

**Capital Blue Cross  
Reserve/Surplus  
Application  
and Supplemental  
Documents**



# Capital BlueCross

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Corporate & Financial Regulation

JUL 23 2004

Pennsylvania  
Insurance Department

July 23, 2004

Stephen J. Johnson  
Deputy Commissioner  
Office of Corporate and Financial  
Regulation  
Commonwealth of Pennsylvania  
Insurance Department  
1326 Strawberry Square  
Harrisburg, PA 17120

Randolph L. Rohrbaugh  
Deputy Commissioner  
Office of Insurance Product Regulation and  
Market Enforcement  
Commonwealth of Pennsylvania  
Insurance Department  
1326 Strawberry Square  
Harrisburg, PA 17120

Dear Messrs. Johnson and Rohrbaugh:

Enclosed please find a clean and re-redacted version of the Application originally submitted to the Department on April 15, 2004 in response to Notice 2004-01 (the "Notice"). They reflect the confidential designations agreed to between our respective counsel which were memorialized in a joint motion to the Commonwealth Court on July 9, 2004, and confirmed by the Order of Judge Pellegrini on July 23, 2004. Also attached is an electronic version of the redacted copy (except for the amicus brief filed as part of Exhibit (b)-2, the A.M. Best Methodology Report filed as Exhibit (b)-4, and the confidential business plan filed as Exhibit (d)-2, which are only available in hard copy).

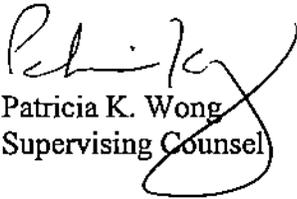
Also, it is our understanding that the Department still plans to provide a thirty (30) day period for public inspection of and comment on the appropriately redacted version of the Application and other materials submitted in response to the Notice. CBC respectfully requests that, after the close of the thirty day period, it be given the opportunity to review all comments submitted in response to the Applications and that it be given an opportunity to respond to those comments.

CBC 00002

Stephen J. Johnson  
Randolph L. Rohrbaugh  
July 23, 2004  
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Please contact me if you have any questions.

Very truly yours,



Patricia K. Wong  
Supervising Counsel



**Preliminary Note:  
Clarifications for the Public Benefit**

As a threshold matter, Capital BlueCross (sometimes referred to as "CBC"), an independent licensee of the Blue Cross Blue Shield Association (the "BCBSA"), wishes to provide certain background information for the benefit of the public concerning the Notice published in the Pennsylvania Bulletin on January 16, 2004 (the "Notice") by the Pennsylvania Insurance Department (the "Department").

The Notice contains a number of information requests, such as the request for CBC's Risk Based Capital ("RBC") level. It indicates that the RBC level of CBC and the other Blue Plans should fall within a range of 350% to 650%; that an RBC level outside that range is likely "excessive." In addition, it requires submission of a business plan setting forth how any "excess" surplus should be distributed. Furthermore, the Notice implies that any "excess" would be distributed to plan participants and to other residents outside of CBC's 21-county service area.

Since publication of the Notice, the Department has materially altered its position concerning many of these matters. During the course of testimony at a preliminary injunction hearing before the Honorable Dan Pellegrini in the Commonwealth Court on March 17, 2004, representatives of the Department and its counsel conceded, despite the actual wording of the Notice, that:

- the use of RBC was never intended as the exclusive method of determining adequate levels of reserves and surplus;
- CBC is free to propose a target RBC ratio outside the 350% to 650% range; and
- CBC may utilize alternate methods of determining reserves and surplus without specifying any particular RBC level.

In addition, Judge Pellegrini has ordered that certain portions of this Application be held confidential in order to prevent disclosure of important and highly confidential and proprietary information concerning CBC and its subsidiaries. The result is that some of the information initially requested by the Department in the Notice cannot and should not be made public.

CBC has asked the Department to re-issue the Notice and explain these developments so that the public will understand the background and be in a better position to comment on our filing. Because the Department has not indicated that it intends to re-issue the Notice, we thought it would be helpful to point out the following:

- The Introduction to our Application below contains a brief explanation of the reasons we disagree with the Department's Notice and sets forth the legal and regulatory basis for our objections.

- Our Application also contains an explanation of the development and intended use of RBC (which was *never* intended as a tool for evaluating maximum surplus). Indeed, Pennsylvania law presently prohibits the disclosure of RBC levels and the use of such levels for the purposes contemplated by the Department. We have included as an exhibit to our Application a position paper by the BCBSA as well as an amicus brief filed by the BCBSA in the recent proceeding supporting CBC and addressing the issue of RBC levels in depth (see Exhibit (b)-2).
- For a number of reasons explained in our Application, CBC believes its reserves and surplus are adequate, but not excessive. We have included as an exhibit to our Application a report by Douglas B. Sherlock, CFA of Sherlock Company, discussing the particular circumstances facing our company and explaining the importance of reserves and surplus for CBC and its policyholders at this point in CBC's history (see Exhibit (d)-2). Sherlock Company assists health plans, their business partners and their investors in the treasury, strategic and control functions of finance.
- By committing to remain independent and by choosing to operate as a fully-integrated health plan exclusively focused on the needs of Central Pennsylvania and the Lehigh Valley, we have brought the levels of competition in our service area to new heights – benefiting all of the residents and providers in our service area. It is often opined by various public officials that more competition is needed among health plans in the Commonwealth. Given that the availability of capital is crucial to CBC's ability to successfully compete, any actions by the Department to weaken CBC will likely have an unintended consequence – reducing competition. Fostering competition and keeping competitors financially strong go hand-in-hand. Weakening CBC could even impact CBC's current work force of over 2,000 employees in Central Pennsylvania and the Lehigh Valley and also have a cascading impact on CBC's vendors.
- Needless to say, we are concerned by any implication on the part of the Department that it can expand its limited authority to approve surplus to take or redirect assets earned by CBC in the course of doing business in our 21-county service area in Central Pennsylvania and the Lehigh Valley for other areas of the Commonwealth and for nonpolicyholders. That would work a fundamental unfairness to CBC, all of its members and the communities it serves.

It is important for all participants in the process to understand that CBC is a business enterprise operating for the benefit of its members in a new and fiercely competitive marketplace. We are seeking to safeguard highly sensitive information that, if released, could adversely impact our competitive position as well as our ability to continue to serve our customer base. We are exercising the rights available to any licensed health plan to ensure that regulatory action taken by the Department is in full compliance with applicable law and regulations and to protect our assets from an unconstitutional taking. Indeed, while we have always had great respect for the Department, we believe that failure to challenge the Department's actions to date would be imprudent, and even amount to a failure to exercise sound stewardship of CBC's hard-earned assets for the benefit of its subscribers.

## **Introduction**

CBC submits this Application intending to preserve its objections to the Notice and the application process related thereto (including the January 5, 2004 letter (the "Letter") which was sent to CBC in conjunction with the Notice). Although CBC does not challenge the jurisdictional authority of the Department to approve CBC's reserves and surplus,<sup>1</sup> there are numerous defects in the manner in which the Department has chosen to proceed as articulated in the Notice. CBC's objections include, but are not limited to, the following:

### **The Application Process Violates The Federal And State Constitutions**

The Notice states in Item (d) that, to the extent that the Department finds there is "excess" surplus, such allegedly "excess" surplus must be "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." The Notice clearly proposes and contemplates the distribution of CBC's property to third parties. Under the Constitutions of Pennsylvania and the United States, the requirement that CBC distribute allegedly "excess" surplus to parties or persons approved by the Department is confiscatory on its face, violates substantive and procedural due process and constitutes a regulatory taking.

The Notice and application procedures further violate CBC's due process rights under the United States and Pennsylvania Constitutions because:

1. The Notice itself is defective because it fails to give CBC or the public accurate notice of the procedures the Department intends to follow or the standards it intends to use to evaluate whether CBC has "excess" surplus.
2. The Notice proceedings constitute a taking of CBC's property without due process of law or just compensation.
3. The Notice fails to provide CBC with an adjudicatory hearing before making the decision that it has any allegedly "excess" surplus.
4. The Notice fails to provide CBC with an adjudicatory hearing before CBC must file a plan for excess surplus to be "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."
5. The Notice does not provide CBC any opportunity to be heard by an unbiased decision maker.

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<sup>1</sup> The Pennsylvania Supreme Court is currently considering the Commonwealth Court's determination in Ciamaichelo v. Independence Blue Cross, 814 A.2d 800, 803 (Pa. Commw. Ct. 2002), that the "Department has exclusive jurisdiction over the setting of rates, approving reserves and surpluses." Ciamaichelo v. Independence Blue Cross, No. 223 MAP 2003 (Pa.). In addition to the objections set forth herein, CBC reserves its right to raise additional objections to these proceedings, including the Department's jurisdiction, that may be appropriate following the Supreme Court's Decision.

6. In violation of the Equal Protection provision, the Notice and the application process only apply to the Blues Plans and not to other hospital or health service plans, any for-profit or nonprofit insurer, or health maintenance or preferred provider organization.

### **The Department Lacks The Authority To Compel The Distribution of Surplus that the Department Deems "Excessive"**

The Notice is an impermissible attempt by the Commissioner and the Department to confer upon themselves authority not granted by the General Assembly. National Solid Wastes Mgmt. Ass'n. v. Casey, 143 Pa. Commw. 577, 587, 600 A.2d 260, 265 (1991).

There is no statutory authority which grants the Department the power to require a solvent insurer to file a plan for distributing its "excess" surplus 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." Indeed, the Department's Notice is nothing more than a non-legislative tax.

The term "social mission" does not have a statutory basis. While professional health services plan corporations ("Blue Shields") have a statutory social mission, 40 Pa. C.S.A. §6303, such provisions do not apply to hospital plan corporations ("Blue Crosses"). Id. §6301(b). Rather, CBC is a nonprofit hospital plan corporation whose statutory purpose is to provide and sustain a nonprofit hospital plan. Id. §6101. By operating a hospital plan, CBC gives subscribers the means to pay for hospital expenses, assists hospitals and subscribers finance the cost of health care, and thus promotes the health of the residents of its 21 county service area.

CBC's position that the Department does not have express or implied authority to compel CBC to file a plan for distributing excess surplus is strengthened by the fact that in other jurisdictions where courts have affirmed the authority of an Insurance Department concerning excess surplus, there was an explicit legislative scheme that established maximum surplus levels and required the filing of, and compliance with, an approved plan to correct any surplus imbalance.<sup>2</sup> The Pennsylvania General Assembly has not given the Insurance Department comparable authority to require the Blue Plans to distribute surplus the Department deems to be "excessive."

### **The Statute Relied Upon by the Department for the Notice And Application Does Not Authorize the Procedures That The Department Seeks To Utilize**

By issuing the Notice, the Department purports to be following the procedures set forth in §6124(b) of the Health Plan Corporations Act. Section 6124(b) states:

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<sup>2</sup> See, e.g., In the Matter of the Excess Surplus Status of Blue Cross and Blue Shield of Minnesota, 624 N.W.2d 264 (Minn. 2001) (affirming decision of Minnesota Insurance Commissioner requiring use of premium rebates to return excess surplus generated by settlement of lawsuit against tobacco companies); cf. In the Matter of New York State Conference of Blue Cross and Blue Shield Plans v. Muhl, 253 A.D.2d 158 (N.Y. A.D. 1999) (statutory scheme explicitly authorized consideration of whether requested rates would produce amounts greater than required to maintain solvency). See also footnotes 16, 17, and 18 below.

Every application for such approval shall be made to the department in writing and shall be subject to the provisions of subsections (c) through (f) of section 6102 of this title (relating to certification of hospital plan corporations) except that the department may substitute publication in the Pennsylvania Bulletin of notice of reasonable opportunity to submit written comments for publication of opportunity for hearing in any case where the right to an oral hearing is not conferred by the Constitution of the United States or the Constitution of Pennsylvania.

40 Pa. C.S.A. § 6124(b) (emphasis added).

Under the clear language of Section 6124(b), the Department may replace publication of notice for a hearing under §6102(e) with publication of notice to submit written comments under §6124(b) only when the applicant does not have a right to a hearing under the United States or Pennsylvania Constitutions. In this case, the determination by the Department that any allegedly "excess" surplus must be "distributed" in Item (d) of the Notice clearly requires a hearing under the United States and Pennsylvania Constitutions and, therefore, the Notice procedure is not available to the Department under §6124(b) by its very terms. The Department must hold a constitutionally valid hearing prior to making any determination that any of CBC's surplus is "excessive" or directing or ordering CBC to distribute its surplus to any entity.

**The Notice Is Defective Because It Does Not Accurately Reflect The Procedures That The Department Is Following**

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The Notice does not accurately reflect either the standard the Department intends to follow or the process it will use in evaluating CBC's Application and is, therefore, defective. At the March 17, 2004 preliminary injunction hearing in Capital Blue Cross v. Koken, No. 172 MD 2004 (Pa. Commw. Ct.), the Department admitted that its Notice did not accurately reflect the Department's actual requirements and processes. For example, the Department's witness testified and admitted that CBC is free to provide a target RBC ratio outside of the 350%-650% RBC range that is mandated by Item (b) of the Notice. See N.T. 50, 105-106. The Department's witness further testified that CBC is free to adopt another methodology, not based on RBC, to evaluate its capital needs. See N.T. 50-52. The Notice affords no such discretion in adopting a methodology outside of RBC. See Item (b) of the Notice.

The Department's own material modifications to the Notice are not in the Notice itself. If CBC includes an RBC target outside the 350%-650% range, or uses a non-RBC methodology, any reasonable person who reads the Notice and compares it to CBC's Application will conclude that CBC has failed to comply with the four corners of the Notice. In short, the Notice does not do what it is meant to do – accurately advise the public of a proceeding before the Department so that they can provide informed commentary. The function of a "[n]otice should be reasonably calculated to inform the parties of the pending action, and the information necessary to provide an opportunity to present objections." Pennsylvania Coal Mining Ass'n v. Insurance Dept., 471 Pa. 437, 452, 370 A.2d 685, 692-93 (Pa. 1977). The Department's Notice is, therefore, inadequate as a matter of law.

