

[x] Consumers Union excluded Blue Shield of California from the 2010 report due to the difference in how Blue Shield's surplus was calculated (as tangible net equity, or TNE) rather than how the other carriers' surplus was calculated in our report (RBC). Although the two calculations serve similar purposes—to analyze each carrier's reserves in light of potential expenditures—the formula underpinning the calculations are different.

[xi] Blue Shield of California website, Our Pledge to Keep Healthcare Affordable, available at https://www.blueshieldca.com/bsca/about-blue-shield/health-reform/our-involvement/healthcare-quality-value/our-pledge.sp. (Accessed 14 April 2015.)

[xii] *With billions in the bank, Blue Shield of California loses its state tax-exempt status*, LA Times, 18 March 2015, available at http://www.latimes.com/business/la-fi-blue-shield-california-20150318-story.html#page=1.

[xiii] CMS's determination of Effective Rate Review Programs, 45 CFR 154.301.

[xiv] Additionally, carriers that propose a rate increase of 10% or greater are required to report on their Medical Loss Ratios (MLRs). Submission of rate filing justification, 45 CFR 154.215(e)(2).

[xv] Colorado Department of Regulatory Agencies, Division of Insurance, *Health Insurance Cost Report to the Colorado General Assembly for Calendar Year 2013*, available at http://1.usa.gov/196MLa2.

[xvi] Determination of the Insurance Commissioner of the Commonwealth of Pennsylvania, In Re: Applications of Capital BlueCross, Highmark Inc., Hospital Service Association of Northeastern Pennsylvania d/b/a Blue Cross of Northeastern Pennsylvania and Independence Blue Cross for

Approval of Reserves and Surplus, 9 February 2005, p. 18, available at http://www.portal.state.pa.us/portal/server.pt/document/496280/bcbs_determination_pdf.

[xvii] *Id.* At 15.

[xviii] Carol Pryor and Catherin Dunham, *The Pennsylvania Community Health Reinvestment Agreement*, August 2006, available at http://bit.ly/1Iw0wN7.

[xix] For example, In California, the Kaiser Foundation Health Plan also failed to achieve MLR minimum in each of the first three years of the ACA. In those years, surplus grew from 1023% TNE to 1736%. Over that same period, the carrier was obligated to issue MLR rebates to consumers. Kaiser is not discussed more fully in this report because of the carrier's unique composition as a complete closed health system that includes the health plan, providers, and infrastructure, making it difficult to discuss alongside other carriers.

[xx] The state is authorized to take regulatory action against an insurer that fails to maintain a RBC equal to or greater than 200%.

[xxi] See The Center for Consumer Information & Insurance Oversight (CCIIO) State Effective Rate Review Programs website available at http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rate_review_fact_sheet.html#ttt.

[xxii] Similarly, another carrier that we did not review in 2010—HMO Minnesota (dba Blue Plus)—also maintained robust surplus growth in the initial years of the ACA. Between 2010 and 2014, Blue Plus's surplus increased 67% and its RBC score increased 97% to 1704%, or roughly eight-times more than RBC-ACL.

[xxiii] The California Physicians' Service actuarial memorandum stated their intent to increase contribution to surplus from 1.15% to 1.95% of revenue.

[xxiv] California has two regulators that oversee health insurance rate setting: California Department of Insurance (CDI) and the Department of Managed Health Care (DMHC). The DMHC was responsible for reviewing and assessing Blue Shield of California's individual and small group health plan filings for the 2015 plan year.

[xxv] Notably, the Department of Managed Health Care (DMHC) outside actuary requested an explanation of the rationale behind increasing contributions to surplus but the response they received was the same as what was originally in the carrier's filing; i.e. the response was non-responsive. See *Letter from Lewis & Ellis, Inc. to Michael Cole*, 24 September 2014, available in the Final PDF Pipeline and the Excel document 09-24-2014 CommentLetterResponse, both available at http://wpso.dmhc.ca.gov/ratereview/Detail.aspx?lrh=oS8THuk9968%24.

[xxvi] In those cases, it may be preferable for the MLR to be set higher, as states are empowered to do under ACA section 2718 and 45 CFR 158.211.

[xxvii] For more on this, see *How Marketplace plans set your health insurance premiums*, available at https://www.healthcare.gov/lower-costs/how-plans-set-your-premiums.

[xxviii] For more on the 3 Rs, see *Explaining Health Care Reform: Risk Adjustment, Reinsurance, and Risk Corridors*, 22 January 2014, available at http://kff.org/health-reform/issue-brief/explaining-health-care-reform-risk-adjustment-reinsurance-and-risk-corridors.

[xxix] See NAIC Health Risk-Based Capital Newsletter, August 2014, Vol. 16.1, available at http://www.naic.org/documents/committees_e_capad_hrbc_newsltr_1408.pdf and NAIC Health Risk-Based Capital (E) Working Group, 17 August 2014, meeting materials available at http://www.naic.org/meetings1408/committees_e_capad_hrbc_2014_summer_nm_materials.pdf.

[xxx] According to the Court of Appeals of the State of Washington, "Premera is comprised of health care service contractors as defined in RCW 48.44.010(9). Premera was formed pursuant to the Washington Nonprofit Miscellaneous and Mutual Corporation Act, ch. 24.06 RCW. Premera Blue Cross and LifeWise Health Plan of Washington were formed pursuant to ch. 24.03 RCW, the Washington Nonprofit Corporation Act." Published Opinion, filed 23 June 2014 at 2.

[xxxi] In December, 2014, the Wall Street Journal reported that UnitedHealth Group Inc. had posted earnings of $1.51 billion, up from $1.43 billion on year earlier. According to the report, UnitedHealth's revenue improved 7.4% to $33.43 billion. Wall Street Journal, *UnitedHealth's Profits Better Than Expected*, 21 January 2015, available at http://www.wsj.com/articles/unitedhealth-results-top-expectations-on-revenue-growth-1421839458.