## **The Health RBC Act Prohibits The Department From Using RBC To Regulate Excess Surplus**

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The Health RBC Act, 40 P.S. §§ 221.1-B to 221.15-B, prohibits the Department from using RBC to regulate “excess” surplus. Under the Health RBC Act, the Department has authority to take certain actions and/or impose certain requirements on an insurer relating to its RBC report only if the insurer’s RBC report is inaccurate or its RBC level is too low (i.e., surplus is inadequate), neither of which is implicated by the Notice and application process. The Department is not authorized to make a determination that any insurer’s RBC level is “excessive” or to take actions or impose requirements based upon a determination by the Department that the RBC level is “excessive.” The legislative history and Model RBC Act establish that RBC was never intended to be used for any purpose other than solvency monitoring.<sup>3</sup> The only authorized purpose for which RBC information may be used is as a solvency monitoring tool so that the Department may take action in the event that an insurer’s RBC level falls below a certain level. See 40 P.S. §§ 221.5-B to 221.8-B. RBC information provided by health insurers is “**intended solely<sup>4</sup> for use by the department to monitor the solvency<sup>5</sup> of health organizations and to determine the need for corrective action . . . .**” 40 P.S. § 221.11-B(d) (emphasis added). Corrective action relates solely to action ordered by the Commissioner when RBC levels fall below certain prescribed levels. See 40 P.S. §§ 221.1-B (definitions of “Authorized Control Event,” “Company Action Level Event,” “Mandatory Control Level Event,” “Regulatory Action Level Event”), 221.5-B, 221.6-B, 221.7-B, 221.8-B.

The Notice, however, proposes a surplus ceiling using RBC as a measure. The Notice states that in its “application . . . [CBC] must, in a manner the Department deems necessary and proper: . . . (b) state the maximum RBC ratio within the 350% to 650% range that is appropriate and; . . . (d) provide 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 . . . [others].” Notice at 2.

Using RBC as a measure to establish a maximum amount of surplus, rather than a tool to detect, monitor and select corrective action for financially troubled insurance companies whose surplus level falls below required minimum RBC levels, is unlawful because it violates the express limitations of the RBC Act. 40 P.S. § 221.11-B(d). See Commonwealth of Pa., Dep’t. of Military Affairs v. Greenwood, 510 Pa. 348, 354-355, 508 A.2d 292, 296 (1986) (reasoning that a Court must give meaning to a “word of limitation” in a statute that “evinces a restrictive legislative intention”); Northampton, Bucks County Mun. Auth. v. Commonwealth of Pa., Dep’t. of Env’tl. Res., 521 Pa. 253,

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<sup>3</sup> See Exhibit (b)-2 for a discussion of legislative history of the RBC Act.

<sup>4</sup> “Solely” is defined as “alone; singly” and “entirely; exclusively.” American Heritage Dictionary 1163 (2d College Ed. 1991).

<sup>5</sup> “Solvency” in the insurance context means “minimum standard of financial health for an insurance company, where assets exceed liabilities. State laws require insurance regulators to step in when solvency of an insurer is threatened and proceed with rehabilitation or liquidation.” Dictionary of Insurance Terms (4<sup>th</sup> edition).

260, 555 A.2d 878, 881-82 (1989) (stating that Courts must honor statutory "words of limitation" that restrict the application of a statute).

### **The Application Process Does Not Adequately Protect CBC's Confidential And Sensitive Information**

The Health RBC Act prohibits the publication or circulation by any person, including the Department, of any statements or representations regarding RBC levels of an insurer. 40 P.S. §221.11-B(c)(1). In addition, hearings under the RBC Act are to be confidential to ensure that the strict confidentiality provisions of §221.11-B are observed. 40 P.S. § 221.9-B.

In order to be responsive to the requests for information contained in the Notice, CBC would have to include highly confidential and competitively sensitive information. CBC has no issue with disclosing that information to the Department to the extent the confidentiality of its competitively sensitive information can be guaranteed. However, to the extent such information were to be made public, it would cause irreparable harm to CBC's competitive position. That is why the Commonwealth Court ordered such information be kept confidential in its preliminary injunction decision on March 23, 2004 in CBC Blue Cross v. Koken, No. 172 MD 2004 (Pa. Commw. Ct.) (the "Preliminary Injunction Opinion & Order"). The application process, however, does not adequately protect CBC's confidential and competitively proprietary information since, but for the Preliminary Injunction Opinion & Order, the Department could potentially overrule CBC's assertion of confidentiality without any further notice to, or opportunity to be heard by, CBC.

### **The Notice And January 5, 2004 Letter Constitute An Improperly Promulgated Regulation**

The Notice and Letter establish a binding norm and, therefore, constitute a new regulation. Regulations must be promulgated in accordance with the requirements of the Commonwealth Documents Law which requires notice and an opportunity to comment. Administrative pronouncements that rise to the level of an improperly propounded regulation may be declared unenforceable. Physicians Ins. Co. v. Callahan, 167 Pa. Commw. 485, 648 A.2d 608 (1994) (finding a MedCAT bulletin providing procedures for primary carrier to follow if it thought that a claim might exceed policy limits was an improperly promulgated regulation); Giant Food Stores, Inc. v. Commonwealth of Pa., Dep't. of Health, 713 A.2d 177, 180 (1998) (a handbook issued by the Department of Health for determining whether grocery stores were in compliance with a federally-mandated program invalidated as a disguised regulation); Orbera v. Commonwealth Unemployment Comp. Bd. of Review, 91 Pa. Commw. 438, 442, 497 A.2d 693, 696 (1985) (an agency bulletin announcing when unemployment benefits would be terminated was an invalid regulation); Elkin v. Commonwealth of Pa., Dep't. of Pub. Welfare, 53 Pa. Commw. 554, 557-558, 419 A.2d 202, 204 (1980) (an agency counsel's legal opinion, which limited the payment of reimbursements for day care services, was an invalid regulation). The Notice rises to the level of an improperly promulgated regulation and is therefore unenforceable.

The Notice and Letter improperly institute an entirely new process through which the Department purports to regulate and spend CBC's "excess" surplus. They improperly

establish binding standards for "properly stated reserve levels" and "appropriate but not excessive surplus levels" not heretofore employed by the Department. These standards are different from the statutory actuarial certification standards used in the preparation and filing of annual financial statements.

Pennsylvania law requires that an insurance company "adhere to the annual or quarterly statement instructions and the accounting practices and procedures manuals prescribed by the National Association of Insurance Commissioners." 40 P.S. § 443(a)(2). The statute provides further that companies which, either intentionally or unintentionally, fail to file an annual statement "in the form . . . provided" are subject to fines and other penalties, including the risk of being ordered to cease doing business, and that persons who knowingly sign a "false" statement shall be guilty of perjury. 40 P.S. § 443(e).

The National Association of Insurance Commissioners' ("NAIC") annual statement instructions provide that annual financial statements shall be supported by "the statement of a qualified health actuary setting forth his or her opinion relating to loss reserves" in the following form:

In my opinion, the amounts carried in the balance sheet on account of the items identified above: (A) Are in accordance with accepted actuarial standards consistently applied and are fairly stated in accordance with sound actuarial principles, . . . (D) Make a good and sufficient provision for all unpaid claims and other actuarial liabilities of the organization under the terms of its contracts and agreements. . .

In contrast, the Letter directs CBC, at subsection (a), to provide an independent actuarial certification of a "point estimate" for reserves and provides further that "[t]he point estimate shall be a 'best' estimate. As such, the point estimate is to be neither excessive nor deficient." The Department further purports to require that, "[i]f the results from (a) above require amendment of an annual statement blank filed by CBC or any of its insurance subsidiaries on or around March 1, 2004, an amended annual statement blank(s) shall be filed within 15 business days of submission of the information herein requested." Thus, the Department is attempting to impose a new and materially different standard for actuarial certification of reserves ("best estimate" that is "neither excessive nor deficient") from that required by existing Pennsylvania law ("good or sufficient provision for all unpaid claims" "in accordance with accepted actuarial standards"). Therefore, the Notice and Letter in fact are new improperly promulgated regulations.

The Notice is also a regulation because it:

1. Establishes a maximum allowable range for surplus;
2. Requires CBC to state a target RBC ratio within that range;
3. Creates a non-statutory remedy; and
4. Compels the filing of a business plan to distribute any allegedly "excess" surplus to benefit plan participants and the Commonwealth's underinsured and uninsured citizens.

**The Commissioner And Her Senior Staff Should Consider Recusing Themselves**

The Commissioner and/or certain members of her senior staff should recuse themselves if there is any commingling of enforcement and adjudicatory responsibilities. The Commissioner and/or certain members of her senior staff should recuse themselves if they have already determined that CBC has "excess" surplus, or how any allegedly "excess" surplus should be distributed. Finally, the Commissioner and/or certain members of her senior staff should recuse themselves if they have been influenced or directed to promulgate the Notice or Letter or to reach a certain result in this matter.

***Tab (a)***

The information in this Tab (a) responds to Item (a) of the Notice:

"In the application, each Blues Plan must, in a manner the Department deems necessary and proper:

- (a) state what reserve levels it [Capital BlueCross] and all of its insurance subsidiaries are holding and what surplus levels it [Capital BlueCross] and all of its insurance subsidiaries are currently maintaining;"

### **Reserve and Surplus Levels**

The Department has not specified a definition of "reserves" or "surplus" in the Notice requesting CBC and the other Blue Plans in the Commonwealth of Pennsylvania to submit this Application.

The terms "reserves" and "surplus" are not specified accounting terms and, as the Insurance Commissioner noted in her testimony opening the Blue Cross/Blue Shield Reserves and Surplus Public Hearing on September 4, 2002, these terms have been erroneously used interchangeably from time to time. As explained by the Commissioner:

"Reserves,' specifically loss reserves, also referred to as 'claims unpaid,' represent a plan's best estimate of what it needs to have to pay for claims. 'Surplus,' however, represents what a plan has in capital after all liabilities have been deducted from assets."

Accordingly, for purposes of this response, we understand the Department is requesting a schedule of assets, liabilities, capital and surplus, including the specific items to be addressed in the independent actuarial opinion and the report of independent public accountants requested by the Department.

Attached as Exhibit (a)-1 are the opinions of John Stenson, a Principal with Deloitte Consulting LLP, addressing the following balances contained in the December 31, 2003 Annual Statement for CBC, Capital Advantage Insurance Company (CAIC), and Keystone Health Plan Central (KHPC): Claims Unpaid; Unpaid Claims Adjustment Expenses and Aggregate Health Policy Reserves.<sup>6</sup> Attached as Exhibit (a)-2 are "agreed upon procedures" reports prepared by Ernst & Young LLP addressing the following items included in the December 31, 2003 Annual Statement of each such entity: Accident and Health Premiums Due and Unpaid and Premiums Received in Advance.<sup>7</sup>

The actuarial opinions and accountants' reports do not differ from the financial information included in our Annual Statements. Accordingly, as indicated in our prior response to the Department's request for information, there is no need to file amended Annual Statements.

As reflected in Exhibits (a)-1 and (a)-2, at December 31, 2003, CBC and its insurance subsidiaries reported the following liabilities, capital and surplus (in thousands):

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<sup>6</sup> Includes Unearned Premium Reserves.

<sup>7</sup> Please note that none of the companies carry a balance for the following Annual Statement captions: Accrued Medical Incentive Pool and Bonus Payments and Aggregate Claim Reserves.

	<u>Consolidated</u>
<b>Total Admitted Assets</b>	<b>\$1,214,896</b>
<b>Less:</b>	
<b>Claims Unpaid</b>	<b>311,998</b>
<b>Unpaid Claims Adjustment Expense</b>	<b>10,164</b>
<b>Aggregate Health Policy Reserves</b>	<b>41,990</b>
<b>Premiums Received in Advance</b>	<b>88,217</b>
<b>Other Liabilities</b>	<b>247,050</b>
<b>Total Liabilities</b>	<b>699,419</b>
<b>Total Capital and Surplus:</b>	<b>515,477</b>

While we believe a consolidated presentation presents the most accurate picture of the company's financial position, as requested by the Department, attached as Exhibit (a)-3 is a chart setting forth the above information for CBC and each of its insurance subsidiaries.

For the reasons noted in the Introduction to this Application and more particularly discussed in our response to Item (b) below, CBC believes the use of RBC to determine maximum surplus levels is inappropriate.

**Actuarial Opinions of John Stenson of Deloitte Consulting LLP<sup>8</sup>**

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<sup>8</sup> Note that no report for Avalon Health Ltd., an inactive HMO, is included since that entity does not carry any balances pertinent to the Department's request.

**STATEMENT OF ACTUARIAL OPINION  
CAPITAL BLUE CROSS**

I, John Stenson, am associated with the firm of Deloitte Consulting LLP. I am a Fellow of the Society of Actuaries, a Member of the American Academy of Actuaries, and I meet the Academy's Qualification Standards for rendering the following opinion. I have been retained by Capital Blue Cross ("CBC") to review its unpaid claims liabilities, unpaid claims adjustment expense liabilities, and its aggregate health policy reserves as of December 31, 2003.

I have examined the assumptions, methods and calculations used in determining the liabilities listed below, as shown in the Annual Statement of CBC and as prepared for filing with the Commonwealth of Pennsylvania as of December 31, 2003.

(1)	Claims Unpaid (Page 3, Line 1)	\$ 73,597,432
(2)	Unpaid Claims Adjustment Expenses (Page 3, Line 3)	\$ 2,206,041
(3)	Aggregate Health Policy Reserves (Page 3, Line 4)	\$ 10,036,906

I have relied upon information supplied by responsible officers or employees of CBC, as audited and reported upon by Ernst & Young, LLP, as to accuracy and completeness of listings and summaries of policies and contracts in force, and other information underlying the loss reserves. In other respects, my examination included such review of the actuarial assumptions and actuarial methods and such test of actuarial calculations as I considered necessary in the circumstances. My examination considered the need for cash flow testing, but none was performed because such tests were determined to be unnecessary. The cash flows associated with CBC's products and investments are believed to be relatively insensitive to influences such as changes in economic conditions.

In my opinion, the amounts carried on the balance sheet on account of the items identified above:

- Are computed in accordance with presently accepted actuarial standards consistently applied and are fairly stated in accordance with sound actuarial principles, except that consideration of the adequacy of CBC's

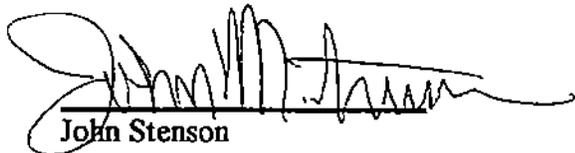
reserves and related actuarial items in conjunction with the assets which support them has not been performed;

- Are based on actuarial assumptions which are in accordance with or stronger than those called for in related contract provisions and are appropriate to the purpose for which the Annual Statement was prepared;
- Meet the requirements of the insurance laws and regulations of the Commonwealth of Pennsylvania;
- Make good and sufficient provision for all unpaid claims and other actuarial liabilities of CBC under the terms of its contracts and agreements, by which I mean that the estimated liabilities are an appropriate measure of reasonably anticipated payments on incurred claims under potentially moderately adverse development, although, consistent with the scope of my review, the adequacy of CBC's reserves and related actuarial items in conjunction with the assets which support them has not been considered;
- Are computed on the basis of actuarial assumptions and methods consistent in all material respects with those used in computing the corresponding items in the Annual Statement of the preceding year-end; and
- Include provision, in the aggregate, for all actuarial reserves and related statement items which ought to be established.

The actuarial methods, considerations and analyses used in forming my opinion conform to the appropriate Standards of Practice as promulgated by the Actuarial Standards Board, which standards form the basis of this statement of opinion.

This statement has been prepared for filing with regulatory authorities of the Commonwealth of Pennsylvania and for is intended for no other purpose.

April 15, 2004



John Stenson  
Fellow, Society of Actuaries  
Member, American Academy of Actuaries

Deloitte Consulting LLP  
400 One Financial Plaza  
Minneapolis, Minnesota 55412  
(612) 397- 4369

**STATEMENT OF ACTUARIAL OPINION  
CAPITAL ADVANTAGE INSURANCE COMPANY**

I, John Stenson, am associated with the firm of Deloitte Consulting LLP. I am a Fellow of the Society of Actuaries, a Member of the American Academy of Actuaries, and I meet the Academy's Qualification Standards for rendering the following opinion. I have been retained by Capital Advantage Insurance Company ("CAIC") to review its unpaid claims liabilities, unpaid claims adjustment expense liabilities, and aggregate health policy reserves as of December 31, 2003.

I have examined the assumptions, methods and calculations used in determining the liabilities listed below, as shown in the Annual Statement of CAIC and as prepared for filing with the Commonwealth of Pennsylvania as of December 31, 2003.

(1)	Claims Unpaid (Page 3, Line 1)	\$ 188,453,689
(2)	Unpaid Claims Adjustment Expenses (Page 3, Line 3)	\$ 6,216,742
(3)	Aggregate Health Policy Reserves (Page 3, Line 4)	\$ 31,671,039

I have relied upon information supplied by responsible officers or employees of CAIC as audited and reported upon by Ernst & Young, LLP, as to accuracy and completeness of listings and summaries of policies and contracts in force, and other information underlying the loss reserves. In other respects, my examination included such review of the actuarial assumptions and actuarial methods and such test of actuarial calculations as I considered necessary in the circumstances. My examination considered the need for cash flow testing, but none was performed because such tests were determined to be unnecessary. The cash flows associated with CAIC's products and investments are believed to be relatively insensitive to influences such as changes in economic conditions.

In my opinion, the amounts carried on the balance sheet on account of the items identified above:

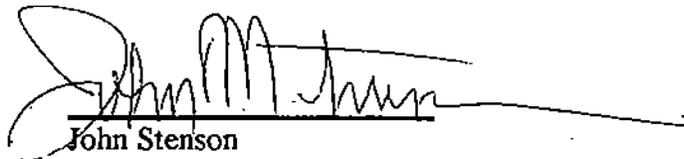
- Are computed in accordance with presently accepted actuarial standards consistently applied and are fairly stated in accordance with sound actuarial principles, except that consideration of the adequacy of CAIC's reserves and related actuarial items in conjunction with the assets which support them has not been performed;

- Are based on actuarial assumptions which are in accordance with or stronger than those called for in related contract provisions and are appropriate to the purpose for which the Annual Statement was prepared;
- Meet the requirements of the insurance laws and regulations of the Commonwealth of Pennsylvania;
- Make good and sufficient provision for all unpaid claims and other actuarial liabilities of CAIC under the terms of its contracts and agreements, by which I mean that the estimated liabilities are an appropriate measure of reasonably anticipated payments on incurred claims under potentially moderately adverse development, although, consistent with the scope of my review, the adequacy of CAIC's reserves and related actuarial items in conjunction with the assets which support them has not been considered;
- Are computed on the basis of actuarial assumptions and methods consistent in all material respects with those used in computing the corresponding items in the Annual Statement of the preceding year-end; and
- Include provision, in the aggregate, for all actuarial reserves and related statement items which ought to be established.

The actuarial methods, considerations and analyses used in forming my opinion conform to the appropriate Standards of Practice as promulgated by the Actuarial Standards Board, which standards form the basis of this statement of opinion.

This statement has been prepared for filing with regulatory authorities of the Commonwealth of Pennsylvania and is intended for no other purpose.

April 15, 2004



John Stenson  
Fellow, Society of Actuaries  
Member, American Academy of Actuaries

Deloitte Consulting LLP  
400 One Financial Plaza  
Minneapolis, Minnesota 55412  
(612) 397- 4369

**STATEMENT OF ACTUARIAL OPINION  
KEYSTONE HEALTH PLAN CENTRAL, INC.**

I, John Stenson, am associated with the firm of Deloitte Consulting LLP. I am a Fellow of the Society of Actuaries, a Member of the American Academy of Actuaries, and I meet the Academy's Qualification Standards for rendering the following opinion. I have been retained by Keystone Health Plan Central, Inc. ("Keystone") to review its unpaid claims liabilities, unpaid claims adjustment expense liabilities, and its aggregate health policy reserves as of December 31, 2003.

I have examined the assumptions, methods and calculations used in determining the liabilities listed below, as shown in the Annual Statement of Keystone and as prepared for filing with the Commonwealth of Pennsylvania as of December 31, 2003.

(1)	Claims Unpaid (Page 3, Item 1)	\$ 49,946,687
(2)	Unpaid Claims Adjustment Expenses (Page 3, Item 3)	\$ 1,741,038
(3)	Aggregate Health Policy Reserves (Page 3, Item 4)	\$ 282,629

I have relied upon information supplied by responsible officers or employees of Keystone as audited and reported upon by Ernst & Young, LLP, as to accuracy and completeness of listings and summaries of policies and contracts in force, and other information underlying the loss reserves. In other respects, my examination included such review of the actuarial assumptions and actuarial methods and such test of actuarial calculations as I considered necessary in the circumstances. My examination considered the need for cash flow testing, but none was performed because such tests were determined to be unnecessary. The cash flows associated with Keystone's products and investments are believed to be relatively insensitive to influences such as changes in economic conditions.

In my opinion, the amounts carried on the balance sheet on account of the items identified above:

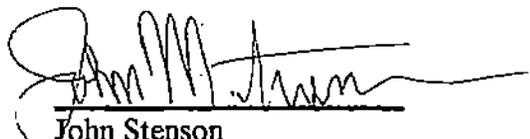
- Are computed in accordance with presently accepted actuarial standards consistently applied and are fairly stated in accordance with sound actuarial principles, except that consideration of the adequacy of Keystone's reserves and related actuarial items in conjunction with the assets which support them has not been performed;

- Are based on actuarial assumptions which are in accordance with or stronger than those called for in related contract provisions and are appropriate to the purpose for which the Annual Statement was prepared;
- Meet the requirements of the insurance laws and regulations of the Commonwealth of Pennsylvania;
- Make good and sufficient provision for all unpaid claims and other actuarial liabilities of Keystone under the terms of its contracts and agreements, by which I mean that the estimated liabilities are an appropriate measure of reasonably anticipated payments on incurred claims under potentially moderately adverse development, although, consistent with the scope of my review, the adequacy of Keystone's reserves and related actuarial items in conjunction with the assets which support them has not been considered;
- Are computed on the basis of actuarial assumptions and methods consistent in all material respects with those used in computing the corresponding items in the Annual Statement of the preceding year-end;
- Include provision, in the aggregate, for all actuarial reserves and related statement items which ought to be established; and
- Appropriately consider the impact of a reinsurance arrangement with Highmark Life and Casualty Group. This reinsurance arrangement transfers appropriate risk at a reasonable premium rate.

The actuarial methods, considerations and analyses used in forming my opinion conform to the appropriate Standards of Practice as promulgated by the Actuarial Standards Board, which standards form the basis of this statement of opinion.

This statement has been prepared for filing with regulatory authorities of the Commonwealth of Pennsylvania and is intended for no other purpose.

April 15, 2004



John Stenson  
Fellow, Society of Actuaries  
Member, American Academy of Actuaries

Deloitte Consulting LLP  
400 One Financial Plaza  
Minneapolis, Minnesota 55412  
(612) 397- 4369

**“Agreed Upon Procedures” Reports of Ernst & Young LLP<sup>9</sup>**

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<sup>9</sup> Note that no report for Avalon Health Ltd., an inactive HMO, is included since that entity does not carry any balances pertinent to the Department’s request.

**REPORT OF INDEPENDENT ACCOUNTANTS ON APPLYING  
AGREED-UPON PROCEDURES**

To the Board of Directors of  
Capital BlueCross

We have performed the procedures enumerated below, which were agreed to by management of Capital BlueCross (the Company) and the Pennsylvania Insurance Department (PID), solely to assist the Company in complying with certain aspects of the Health Plan Corporations Act, 40 P.S. 6101 *et seq.* requirements of the Commonwealth of Pennsylvania Insurance Law which addresses the assessment of surplus levels maintained by the Company as of December 31, 2003, as communicated to the Company in the January 5, 2004 letter received from the PID (the Requirements). The Company's management is responsible for compliance with the Requirements. This agreed-upon procedures engagement was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants. The sufficiency of these procedures is solely the responsibility of those parties specified in this report. Consequently, we make no representation regarding the sufficiency of the procedures described below either for the purpose for which this report has been requested or for any other purpose.

The procedures that we performed for the Company are as follows:

***A. Accident and Health Premiums Due and Unpaid***

1. We obtained a summary from the Company of the components of the accounts receivable balance that comprise the accident and health premiums due and unpaid line in the Annual Statement. The summary is as follows:

Gross accounts receivable	\$2,811,097
Less: unapplied cash	(146,551)
Less: non-admitted balances	(919,300)
<u>Plus/Less: any other miscellaneous debits or credits (see step 5)</u>	<u>405,430</u>
Net accounts receivable recorded in the Annual Statement	<u>\$2,150,676</u>

2. We obtained a summary from the Company of the general ledger accounts that comprise the gross accounts receivable balance. We noted that fourteen general ledger accounts comprise the gross accounts receivable balance of \$2,811,097.

3. For the gross accounts receivable accounts included in the accident and health premiums due and unpaid line item that are supported by one or more detailed aging reports, we compared the balance, per the general ledger, to the aging reports. We identified a reconciling item of \$6,820,346 between one general ledger account and the related aging reports. We verified through review of the Company's reconciliation and discussion with management that this item related to misapplication of cash receipts for two of the Company's subscriber groups between the detailed aging reports of the Company and such aging reports of Capital Advantage Insurance Company, the Company's subsidiary. This reconciling item also exists with offsetting impact on Capital Advantage Insurance Company's reconciliation at December 31, 2003.
4. We summarized the aging by category (e.g., 0-30 days/ 30-60 days/ 60-90 days/ 90+ days) for each of the aging reports obtained in step 3 and noted that the amounts agreed to the aging reports per the reconciliation noted in step 3. We noted that the total amount in the "90+" aging category per the summary was non-admitted by the Company.
5. For accounts receivable accounts included in the accident and health premiums due and unpaid line item that are not supported by a detailed aging report, which totaled \$405,430 as of December 31, 2003, we agreed the account balance per the general ledger to a supporting schedule or reconciliation prepared by the Company. These amounts included accounts used to record premium overpayments and underpayments under the Company's CMBS premium billing system and an account used to record claims paid by the Company to be billed to the federal government for the Federal Employees Program. Based on the information reviewed, we verified that none of the accounts receivable amounts were 90 or more days past due.
6. We obtained a detailed listing from the Company of all credit balances for the Company and Capital Advantage Insurance Company recorded in each accounts receivable account. The total of all such credit balances for the Company and Capital Advantage Insurance Company was \$34,574 as of December 31, 2003.
7. We obtained a listing from the Company of all unapplied cash account balances included in the accident and health premiums due and unpaid line. We verified that the listing consisted of one account with a balance of \$146,551 as of December 31, 2003 that is used to record unapplied cash from the Company's CMBS premium billing system.
8. We agreed the unapplied cash account balance noted in step 7 to a detailed unapplied cash listing that supported the balance recorded in the general ledger. We did not identify any reconciling items between the detailed listing and the general ledger balance.

9. We verified through review of the Company's supporting documentation and discussions with management that the Company did not have any debit balances recorded in its unapplied cash account identified in step 7.
10. We obtained a listing from the Company of all non-admitted accounts receivable balances included in the accident and health premiums due and unpaid line. These balances consisted of all accounts that the Company believes are not collectible. We agreed the non-admitted accounts receivable balances >90 days to the over 90 day amounts on the aging reports obtained in step 3 without exception. We verified through review of the listing referenced above and discussions with management that the Company has further non-admitted receivable balances <90 days that it believes are not collectible based on the subscriber group's past history and other factors. Such additional non-admitted amounts were \$729,616 as of December 31, 2003. We also agreed these balances to aging reports obtained in step 3 without exception.
11. We selected, on a haphazard basis, a sample of 20 individual accounts receivable balances from each system that generates an aging report. We agreed these balances to supporting documentation and agreed the invoice date to a supporting invoice. We noted no exceptions as a result of these procedures. We also performed a recalculation of the aging of each of the individual accounts receivable balances based on the invoice date and noted no exceptions.
- 12.-15. As noted in step 10, the Company non-admits all accounts receivable balances that it believes are not collectible. Therefore, the Company does not record a bad debt reserve for statutory accounting purposes.

***B. Accident and Health Premiums Received in Advance***

1. We obtained a summary from the Company of the components that comprise the accident and health premiums received in advance line in the Annual Statement. The balance is comprised of one component with a balance of \$25,533,021 as of December 31, 2003 that relates to two groups that had prepaid their premiums.
2. We obtained a summary from the Company of the general ledger accounts that are included in the accident and health premiums received in advance line in the Annual Statement. This included two accounts totaling \$25,533,021 as of December 31, 2003.
3. We agreed the individual account balances to detailed schedules that support the balance recorded in the general ledger without exception and noted no reconciling items between the detailed schedules and the general ledger.

4. We verified through review of the Company's supporting documentation and discussions with management that there are no accounts receivable that relate to premiums received in advance.
5. We verified through review of the Company's supporting documentation and discussions with management that the Company did not have any debit balances recorded in the premiums received in advance line.
6. For both of the specific customers identified in step B.1. above who had prepaid their premiums, we recalculated the premiums received in advance as of December 31, 2003 to ensure that the amounts related to service after December 31, 2003 were based on the remittance advices. We noted no exceptions.

We were not engaged to, and did not, conduct an examination, the objective of which would be the expression of an opinion on compliance with the Requirements. Accordingly, we do not express such an opinion. Had we performed additional procedures, other matters might have come to our attention that would have been reported to you.

This report is intended solely for the information and use of the Company and the PID and is not intended to be and should not be used by anyone other than these specified parties.

*Ernst + Young LLP*

April 7, 2004

REPORT OF INDEPENDENT ACCOUNTANTS ON APPLYING  
AGREED-UPON PROCEDURES

To the Board of Directors of  
Capital Advantage Insurance Company

We have performed the procedures enumerated below, which were agreed to by management of Capital Advantage Insurance Company (the Company) and the Pennsylvania Insurance Department (PID), solely to assist the Company in complying with certain aspects of the Health Plan Corporations Act, 40 P.S. 6101 *et seq.* requirements of the Commonwealth of Pennsylvania Insurance Law, which addresses the assessment of surplus levels maintained by Capital BlueCross (CBC), the Company's parent, as of December 31, 2003, as communicated to CBC in the January 5, 2004 letter received from the PID (the Requirements). The Company's management is responsible for compliance with the Requirements. This agreed-upon procedures engagement was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants. The sufficiency of these procedures is solely the responsibility of those parties specified in this report. Consequently, we make no representation regarding the sufficiency of the procedures described below either for the purpose for which this report has been requested or for any other purpose.

The procedures that we performed are as follows:

***A. Accident and Health Premiums Due and Unpaid***

1. We obtained a summary from the Company of the components of the accounts receivable balance that comprise the accident and health premiums due and unpaid line in the Annual Statement. The summary is as follows:

Gross accounts receivable	\$8,695,321
Less: unapplied cash	(34,327)
Less: non-admitted balances	(469,150)
<u>Plus/Less: any other miscellaneous debits or credits</u> <u>(see step 5)</u>	<u>(734,234)</u>
Net accounts receivable recorded in the Annual Statement	<u>\$7,457,610</u>

2. We obtained a summary from the Company of the general ledger accounts that comprise the gross accounts receivable balance. We noted that eighteen general ledger accounts comprise the gross accounts receivable balance of \$8,695,321.

3. For the gross accounts receivable accounts included in the accident and health premiums due and unpaid line item that are supported by one or more detailed aging reports, we compared the balance, per the general ledger, to the aging reports. We identified a reconciling item of \$6,820,346 between one general ledger account and the related aging reports. We verified through a review of the Company's reconciliation and discussion with management that this item related to misapplication of cash receipts for two of the Company's subscriber groups between the detailed aging reports of the Company and CBC. This reconciling item also exists with offsetting impact on CBC's reconciliation at December 31, 2003.
4. We summarized the aging by category (e.g., 0-30 days/ 30-60 days/ 60-90 days/ 90+ days) for each of the aging reports obtained in step 3 and verified that the amounts agreed to the aging per the reconciliation noted in step 3. We noted that the total amount in the "90+" aging category per the summary was non-admitted by the Company.
5. For accounts receivable accounts included in the accident and health premiums due and unpaid line item that are not supported by a detailed aging report, which totaled \$734,234 as of December 31, 2003, we agreed the account balance, per the general ledger, to a supporting schedule or reconciliation prepared by the Company. From our review of the documentation and discussions with management, we determined that these amounts included accounts used to record certain adjustments due to and from providers.
6. We obtained a detailed listing from the Company of all credit balances recorded for the Company and CBC in each accounts receivable account. The total of all such credit balances for the Company and CBC was \$34,574 as of December 31, 2003.
7. We obtained a listing from the Company of all unapplied cash account balances included in the accident and health premiums due and unpaid line. We verified that the listing consisted of one account with a balance of \$34,327 as of December 31, 2003 that is used to record unapplied cash from the Company's CMBS premium billing system.
8. We agreed the unapplied cash account balance noted in step 7 to a detailed listing that supported the balance recorded in the general ledger. We did not identify any reconciling items between the detailed listing and the general ledger balance.
9. We verified through review of the Company's supporting documentation and discussions with management that the Company did not have any debit balances recorded in its unapplied cash account identified in step 7.

10. We obtained a listing from the Company of all non-admitted accounts receivable balances included in the accident and health premiums due and unpaid line. These balances consisted of all accounts that the Company believes are not collectible. We agreed the non-admitted accounts receivable balances > 90 days to the over 90 day amounts on the aging reports obtained in step 3 without exception. We verified through review of the listing referenced above and discussions with management that the Company has further non-admitted receivable balances < 90 days that it believes are not collectible based on the subscriber group's past history and other factors. Such additional non-admitted amounts were \$341,904 as of December 31, 2003. We also agreed these balances to aging reports obtained in step 3 without exception.
11. We selected, on a haphazard basis, a sample of 20 individual accounts receivable balances from each system that generates an aging report. We agreed these balances to supporting documentation and agreed the invoice date to a supporting invoice. We noted no exceptions as a result of these procedures. We also performed a recalculation of the aging of each of the individual accounts receivable balances based on the invoice date and noted no exceptions.
- 12.-15. As noted in step 10, the Company non-admits all accounts receivable balances that it believes are not-collectible. Therefore, the Company does not record a bad debt reserve for statutory accounting purposes.

***B. Accident and Health Premiums Received in Advance***

1. We obtained a summary from the Company of the components that comprise the accident and health premiums received in advance line in the Annual Statement. The balance is comprised of two components with a total balance of \$21,582,018 as of December 31, 2003. The components included customer prepayments of \$21,376,464 and unapplied cash related to the FACETS billing system of \$205,554.
2. We obtained a summary from the Company of the general ledger accounts that are included in the accident and health premiums received in advance line in the Annual Statement. This included two accounts totaling \$21,582,018 as of December 31, 2003.
3. We agreed the individual account balances to detailed schedules that support the balance recorded in the general ledger without exception and noted no reconciling items between the detailed schedules and the general ledger.
4. We verified through review of the Company's supporting documentation and discussions with management that accounts receivable of \$205,554 relates to premiums received in advance for which there is unapplied cash, as noted in step B.1. above. The remainder of

the premiums received in advance relate to various subscriber groups that had prepaid their premiums.

5. We verified through review of the Company's supporting documentation and discussions with management that the Company did not have any debit balances recorded in the accident and health premiums received in advance line.
6. For 20 individual subscriber groups selected haphazardly, we recalculated the premiums received in advance as of December 31, 2003 and verified, based on the remittance advices, that the amounts related to service provided after December 31, 2003. We noted no exceptions.

We were not engaged to, and did not, conduct an examination, the objective of which would be the expression of an opinion on compliance with the Requirements. Accordingly, we do not express such an opinion. Had we performed additional procedures, other matters might have come to our attention that would have been reported to you.

This report is intended solely for the information and use of the Company and the PID and is not intended to be and should not be used by anyone other than these specified parties.

*Ernst + Young LLP*

April 7, 2004

REPORT OF INDEPENDENT ACCOUNTANTS ON APPLYING  
AGREED-UPON PROCEDURES

To the Board of Directors of  
Keystone Health Plan Central, Inc.

We have performed the procedures enumerated below, which were agreed to by management of Keystone Health Plan Central, Inc. (the Company) and the Pennsylvania Insurance Department (PID), solely to assist the Company in complying with certain aspects of the Health Plan Corporations Act, 40 P.S. 6101 *et seq.* requirements of the Commonwealth of Pennsylvania Insurance Law, which addresses the assessment of surplus levels maintained by Capital BlueCross, the Company's parent, as of December 31, 2003, as communicated to CBC in the January 5, 2004 letter received from the PID (the Requirements). The Company's management is responsible for compliance with those requirements. This agreed-upon procedures engagement was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants. The sufficiency of these procedures is solely the responsibility of those parties specified in this report. Consequently, we make no representation regarding the sufficiency of the procedures described below either for the purpose for which this report has been requested or for any other purpose.

The procedures that we performed are as follows:

**A. Accident and Health Premiums Due and Unpaid**

1. We obtained a summary from the Company of the components of the accounts receivable balance that comprise the accident and health premiums due and unpaid line in the Annual Statement. The summary is as follows:

Gross accounts receivable	\$26,476,632
Less: non-admitted balances > 90 days	(18,376)
Less: other allowances for doubtful accounts in addition to 90 days non-admitted balances	(628,224)
Net accounts receivable recorded in the Annual Statement	<u>\$25,830,032</u>

2. We obtained a summary from the Company of the general ledger accounts that comprise the gross accounts receivable balance. We noted three general ledger accounts that comprise the gross accounts receivable balance of \$26,476,632.

3. For the gross accounts receivable accounts included in the accident and health premiums due and unpaid line item that are supported by one or more detailed aging reports, we compared the balance, per the general ledger, to the aging report. We identified a reconciling item of \$29,363,412 between one general ledger account and the related aging reports. We verified through review of the Company's reconciliation and discussion with management that this item was for February 2004 premiums for subscriber groups that were billed in December 2003 and had a due date in January 2004.
4. We summarized the aging by category (e.g., 0-30 days/ 30-60 days/ 60-90 days/ 90+ days) for each of the aging reports obtained in step 3 and noted that the amounts agreed to the aging reports per the reconciliation noted in step 3 to the general ledger accounts.
5. We verified through review of the Company's supporting documentation and discussions with management that all balances included in the accident and health premiums due and unpaid line were supported by aging reports.
6. We obtained a detailed listing from the Company of all credit balances recorded in each accounts receivable account. The total of all such credit balances was \$15,090 as of December 31, 2003.
- 7.-9. We verified through review of the Company's supporting documentation and discussions with management that the Company did not have any unapplied cash account balances included in the accident and health premiums due and unpaid line.
10. We obtained a listing from the Company of all non-admitted accounts receivable balances included in the accident and health premium due and unpaid line. We compared the non-admitted accounts receivable balances to the over 90 day amounts on the aging reports obtained in step 3 and verified that \$630,510 of the over 90 day amounts per the aging related to receivables from the Commonwealth of Pennsylvania for the adult Basic CHIP program that are admissible in accordance with Statement of Statutory Accounting Principles No. 84, *Certain Health Care Receivables and Receivables under Government Insured Plans*. No exceptions were noted.
11. We selected, on a haphazard basis, a sample of 20 individual accounts receivable balances from each system that generates an aging report. We agreed these balances to supporting documentation and agreed the invoice date to a supporting invoice. We noted no exceptions as a result of these procedures. We also performed a recalculation of the aging of the individual receivable balances based on their invoice dates and noted no exceptions.

12. The Company has five general ledger accounts which total the bad debt reserve balance of \$628,224 as of December 31, 2003. We verified through review of the Company's supporting documentation and discussions with management that the bad debt reserve balance included a provision for specific accounts receivable less than 90 days old that the Company believes may be uncollectible. The bad debt reserve included an amount of \$283,194 of specific receivables from the Commonwealth for the adult Basic CHIP program, and is necessary mostly due to membership retroactivity changes.
13. Through discussions with management, we verified that the Company calculated the portion of its bad debt reserve (\$345,030) not related to specific receivables based upon a review of its prior years' write-off history and the current aging of its accounts receivable. The following is a schedule of this portion of bad debt reserve as a percentage of each aging category, excluding the receivables of \$630,510 from the Commonwealth of Pennsylvania that related to adult Basic CHIP as noted in step 10, as of December 31, 2003:

Description	0-60 Days	61-90 Days	Total
Bad debt reserve as % of the aging category	1.78%	100%	2.1%
Bad debt reserve allocated to the aging category	\$ 292,285	\$52,745	\$ 345,030
Accounts receivable aging balance	\$16,474,769	\$52,745	\$16,527,514

14. We verified through review of the Company's supporting documentation and discussions with management that all of the Company's accounts receivable reported in accident and health premiums due and unpaid are supported by aging reports.
15. We verified through review of the Company's supporting documentation and discussions with management that the Company's write-offs of accounts receivable for the year ended December 31, 2003 totaled \$303,093 which was 1.1% of gross accounts receivable.

***B. Accident and Health Premiums Received in Advance***

1. We obtained a summary from the Company of the components that comprise the accident and health premiums received in advance line in the Annual Statement. The balance is comprised of unearned premiums of \$42,102,040 as of December 31, 2003.
2. We obtained a summary from the Company of the general ledger accounts that are included in the accident and health premiums received in advance line in the Annual Statement. This included ten accounts totaling \$42,102,040 as of December 31, 2003.
3. We compared the individual account balances to detailed Company prepared schedules that support the balance recorded on the general ledger without exception and noted no reconciling items between the detailed schedules and the general ledger.
4. We verified through review of the Company's supporting documentation and discussions with management that the Company had accounts receivable totaling \$17,461,640 as of December 31, 2003 related to unearned premiums.
5. Based on our review of the Company's supporting documentation and discussions with management, the Company did not have any debit balances recorded in the premiums received in advance line.
6. We selected, on a haphazard basis, a sample of 20 items from the system that generates a detailed listing of premiums received in advance and we verified, based on remittance advices, that the service period on the invoice was subsequent to December 31, 2003. We noted no exceptions as a result of these procedures.

We were not engaged to, and did not, conduct an examination, the objective of which would be the expression of an opinion on compliance with the Requirements. Accordingly, we do not express such an opinion. Had we performed additional procedures, other matters might have come to our attention that would have been reported to you.

This report is intended solely for the information and use of the Company and the PID and is not intended to be and should not be used by anyone other than these specified parties.

*Ernst + Young LLP*

April 7, 2004

**Exhibit (a)-3**

At December 31, 2003 CBC and its insurance subsidiaries (that is, Capital Advantage Insurance Company ("CAIC"), Keystone Health Plan Central ("KHPC"), and Avalon Health, Ltd. ("Avalon")), reported the following admitted assets, liabilities, and capital and surplus (in thousands):

	CBC	CAIC	KHPC	Avalon	Eliminations	Consolidated
Total Admitted Assets	<u>\$ 890,661</u>	<u>\$ 494,247</u>	<u>\$ 199,072</u>	<u>\$ 7,760</u>	<u>\$ (376,844)</u>	<u>\$ 1,214,896</u>
Claims Unpaid	\$ 73,597	\$ 188,454	\$ 49,947			\$ 311,998
Unpaid Claims Adj. Exp.	2,206	6,217	1,741			10,164
Aggregate Health Policy Res.	10,037	31,671	282			41,990
Premiums Received in Adv.	24,533	21,582	42,102			88,217
Other Liabilities	<u>264,811</u>	<u>49,587</u>	<u>34,164</u>	<u>2,234</u>	<u>(103,746)</u>	<u>247,050</u>
Total Liabilities	<u>375,184</u>	<u>297,511</u>	<u>128,236</u>	<u>2,234</u>	<u>(103,746)</u>	<u>699,419</u>
Total Capital and Surplus	<u>\$ 515,477</u>	<u>\$ 196,736</u>	<u>\$ 70,836</u>	<u>\$ 5,526</u>	<u>\$ (273,098)</u>	<u>\$ 515,477</u>

***Tab (b)***

The information in this Tab (b) responds to Item (b) of the Notice:

- “(b) state the maximum RBC ratio within the 350% to 650% range that is appropriate, and explain the rationale for that maximum ratio.”

### **Current RBC Levels**

The RBC levels for CBC and each of its insurance subsidiaries at December 31, 2003 are set forth in Exhibit (b)-1 of our response to Item (b).

Based upon the terms of the Notice as modified by the Department and as documented in the recent opinion of Judge Pellegrini, CBC is not obligated to provide the Department with a maximum RBC ratio within the range suggested by the Department or to provide a rationale for the use of that maximum ratio.

For the reasons indicated in the Introduction and set forth below, CBC believes the use of RBC is an inappropriate measure to determine whether surplus is excessive. As the Department itself conceded in the course of testimony at the hearing before Judge Pellegrini, the Notice was never intended to preclude other methods of determining an appropriate surplus. Therefore, in accordance with the Department's revised instructions and Judge Pellegrini's opinion and order, CBC is providing an alternative approach for determining reserves and surplus without specifying any particular RBC level.

### **An Alternative Approach**

CBC's current levels of reserves and surplus are not excessive by any measure in light of the dynamic marketplace in which CBC now competes and its plans to draw upon the company's capital for a number of critical strategic purposes over the next few years. CBC's Board of Directors strongly believes that it cannot continue to be an effective steward of the company's business, nor can the company continue to serve its customers, members and participating providers without access to funds that the company has built-up over time.

It is the unique role of a company's Board of Directors to determine targeted or appropriate surplus levels and to direct the strategic use of those funds. This is particularly important in the case of Blue plans like CBC. Among other things, CBC's reserves and surplus are the sole source of satisfying member and provider claims; they serve as the ultimate "backstop" to protect against unforeseen contingencies; and if surplus is depleted, the ability of a Blue plan such as CBC to rebuild surplus levels by raising funds in the capital markets is quite limited.

Set forth below is a discussion explaining in more detail (i) why CBC requires its current reserves and surplus; (ii) why RBC is not an appropriate measure of excess surplus; and (iii) what measures are more appropriate for evaluating surplus levels for a company like CBC.

**(i) Why CBC Requires its Current Reserves and Surplus**

As a threshold matter, it is important to consider the various reasons why a company like CBC needs reserves and surplus:

- CBC requires reserves and surplus in order to ensure that claims of members are timely paid; that participating providers are promptly reimbursed for health care services; and that the company's various vendors are paid in accordance with the terms of the company's contractual obligations to them.
- CBC and the other Blue plans are not permitted to participate in the Pennsylvania Guarantee Fund. Consequently, the sole source of payment for member and provider claims is CBC's reserves and surplus. It is also the sole source of payment for our vendors .
- CBC's reserves and surplus also serve as a "backstop" for unforeseen contingencies such as large, unanticipated increases in utilization of health services arising out of epidemics (such as the outbreak of the SARS in Asia and in Canada), the AIDS crisis, and other catastrophes such as terrorist attacks. Further, unforeseen government mandates, such as proposed legislation mandating certain rating methodologies for small groups, negatively impact surplus.
- CBC requires reserves and surplus to absorb operating losses caused by competition in Central Pennsylvania and the Lehigh Valley. CBC was one of only two members of the Blue Cross and Blue Shield system that suffered a net loss in calendar 2003, in large part resulting from its transition to a full service health insurance carrier and its participation in a competitive market.
- Unlike for-profit commercial insurers, which have ready access to lower cost capital through the sale of equity securities, CBC must look solely to its surplus in order to fund the growth and development of new infrastructure (such as investment in new claims processing, data and telephonic systems and in operating facilities) or rely on high cost debt.
- Surplus is the principal source of funding for development of new products and services for CBC's members. Such products and services include, but are not limited to, consumer-driven and e-commerce products and many other new products and services stemming from the recently passed Medicare Modernization Act covering Health Savings Accounts (HSAs), prescription drug benefits and Medicare itself. While it is true that other sources of funds, such as debt, are available, these would add higher costs that would have to be borne and repaid by policyholders. Since CBC and other non-profit plans can only look internally to meet their capital needs, CBC is at a competitive disadvantage with for-profit insurers.

Historically, CBC has not generated an underwriting gain. As indicated in our March 22, 2004 filing with the Department, CBC and its insurance subsidiary CAIC have not generated a profit on any underwritten business (i.e., non-group, community rated and experience rated) for over seven years. Recently, there has been an unprecedented escalation of health care costs nationwide and in Central Pennsylvania and the Lehigh Valley; and competition among payors has intensified. Particularly under these circumstances, CBC felt it was necessary to draw upon its investment income and surplus in an attempt to hold down the level of health care premiums for its subscribers.

**(ii) Why RBC is Not an Appropriate Measure of Excess Surplus**

Attached as Exhibit (b)-2 is a copy of a Blue Cross and Blue Shield Association ("BCBSA") position paper and an amicus brief filed by the BCBSA in the recent proceeding in Commonwealth Court before Judge Pellegrini. Exhibit (b)-2 discusses the history of RBC in some detail, focusing on both appropriate and inappropriate uses of RBC levels.

As noted in the attached BCBSA materials, the RBC formula was developed by a Committee of the National Association of Insurance Commissioners (NAIC) that in turn commissioned an Advisory Committee of insurance industry experts to prepare a recommendation. The RBC formula was then developed to represent a minimum acceptable level of capital – not a maximum level. The Advisory Committee was concerned about the potential that some parties might fail to appreciate the implications of its conclusion and might attempt to invoke the NAIC RBC formula for non-diagnostic purposes. In fact, the Advisory Committee cautioned:

"We believe that every effort must be made, by industry and the NAIC, to prevent abuse and misrepresentation of company RBC ratios. In particular, we encourage the NAIC to publicly state that the formula was designed solely as a filter to distinguish between weakly and strongly capitalized companies, and was not designed for, is not validated for, and should not be used for ranking or rating companies."<sup>10</sup>

In debating and ultimately accepting the Advisory Committee's recommendation, and in developing a Model Act encompassing the use of these RBC formulas, the NAIC made repeated statements affirming the positions stated above:

"The [Working Group] discussed problems associated with using RBC results for other purposes... Tying other regulatory provisions to surplus amounts above the RBC thresholds is problematic in that ***the formula was not developed to measure financial strength or capital adequacy beyond a minimum regulatory requirement*** (emphasis added)."<sup>11</sup>

The NAIC adopted the Advisory Committee's recommendation in developing a model act encompassing the use of the RBC formula:

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<sup>10</sup> Report of the Advisory Committee to the NAIC Working Group, November 7, 1991. Reproduced in Bernard L. Webb and Claude C. Lilly III, *Raising The Safety Net: Risk-Based Capital for Life Insurance Companies*, NAIC, 1994 (hereafter, "Webb & Lilly"), page 115.

<sup>11</sup> NAIC Proceedings 1993 3<sup>rd</sup> Quarter, page 228.

“Section 8 [of the draft NAIC RBC Model Act] has been amended to include a prohibition on the use of the RBC Instructions, RBC Reports, Adjusted RBC Reports, RBC Plans and Revised RBC Plans as evidence in rate proceedings or to calculate or derive any element of an appropriate premium level or rate of return. As noted in earlier reports, the [Model Law Resource Group] believes that unless such a provision is include[d], **commissioners in some states adopting the model will make the ‘floor’ capital established by the model into a ‘ceiling’ for rate making and rate [of] return purposes.**” [Emphasis supplied.]<sup>12</sup>

***The Department appears to be following the very path that prompted the articulation of these concerns by the NAIC.***

Further, at the time of the implementation of its RBC formula, the NAIC commissioned a book, in order to articulate and to document the principles underlying the NAIC’s approach to developing risk-based capital standards. In that book the NAIC emphasized that its RBC formula was not intended to measure a company’s target level of capital, or to suggest that levels of capital above the regulatory minimums were unwarranted:

“Just as the current state-by-state fixed minimum capital and surplus levels are by no means a “target” level of capitalization, neither is the RBC generated by the NAIC formula...Companies are still free to make their own capitalization decisions above the regulatory minimum RBC thresholds... **The NAIC formula...allows companies to operate freely at any given level above the minimum threshold.** Companies that fall beneath those thresholds are subject to regulatory action; companies above the threshold are not... [A] company’s optimal or target level of capitalization may be well above the minimum threshold set by the NAIC formula...”<sup>13</sup> [Emphasis supplied.]

A contemporaneous article in an NAIC published journal, co-authored by the NAIC’s then-director of research, reinforces the fact that the NAIC’s RBC formula is wholly unrelated to appropriate target levels of capital for an insurance company:

“These new risk-based capital standards do not set a target capital level or even an optimal capital level...Companies are free to hold capital above and beyond the minimum level established by the RBC formula, and virtually all companies do, but **the exact level of capital is an internal business decision outside the scope of regulatory monitoring.** That optimum capital level chosen by the company can be well outside the company action level RBC determined by the NAIC formula...[I]t is important to appreciate that the RBC formula should not bind an adequately capitalized firm.”<sup>14</sup> [Emphasis supplied.]

Since the RBC formula was developed specifically for determining a minimum acceptable level of surplus (and not a maximum), its use for other purposes presents a number of inherent difficulties:

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<sup>12</sup> NAIC Proceedings 1993 3<sup>rd</sup> Quarter, page 290.

<sup>13</sup> Webb and Lilly, page 13.

<sup>14</sup> Robert W. Klein and Michael M. Barth, “Solvency Monitoring in the Twenty-First Century,” *NAIC Journal of Insurance Regulation*, Vol. 13., No. 3, 1995, page 274.

- RBC levels are not designed to differentiate among adequately capitalized companies.
- It is not possible to conclude, based solely on RBC calculations, that a company with a higher RBC level (such as 500%) is necessarily financially stronger than a company with a lower RBC level (such as 400%). RBC measures solvency (not financial strength).
- RBC levels do not take company size into account. So, although one company may have a higher RBC level (over 650%), this does not necessarily mean that it has greater "excess" capital than a bigger company with an RBC level lower than 650%. This is because the bigger company is better able to cope with unforeseen contingencies – simply said, bigger companies can absorb bigger unforeseen losses.

**(a) A Departure from Historical Practice**

Historically, the Department has rightly been concerned with *minimum levels* of reserves and surplus. As such, the Department's request for an application to approve maximum surplus levels is novel -- this is the first such request in the history of the Department's regulation of Blue plans and other insurers – and reflects a dramatic departure from historical practice.

The Department has only recently also changed its views on the adequacy of CBC's capital and surplus. In the fall of 2001, when CBC was forced to evolve from a hospital plan corporation into a full service health plan (that is, a health plan that could offer both hospital benefits as well as benefits for professional provider services), the Department sought and obtained a confidential business plan from CBC. That confidential business plan contained five year projections which among other things reflected RBC levels *higher than those in effect today*. The Department was not concerned at that time whether surplus levels were too high – rather the concern repeatedly expressed by the senior members of the Department was *whether projected surplus levels would be sufficient* for CBC to compete against its former business partner and others in Central Pennsylvania and the Lehigh Valley. Indeed, CBC relied upon that business plan (as well as the Department's understanding of our future business needs) in moving forward, and as a result, the company subsequently made a number of substantial investments (such as the purchase of a new claims processing system and other infrastructure improvements, the acquisition of Keystone Health Plan Central as well as the purchase of an office building intended to lower long-term leasing costs) – all premised upon the continued availability of significant surplus to enable us to meet the demands of a fiercely competitive marketplace.

**(b) RBC Levels are Static, Not Dynamic**

Most importantly, RBC levels are not dynamic -- they only provide a "snapshot" calculated at year end – a static test that can rapidly become outdated in a fast-changing environment. RBC levels certainly do not take into account future events and economic forces affecting the company's operations. As a result, we do not believe a static calculation of CBC's RBC level is adequate to reflect CBC's plans with respect to capital investments, or targeted marketing decisions, or substantially increased

competition for customers in CBC's market, or provider expectations as to increased reimbursement, or new product development needs or industry claim cycles.

To illustrate this point, CBC has attached as Exhibit (b)-3 a confidential comparison of those underwriting gains and losses projected in a confidential business plan for CBC and CAIC filed with the Department in the fall of 2001<sup>15</sup> with the actual underwriting gains and losses during calendar years 2002 and 2003. We believe it is important to point out that while our initial estimates regarding enrollment, product pricing, and allocation of business between our two insurance entities were, not surprisingly, different than those projected in 2001, our cumulative underwriting result was within 2.4% of our projections. This also demonstrates that we fulfilled our pledge, made to the public and to the Department, that we would not ask our members to fund our transition costs to a full service health plan.

We note that in large part due to CBC's launch of its new business initiatives and its transition to a full-service health insurance carrier, thereby further contributing to the competitive environment, CBC was only one of two plans in the Blue Cross Blue Shield System that suffered a net loss in fiscal 2003.

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In other words, RBC can only measure results after the fact – it looks backwards and is not a suitable or accurate tool for planning or projecting reserve and surplus levels going forward.

**(c) Statutory Standards in Other States**

In some states, the legislatures have adopted statutes setting forth the procedures and standards for the Department's review of the appropriate levels of reserves and surplus. No other state has adopted the novel procedure followed by the Department, which seeks to impose standards without benefit of the authority conferred by a statute or any formally adopted regulation.

As an example, the state of Minnesota employs a benchmark of 33 1/3% of incurred claims plus administrative expenses.<sup>16</sup> The state of North Carolina employs a benchmark of average month claims plus administrative expenses plus selling expenses times six.<sup>17</sup> The state of Michigan, pursuant to specific statutory authority, does in fact use an RBC standard, but establishes an RBC level of 200% times 5 (or 1000%).<sup>18</sup> If any of these tests in any of these states were to be applied to CBC, CBC's existing surplus would fall within the permissible statutorily established range. So, *using the statutory standards adopted by these states*, CBC's surplus levels are not excessive.

<sup>15</sup> The confidential business plan has been included as Exhibit (d)-2 to this Application.

<sup>16</sup> Minn. Stat. §62C.09(4).

<sup>17</sup> N.C. Gen. Stat. §58-65-95(d).

<sup>18</sup> Mich. Comp. Laws §550.1204a(5).

Moreover, a noted rating agency, A.M. Best, believes: "...all minimum state regulatory requirements for capital and surplus are too low."<sup>19</sup>

**(d) The Need for Quantitative and Qualitative Measures**

Only a mix of quantitative and qualitative measures must be considered in connection with any legitimate attempt to determine what constitutes a strong and sufficient surplus.<sup>20</sup> For example, in its methodology for rating health insurance companies (see Exhibit (b)-4), A.M. Best emphasizes that a mix of quantitative and qualitative measures is required to analyze capital adequacy:

"While A.M. Best's analysis of capital adequacy begins with a BCAR assessment at each operating insurer, several other quantitative factors play significant roles in the rating, including:

- MCORBC when available.
- Underwriting leverage (net premiums written to capital and surplus).
- Equity per member per month (capital and surplus to member months). This measures the amount of capital and surplus spread over the membership base.
- Asset leverage (total liabilities to total assets).
- Premium leverage (level of premiums to capital and surplus).
- Months reserves (capital and surplus to monthly average expenses).

Quantitative models for capital measurement, however, are essentially static. They indicate capital adequacy at a fixed point in time, given the business risk typical for the lines of business offered that year. For this reason, A.M. Best makes a qualitative assessment of the risks related to local market and regulatory conditions, risks unique to the company, or future risks that could develop as various conditions change."<sup>21</sup>

**(iii) Alternative Measurements: The Need for a Dynamic Approach .**

Given all the issues we have cited with static approaches to surplus evaluation, we recommend that for purposes of evaluating surplus, the Department adopt a multi-variable dynamic approach to surplus evaluation. Such a multi-variable dynamic model may incorporate several static measures, as well as projections that take into account the long-term future environment within which our company will operate. Central Pennsylvania and the Lehigh Valley are highly competitive marketplaces. Our customers and providers have strong expectations and we will need to be operationally efficient and financially strong to meet those expectations.

An appropriate multi-variable dynamic approach must include both quantitative and qualitative elements requiring both objective and subjective evaluations. Current and expected future conditions must be evaluated in order to determine an appropriate level of surplus. The approach applied to CBC must be especially prudent and conservative

<sup>19</sup> A.M. Best Co. Methodology, October 27, 2003, "Rating Health Insurance Companies," © 2003 by A.M. Best Company, Inc. (hereafter "A.M. Best Methodology"). See Exhibit (b)-4, page 1.

<sup>20</sup> See Report of Douglas B. Sherlock, CFA of Sherlock Company at Exhibit (d)-1.

<sup>21</sup> See Exhibit (b)-4, pages 1 and 2.

since CBC must be prepared to meet minimum financial requirements under the most negative scenarios because:

- Competitive losses could be incurred.
- CBC is not a publicly traded company.
- All of our capital has to be internally generated.
- CBC is not permitted to participate in the Pennsylvania Guarantee Fund.
- Because of the highly competitive and negative regulatory environment which exists in Pennsylvania, credit analysts would consider CBC a high risk debtor and not offer us timely, liquid, or affordable relief in the event of severe financial need.
- Our customers demand that their partners be financially strong and stable. This is certainly the case with employer groups that provide benefits to their employees. We have always been and we will always want to be in the position of meeting our customers' expectations.

A multi-variable, dynamic approach to surplus evaluation necessarily precludes the use of any one formula. Rather, it requires a case-by-case analysis of both qualitative and quantitative factors coupled with scenario testing to assess the sensitivity and robustness of capital such as forecasting risks and assessing the amount of capital needed to survive 99% of economic scenarios considered possible to occur over the course of the next five years. The establishment of any formal regulatory standards requires detailed completion of such an analysis.

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- To use a single "bright line" quantitative measure such as RBC to determine appropriate surplus in today's dramatically changing health care environment would be as foolish as trying to fly an airplane looking only at its altimeter without regard to weather conditions, wind speed, wind direction, terrain, location or other air traffic in the area. In short, the probability of a disaster would be too high to be acceptable.

For all of the foregoing reasons, and taking into account our recent financial performance, economic and other variables, CBC believes its existing reserves and surplus are at an appropriate, but not excessive level to support our current business needs and our future plans.

RBC Levels

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**Issue Brief of the Blue Cross Blue Shield Association:  
History of RBC in Relation to Target Capital Levels  
And  
Amicus Curiae Brief of Blue Cross and Blue Shield Association  
In Support of Petitioner Capital BlueCross**



**Blue Cross BlueShield  
Association**

An Association of Independent  
Blue Cross and Blue Shield Plans

**ACTUARIAL SERVICES**

# Issue Brief

Blue Cross and Blue Shield  
Association  
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**Subject: History of RBC in Relation to Target Capital Levels**  
**Date: March 29, 2004**  
**Author: Rowen B. Bell, Associate Actuary**  
(312.297.6093 / [rowen.bell@bcbsa.com](mailto:rowen.bell@bcbsa.com))

This Issue Brief provides Blue Plans with historical context relative to the NAIC Risk-Based Capital ("RBC") formula's specific purpose as a tool for assessing insurer solvency rather than as a metric for determining an insurer's target capital level or maximum capital level. This subject has recently taken on greater pertinence in light of regulatory initiatives in several states that would impose RBC-based maximum capital levels or excess reserve give-backs.

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In January 2004, the Pennsylvania Insurance Department ("PID") issued Notice 2004-01, "Reserve and Surplus Levels of Hospital Plan and Professional Services Health Plan Corporations", which instructed each of the four Pennsylvania-based Blue Plans to submit an application to PID for approval of its reserve and surplus. As part of this application, each Blue Plan was instructed to "state the maximum RBC ratio within the 350% to 650% range that is appropriate, and explain the rationale for that maximum RBC ratio," and also to "provide 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..."

In February 2004, Capital Blue Cross ("CBC") filed a Petition for Review with the Commonwealth Court of Pennsylvania, requesting preliminary injunctive relief from the requirements of Notice 2004-01. In its petition, CBC stated that "the NAIC's intent in creating the RBC Model Act was to establish minimum capital standards for insurance companies" and also that "the sole purpose of [the] RBC Report is to enable [PID] to monitor the financial position of those companies to ensure solvency". As such, CBC argued that PID lacked the statutory authority "to use RBC information for any purpose other than as a solvency monitoring tool" or "to establish a surplus 'range' using RBC as a measure".

**Brand Protection  
and Financial Services**

In March 2004, with the consent of CBC as well as the other three Pennsylvania-based Blue Plans, BCBSA filed an *amicus curiae* brief in support of CBC's petition.<sup>1</sup>

The remainder of this Issue Brief consists of a research paper that formed the basis for the BCBSA amicus brief. This paper provides background and references by drawing extensively from the documentary record surrounding the initial development of NAIC RBC one decade ago, and it argues that making use of the RBC formula to establish maximum capital levels is contrary to the NAIC's intent in developing the RBC formula and Model Act.

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The RBC formula for health organizations, and the RBC Model Act related to that formula, are derivatives of the NAIC's earlier RBC formula and related Model Act for life and accident and health ("life/A&H") insurers. Thus, to place the NAIC's approach to RBC for health organizations into proper perspective, it is appropriate to delve into the historical record regarding the development of the NAIC's approach to RBC for life/A&H insurers, since the principles underlying NAIC RBC for life/A&H insurers apply equally to NAIC RBC for health organizations.

In 1990, the NAIC embarked on a project to explore the development of a risk-based capital standard for life/A&H insurers. To carry out this project, the NAIC formed a Life Risk-Based Capital Working Group ("Working Group"), which in turn commissioned an Advisory Committee of insurance industry experts to prepare a recommendation. One of the key aspects addressed in the Advisory Committee's 1991 report to the Working Group is that the nature of a risk-based capital formula is indelibly connected to the intended purpose of that formula:

"Depending on their intended use, RBC formulas vary widely in...the relative level of capital developed by the formula.... In general, formulas can be designed that develop: (1) Capital levels that represent minimum acceptable operating amounts; (2) Higher levels consistent with the capital needs of a well-managed going concern; or (3) Still higher levels allowing for a company's plans for future growth or diversification. The target level chosen depends greatly on the intended use of the formula..."<sup>2</sup>

The Advisory Committee concluded that it was both necessary and appropriate to focus its efforts on developing a formula whose output represented a minimum acceptable level of capital rather than a maximum level of capital:

"RBC can be developed as a high, "AAA" target for a company to strive for, or as a diagnostic tool for use by regulators in discriminating between strongly and weakly capitalized companies. Both the nature of the development process and the formula itself will differ depending on whether we seek a high standard or a diagnostic

<sup>1</sup> Last week, CBC's request for an injunction was denied by the Commonwealth Court of Pennsylvania. However, a preliminary injunction was granted "to the extent that all [business] plans submitted [to PID] will be kept confidential until further order of the Court."

<sup>2</sup> Report of the Advisory Committee to the NAIC Life Risk-Based Capital Working Group, November 27, 1991. Reproduced in Bernard L. Webb and Claude C. Lilly III, Raising the Safety Net: Risk-Based Capital for Life Insurance Companies, NAIC, 1994 (hereafter, "Webb & Lilly"), page 115.

standard. The Committee concluded that a single formula could not serve both purposes and focused its attention on the development of a sound diagnostic standard.”<sup>3</sup>

However, the Advisory Committee was concerned about the potential that some parties might fail to appreciate the implications of its conclusion and might attempt to invoke the NAIC RBC formula for non-diagnostic purposes:

“We believe that every effort must be made, by industry and the NAIC, to prevent abuse and misrepresentation of company RBC ratios. In particular, we encourage the NAIC to publicly state that the formula was designed solely as a filter to distinguish between weakly and strongly capitalized companies, and was not designed for, is not validated for, and should not be used for ranking or rating companies.”<sup>4</sup>

In debating and ultimately accepting the Advisory Committee’s recommendation of a risk-based capital formula for life/A&H insurers, and in developing a Model Act encompassing the use of that RBC formula, the NAIC made repeated statements affirming the positions articulated above:

“The [Working Group] discussed problems associated with using RBC results for other purposes.... Tying other regulatory provisions to surplus amounts above the RBC thresholds is problematic in that the formula was not developed to measure financial strength or capital adequacy beyond a minimum regulatory requirement.”<sup>5</sup>

“The formula that is proposed is a threshold capital formula rather than a target capital formula. It has been designed to identify companies with capital levels that require regulatory attention. The formula has not been designed to differentiate among adequately capitalized companies. Therefore, it would be entirely inappropriate to use this formula to rate or rank adequately capitalized companies.”<sup>6</sup>

“Section 8 [of the draft NAIC RBC Model Act] has been amended to include a prohibition on the use of the RBC Instructions, RBC Reports, Adjusted RBC Reports, RBC Plans and Revised RBC Plans as evidence in rate proceedings or to calculate or derive any element of an appropriate premium level or rate of return. As noted in earlier reports, the [Model Law Resource Group] believes that unless such a provision is included[,] commissioners in some states adopting the model will make the ‘floor’ capital established by the model into a ‘ceiling’ for rate making and rate [of] return purposes.”<sup>7</sup>

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<sup>3</sup> Report of the Advisory Committee to the NAIC Life Risk-Based Capital Working Group, November 27, 1991. Reproduced in Webb & Lilly, page 119.

<sup>4</sup> Report of the Advisory Committee to the NAIC Life Risk-Based Capital Working Group, November 27, 1991. Reproduced in Webb & Lilly, page 122.

<sup>5</sup> NAIC Proceedings 1993 3<sup>rd</sup> Quarter, page 228.

<sup>6</sup> NAIC Proceedings 1992 4<sup>th</sup> Quarter, page 557.

<sup>7</sup> NAIC Proceedings 1993 3<sup>rd</sup> Quarter, page 290.

At the time of the implementation of its RBC formula for life/A&H insurers, the NAIC commissioned a book, Raising the Safety Net: Risk-Based Capital for Life Insurance Companies by Bernard L. Webb and Claude C. Lilly III, in order to articulate and document the principles underlying the NAIC's approach to developing risk-based capital standards. In that book, the NAIC emphasized that its RBC formula was not intended to measure a company's target level of capital, or to suggest that levels of capital above the regulatory minimums were unwarranted:

"Just as the current state-by-state *fixed* minimum capital and surplus levels are by no means a 'target' level of capitalization, neither is the RBC generated by the NAIC formula. ... Companies are still free to make their own capitalization decisions above the regulatory minimum RBC thresholds... The NAIC formula...allows companies to operate freely at any given level above the minimum threshold. Companies that fall beneath those thresholds are subject to regulatory action; companies above the threshold are not. ... [A] company's optimal or target level of capitalization may be well above the minimum threshold set by the NAIC formula..."<sup>8</sup>

The NAIC book also contains a strong caution that, since the formula was designed as a diagnostic tool, it is inappropriate to utilize it as a barometer of financial strength:

"The RBC levels determined under the NAIC formula are still minimum capital levels. The fact that a company's RBC ratio is 500 percent does not mean that that company is in strong financial condition, nor does an RBC ratio of 500 percent imply that that company is financially stronger than an insurer with an RBC ratio of 400 percent. The RBC ratio indicates whether or not a company is subject to regulatory action because it fell below the minimum standards. Attempts to rank companies by their RBC levels are foolish and indicate a serious lack of understanding of the NAIC's RBC system."<sup>9</sup>

A contemporaneous article in an NAIC-published journal, co-authored by the NAIC's then-director of research, reinforces the fact that the NAIC RBC formula is wholly unrelated to the issue of the appropriate target level of capital for an insurance company:

"The NAIC RBC formula was designed to establish a regulatory minimum level of capital based on risk... These new risk-based capital standards do not set a target capital level or even an optimal capital level... Companies are free to hold capital above and beyond the minimum level established by the RBC formula, and virtually all companies do, but the exact level of capital is an internal business decision outside the scope of regulatory monitoring. That optimum capital level chosen by the company can be well outside the company action level RBC determined by the NAIC formula... [I]t is important to appreciate that the RBC formula should not bind an adequately capitalized firm."<sup>10</sup>

<sup>8</sup> Webb & Lilly, page 13.

<sup>9</sup> Webb & Lilly, page 55.

<sup>10</sup> Robert W. Klein and Michael M. Barth, "Solvency Monitoring in the Twenty-First Century", *Journal of Insurance Regulation*, Vol. 13, No. 3, 1995, page 274.

More recent discussions by the NAIC Risk-Based Capital Task Force reaffirm that the NAIC's position on the purpose and function of its RBC formula has not changed in the years since that formula was initially developed:

"Mr. Gorski [of Illinois] stated that...the [RBC] formula was not designed to differentiate between well-capitalized companies and extremely well capitalized companies as the formula does not contain the precision required to accomplish that... Mr. Blumer [of Wisconsin] stated that the purpose of risk-based capital was to establish a requirement of regulatory capital and provide the regulator with the ability to take regulatory action if a company's capital is below that requirement. ... Mr. Blumer stated that there are several examples of why a specified percentage above authorized control level does not tell a regulator anything... Mr. Blumer reiterated that the purpose of risk-based capital was not to determine who should or should not be afforded something based on a specified risk-based capital ratio."<sup>11</sup>

In conclusion, the documentary record sheds considerable light on the intent of the NAIC with respect to its RBC formula and strongly indicates that the PID's proposed use of that RBC formula, as articulated in Notice 2004-01, is inconsistent with that intent.

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<sup>11</sup> Minutes of NAIC Risk-Based Capital Task Force meeting, September 12, 2000.



### Interest of Blue Cross Blue Shield Association

The Blue Cross Blue Shield Association ("BCBSA"), an Illinois non-profit corporation with headquarters in Chicago, Illinois, is the trade association and licensor of the BLUE CROSS® and BLUE SHIELD® marks and names for Capital Blue Cross ("CBC") and 40 other independent Blue Cross and/or Blue Shield health insurers ("Blue Plans") throughout the United States. BCBSA has a long history of participation in the process by which the National Association of Insurance Commissioners ("NAIC") originally developed, and continues to maintain, the risk-based capital ("RBC") formula and model legislation applicable to health insurers which has been enacted in Pennsylvania and at least 25 other states. As such, BCBSA wishes to provide the Commonwealth Court of Pennsylvania with additional background and perspective in support of CBC's statements that "the NAIC's intent in creating the RBC Model Act was to establish minimum capital standards for insurance companies"<sup>1</sup> and "the sole purpose of this RBC Report is to enable the Department to monitor the financial position of those companies to ensure solvency"<sup>2</sup>.

### Argument

BCBSA is not asserting that a state insurance regulator cannot or should not regulate a health insurer's capital (the term "capital" as used herein is synonymous with the term "surplus" as used in the Department's notice), collect data from the insurer to ascertain its RBC level, or use RBC to establish a minimum level of capital that an insurer should maintain. BCBSA's sole concern is that evaluating a health insurer's capital needs in terms of a maximum surplus is a complex assessment that needs to take into account far more than the NAIC RBC formula is designed to do. Establishing maximum capital levels based solely or substantially on the RBC formula is, in violation of the NAIC's intent and the language of the RBC Model Act promulgated by the NAIC.

The RBC formula for health organizations, a term which includes Blue Plans, and the RBC Model Act related to that formula, are derivatives of the NAIC's earlier RBC formula and related Model Act for life and health insurers. (The Commonwealth of Pennsylvania has enacted both Model Acts.) Thus, to place the NAIC's approach to RBC for health organizations into proper perspective, it is appropriate to delve into the historical record regarding the development of the

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<sup>1</sup> CBC's Petition for Review, paragraph 12.

<sup>2</sup> CBC's Petition for Review, paragraph 14.

NAIC's approach to RBC for life and health insurers, since the principles underlying NAIC RBC for life and health insurers apply equally to NAIC RBC for health organizations.

In 1990, the NAIC embarked on a project to explore the development of a risk-based capital standard for life and health insurers. To carry out this project, the NAIC formed a Life Risk-Based Capital Working Group ("Working Group"), which in turn commissioned an Advisory Committee of insurance industry experts to prepare a recommendation. One of the key aspects addressed in the Advisory Committee's 1991 report to the Working Group is that the nature of a risk-based capital formula is indelibly connected to the intended purpose of that formula:

"Depending on their intended use, RBC formulas vary widely in...the relative level of capital developed by the formula....In general, formulas can be designed that develop: (1) Capital levels that represent minimum acceptable operating amounts; (2) Higher levels consistent with the capital needs of a well-managed going concerns; or (3) Still higher levels allowing for a company's plans for future growth or diversification. The target level chosen depends greatly on the intended use of the formula..."<sup>3</sup>

The Advisory Committee concluded that it was both necessary and appropriate to focus its efforts on developing a formula whose output represented a minimum acceptable level of capital rather than a maximum level of capital:

"RBC can be developed as a high, "AAA" target for a company to strive for, or as a diagnostic tool for use by regulators in discriminating between strongly and weakly capitalized companies. Both the nature of the development process and the formula itself will differ depending on whether we seek a high standard or a diagnostic standard. The Committee concluded that a single formula could not serve both purposes and focused its attention on the development of a sound diagnostic standard."<sup>4</sup>

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<sup>3</sup> Report of the Advisory Committee to the NAIC Working Group, November 27, 1991. Reproduced in Bernard L. Webb and Claude C. Lilly III, *Raising The Safety Net: Risk-Based Capital for Life Insurance Companies*, NAIC, 1994 (hereafter, "Webb & Lilly"), page 115.

<sup>4</sup> Report of the Advisory Committee to the NAIC Working Group, November 27, 1991. Reproduced in Webb & Lilly, page 119.

However, the Advisory Committee was concerned about the potential that some parties might fail to appreciate the implications of its conclusion and might attempt to invoke the NAIC RBC formula for non-diagnostic purposes:

"We believe that every effort must be made, by industry and the NAIC, to prevent abuse and misrepresentation of company RBC ratios. In particular, we encourage the NAIC to publicly state that the formula was designed solely as a filter to distinguish between weakly and strongly capitalized companies, and was not designed for, is not validated for, and should not be used for ranking or rating companies."<sup>5</sup>

In debating and ultimately accepting the Advisory Committee's recommendation of a risk-based capital formula for life and health insurers, and in developing a Model Act encompassing the use of these RBC formula (and ultimately, the RBC formula for health organizations), the NAIC made repeated statements affirming the positions articulated above:

"The [Working Group] discussed problems associated with using RBC results for other purposes....Tying other regulatory provisions to surplus amounts above the RBC thresholds is problematic in that the formula was not developed to measure financial strength or capital adequacy beyond a minimum regulatory requirement (emphasis added)."<sup>6</sup>

"The formula that is proposed is a threshold capital formula rather than a target capital formula. It has been designed to identify companies with capital levels that require regulatory attention. The formula has not been designed to differentiate among adequately capitalized companies. Therefore, it would be entirely inappropriate to use this formula to rate or rank adequately capitalized companies."<sup>7</sup>

At the time of the implementation of its RBC formula for life and health insurers, the NAIC commissioned a book, *Raising the Safety Net: Risk-Based Capital for Life Insurance Companies* by Bernard L. Webb and Claude C. Lilly III, in order to articulate and document the principles underlying the NAIC's approach to developing risk-based capital standards. In that

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<sup>5</sup> Report of the Advisory Committee to the NAIC Working Group, November 27, 1991. Reproduced in Webb & Lilly, page 122.

<sup>6</sup> NAIC Proceedings 1993 3<sup>rd</sup> Quarter, page 228.

<sup>7</sup> NAIC Proceedings 1993 4<sup>th</sup> Quarter

book, the NAIC emphasized that its RBC formula was not intended to measure a company's target level of capital, or to suggest that levels of capital above the regulatory minimums were unwarranted:

"Just as the current state-by-state fixed minimum capital and surplus levels are by no means a 'target' level of capitalization, neither is the RBC generated by the NAIC formula. ... Companies are still free to make their own capitalization decisions above the regulatory minimum RBC thresholds... The NAIC formula...allows companies to operate freely at any given level above the minimum threshold. Companies that fall beneath those thresholds are subject to regulatory action; companies above the threshold are not. ... [A] company's optimal or target level of capitalization may be well above the minimum threshold set by the NAIC formula..."<sup>8</sup>

The NAIC book also contains a strong caution that, since the formula was designed as a diagnostic tool, it is inappropriate to utilize it as a barometer of financial strength:

"The RBC levels determined under the NAIC formula are still minimum capital levels. The fact that a company's RBC ratio is 500 percent does not mean that that company is in strong financial condition, nor does an RBC ratio of 500 percent imply that that company is financially stronger than an insurer with an RBC ratio of 400 percent. The RBC ratio indicates whether or not a company is subject to regulatory action because it fell below the minimum standards."<sup>9</sup>

A contemporaneous article in an NAIC-published journal, co-authored by the NAIC's then-director of research, reinforces the fact that the NAIC RBC formula is wholly unrelated to the issue of the appropriate target level of capital for an insurance company:

"The NAIC RBC formula was designed to establish a regulatory minimum level of capital based on risk... These new risk-based capital standards do not set a target capital level or even an optimal capital level... Companies are free to hold capital above and beyond the minimum level established by the RBC formula, and virtually all companies do, but the exact level of capital is an internal business decision outside the scope of regulatory

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<sup>8</sup>Webb & Lilly, page 13.

<sup>9</sup>Webb & Lilly, page 55.

monitoring. That optimum capital level chosen by the company can be well outside the company action level RBC determined by the NAIC formula... [I]t is important to appreciate that the RBC formula should not bind an adequately capitalized firm."<sup>10</sup>

More recent discussions by the NAIC RBC Task Force reaffirm that the NAIC's position on the purpose and function of its RBC formula has not changed in the years since that formula was initially developed:

"Mr. Gorski [of Illinois] stated that...the [RBC] formula was not designed to differentiate between well-capitalized companies and extremely well capitalized companies as the formula does not contain the precision required to accomplish that... Mr. Blumer [of Wisconsin] stated that the purpose of risk-based capital was to establish a requirement of regulatory capital and provide the regulator with the ability to take regulatory action if a company's capital is below that requirement. ... Mr. Blumer stated that there are several examples of why a specified percentage above authorized control level does not tell a regulator anything... Mr. Blumer reiterated that the purpose of risk-based capital was not to determine who should or should not be afforded something based on a specified risk-based capital ratio."<sup>11</sup>

Further evidence that the sole and limited purpose for RBC ratios is minimum surplus and solvency surveillance can be found in 40 P.S. § 221.11-B(c)(1) which is a part of Pennsylvania's legislation regarding risk based capital requirements for health organizations, which provides as follows:

"Except as required by this article, the publication, dissemination, circulation or placement before the public, or directly or indirectly causing the publication, dissemination, circulation or placement before the public, of an assertion, representation or statement with regard the RBC levels or component derived in the calculation of RBC levels of a health organization, including assertions, representations or statements intended or used to rank health organizations, by an insurer, agent, broker or other person in a newspaper, magazine or other publication, notice, pamphlet, letter or other

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<sup>10</sup> Robert W. Klein and Michael M. Barth, "Solvency Monitoring in the Twenty-First Century", *NAIC Journal of Insurance Regulation*, Vol. 13, No. 3, 1995, page 274.

<sup>11</sup> Minutes of NAIC Risk-Based Capital Task Force meeting, September 12, 2000.

printed matter or by broadcast or electronic transmission, is prohibited. (Emphasis added)”

The fact that any statement or assertion placed before the public regarding RBC levels, including any statements intended or used to rank health organizations, is prohibited, clearly reflects the legislative intent that RBC levels are not to be used to indicate levels or financial strength of health organizations; yet, the Pennsylvania Insurance Department’s setting an RBC for a health organization and declaring that the health organization is so capitalized at that level that any additional capital above that level is unneeded and results in over capitalization, is clearly the making of a statement of full financial health by the insurance department based on an RBC level.

**Conclusion**

In conclusion, BCBSA respectfully submits that the documentary record sheds considerable light on the intent of the NAIC with respect to its RBC formula and strongly indicates that the Pennsylvania Insurance Department’s proposed use of that RBC formula, as articulated in Notice 2004-01<sup>12</sup>, is inconsistent with that intent.

Respectfully Submitted,

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DATED: March 16, 2004

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<sup>12</sup>See CBC’s Petition for Review, paragraph 6.

CERTIFICATE OF SERVICE

I hereby certify that I am this day serving the foregoing document in the manner indicated, addressed to the following counsel of record:

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DATED: March 15, 2004

**Comparison of Projected versus Actual Underwriting Gain/Loss  
For the Years 2002 and 2003**

**CONFIDENTIAL**  
INFORMATION INTENTIONALLY OMITTED

**A.M. Best Methodology Report**

# A.M. BEST

**METHODOLOGY**
**OCTOBER 27, 2003**

## Rating Health Insurance Companies

The purpose of this report is to provide transparency regarding A.M. Best Co.'s criteria for assigning financial strength ratings (FSR) to health insurance carriers, including traditional life/health insurance companies, health maintenance organizations (HMOs) and Blue Cross and Blue Shield plans. This methodology also updates A.M. Best's previously published health-care rating methodology to reflect changes in the marketplace.

The constantly changing operating environment and the unstable, escalating rate of inflation for health-care costs make it difficult for carriers to anticipate the medical cost factor in the pricing of policies that will be in effect for 12 months. The resulting volatility of earnings, combined with the thin capitalization that is characteristic of many health insurers, creates a fertile environment for financial impairment. More vulnerable are small health carriers with product and geographic concentrations and a lack of resources necessary for innovative responses to changes in the environment. As a result of these factors, the demand for financial strength ratings on these companies has increased.

### Health Insurer Rating Criteria

An A.M. Best financial strength rating is an opinion about an insurer's financial strength and its ability to meet ongoing obligations to policyholders. The assigned rating is derived from an in-depth evaluation of a company's balance-sheet strength, operating performance and business profile, compared with A.M. Best's quantitative and qualitative standards. The required analysis reflects all sources of risk to which the health insurer is exposed. The entire group, including all of the rated entity's affiliates and their internal relationships, are considered. For the noninsurance subsidiaries, A.M. Best performs a detailed, internal analysis of their risk profile and the resulting effect on rated entities within the group.

*This report was written by Dana B. Mehta, assistant vice president.*



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An important component of the evaluation process requires an interactive exchange of information, both public and confidential, with the insurer's management. Once assigned, ratings are re-evaluated continually for changes that might arise during the year or in conjunction with A.M. Best's ongoing dialogue with company management.

A.M. Best's criteria for analyzing health insurance carriers are broadly similar to that for life insurers. Key differences are the focus on benchmarks, ratios and qualitative factors relevant to the health-care operating environment. This report primarily details those elements of the rating analysis that are different for health insurers. For more detailed information on A.M. Best's criteria for life/health insurance companies, visit [www.ambest.com/ratings](http://www.ambest.com/ratings).

### Balance-Sheet Strength

In determining a company's ability to meet its current and ongoing obligations to policyholders, the most important area to evaluate is its balance-sheet strength. A critical measure of balance-sheet strength is the adequacy of a health insurer's capital and surplus to support its financial and operating practices. The net required capital to support these practices and the company's other risk exposures—primarily related to product mix and underwriting—is evaluated by Best's Capital Adequacy Ratio (BCAR). Other considerations in assessing balance sheet strength are reserves, reinsurance and asset quality.

### Capital Adequacy

A.M. Best believes all minimum state regulatory requirements for capital and surplus are too low. An A.M. Best Secure rating—(Very Good) B+ and higher—calls for substantially higher amounts of capital than what is assessed under the Managed Care Organization Risk Based Capital (MORBC) authorized control level, as promulgated by the National Association of Insurance Commissioners.

While A.M. Best's analysis of capital adequacy begins with a BCAR assessment at each operating insurer, several other quantitative

factors play significant roles in the rating, including:

- MCORBC when available.
- Underwriting leverage (net premiums written to capital and surplus).
- Equity per member per month (capital and surplus to member months). This measures the amount of capital and surplus spread over the membership base.
- Asset leverage (total liabilities to total assets).
- Premium leverage (level of premiums to capital and surplus).
- Months reserves (capital and surplus to monthly average expenses).

Quantitative models for capital measurement, however, are essentially static. They indicate capital adequacy at a fixed point in time, given the business risk typical for the lines of business offered that year. For this reason, A.M. Best makes a qualitative assessment of the risks related to the local market and regulatory conditions, risks unique to the company, or future risks that could develop as various conditions change.

#### *External Capital Support*

Another consideration in the assessment of capital adequacy is capital available from external sources, such as borrowings from the capital markets and private sources or contributions from an affiliate. The amounts that must be repaid to a lender—whether a parent or a third-party—aren't automatically considered permanent capital, although a regulator's permission might be required before payments are made. Capital composed of retained earnings or paid-in amounts is considered superior to capital that includes subsidiary borrowings.

Although a health insurance carrier might be thinly capitalized, it might be a subsidiary of a well-capitalized, national or multiregional holding company encompassing numerous HMOs and insurance companies. Holding companies and their associated capital structures can have a significant impact on the overall financial strength of an insurance company subsidiary. They can provide subsidiaries with various levels of financial flexibility, including capital infusions. Conversely, debt and other securities, typically obligations of a holding company, can reduce a corporation's financial flexibility, depending on the magnitude of those obligations, and place significant

dividend demands on a subsidiary, limiting growth of its surplus.

A.M. Best recognizes that efficient capital management at such organizations calls for maintaining most of the capital at the holding-company level, from which support can be disbursed downstream to an operating entity. To determine whether a rating is secure, A.M. Best measures both the willingness and the ability of the parent to provide support. The level of capital at the operating entity, however, remains important.

A.M. Best prefers that the holding company provide explicit support in the form of a minimum amount of capital to be maintained at the entity and the parent's commitment to provide cash infusions if the subsidiary generates losses. However, willingness to provide support also may be indicated through discussions with management, preferably backed with evidence of a history of support.

A.M. Best assesses the parent's ability to provide support based on its financial

## A.M. Best Co.

### Methodology

October 27, 2003

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The Insurance Information Source

resources, such as the availability of cash and liquid assets and the sources and uses of funds at the holding company. To perform this assessment, A.M. Best looks at the parent's financial leverage and financial flexibility, using the ratio of total debt to total capital and coverage compared with the maximum for a rating category.

A.M. Best makes its evaluation of financial leverage based on the level to which the company manages, rather than the level at the time of the rating action. In addition, the level of coverage is deemed important. Companies in the Secure rating categories typically are expected to have coverage in excess of three times. Financial flexibility is evaluated based on the availability of funds from external sources, such as those obtained from the issuance of public and private debt, equity, and surplus notes and trust-preferred securities.

Cash flow available to the holding company from within the group depends primarily on the dividend-paying capacity of, and certain corporate service fees from, regulated and unregulated subsidiaries. Dividend capacity, in turn, depends on the organizational structure, recognizing that a generally flat structure is preferable to a stacked structure. The presence of profitable, nonregulated subsidiaries is viewed positively, as there are no limitations on the amount of dividends that may be sent upstream.

Expected uses of funds are for debt service, corporate expenses, capital infusions to subsidiaries and capital expenditures. A significant excess of funds may be channeled into a stock repurchase program. A.M. Best views stock repurchase programs cautiously. The volatility of the health insurance industry requires holding a prudent quantity of funds for unexpected, adverse developments, although how much isn't easily determined and would be based on each organization's risk characteristics at the time of the rating.

### Reserves

Reserve levels also are given considerable attention as another risk exposure on the balance sheet. A.M. Best reviews historical reserve development and current reserve margin above any third-party estimate. A.M. Best also evaluates a company's policy for the desired level of margin and premium stabilization funds and whether these percentages are maintained consistently.

### Asset Quality and Reinsurance

Other considered balance-sheet exposures are investment asset policy; actual asset quality measured by exposure of surplus to risky assets; asset diversity; parent-company equity exposure to intangibles; quality of intangibles and off-balance-sheet exposures and commitments such as guarantees; pending litigation; and the funding status of a defined-benefit plan. An important aspect of asset quality is liquidity because of the short-tailed nature of health liabilities. A.M. Best, therefore, takes a negative view of investments in illiquid assets such as investment real estate, mortgages, certain private placements and securities with certain structures.

A.M. Best also examines a company's reinsurance program to determine whether its retained risk is commensurate with the size of its capital level.

### Operating Performance

Operating performance is a major contributor to capital growth or erosion. When evaluating operating performance, A.M. Best analyzes the stability and sustainability of a company's sources of earnings in relation to its product mix. The degree of volatility in a company's earnings and the impact this could have on capitalization and balance-sheet strength is of particular interest.

Operating performance is measured by the trends in growth of earnings, return on revenue and return on equity. Other considerations are medical loss ratios and administrative cost ratios. A.M. Best examines the source and sustainability of earnings from operations by business segment. The mix is examined for diversity by product, market segment and geographic region.

Earnings from the commercial segment generally are considered the most stable because of the company's ability to control pricing. Earnings from government sources are deemed the most volatile. The government imposes controls over premium levels and lengthy notification requirements for exiting the business, raising the potential for greater losses. Eventually, exits from these businesses reduce membership, thereby increasing unit administrative costs for the remaining business.

The drivers of profitability in commercial lines are premium growth in concert with medical-cost inflation and growth of enroll-

ment. Pricing is a significant area of concern. Underestimating medical-cost trends can prove costly, while appropriate pricing shelters the company from adverse selection and furthers earnings sustainability.

In the assessment of the sustainability of earnings, A.M. Best examines the company's commitment to:

- Pricing discipline;
- Presence and power of competitors;
- Regulatory mandates and price controls;
- Amount of product differentiation;
- Effectiveness of the company's controls over rising claims costs through cost shifting and disease management;
- Persistency of the business; and
- Administrative expense management, although A.M. Best deems as necessary those expenditures for technological development that enhance administrative efficiency, speed claims payment, improve service and meet mandatory requirements. The unit costs of these expenses, however, can be greatly reduced by building economies of scale.

A key aspect of an organization's operations is how effectively it manages and anticipates medical-cost trends. A.M. Best probes into the various components of health-care expenses that drive changes in the medical loss ratio, including, but not limited to, inpatient and outpatient utilization patterns; new technologies; medical-cost inflation; trends in provider reimbursement rates; and pharmacy costs, recognizing that local market conditions affect these factors.

A.M. Best also examines earnings from investments. A.M. Best expects a company's investment strategy to focus on liquidity and asset quality, rather than on generating high income. Greater reliance on operating earnings, rather than investment income, is viewed positively.

While earnings are important, the strength of operating cash flow and its growth trend are critical for timely payment of claims. These are indicators of a company's claims-paying ability, which depends on superior liquidity as health-care claims are generally a short-tailed liability. Generally, a company that is rated at A- (Excellent) or above is expected to demonstrate the ability to generate strong and increasing operating cash flow. Strong earnings and cash flow also support debt-service coverage if there is debt.

## Business Profile

Business profile is an important component of A.M. Best's rating evaluation, and the strength of a company's business profile becomes an even greater consideration at the higher rating levels. The factors that comprise an insurer's business profile drive current and future operating performance and, in turn, affect long-term financial strength and the company's ability to meet its obligations to policyholders.

Business profile is influenced by the degree of risk inherent in the company's mix of business, its competitive market position and the depth and experience of its management. Lack of size or growth aren't considered negative rating factors unless A.M. Best believes these issues have a negative influence on the company's prospective operating performance and balance-sheet strength.

## Operating Environment and Marketplace

A.M. Best evaluates the advantages and constraints of the company's operating environment, such as the maturity or growth of the marketplace, regulatory constraints and the strength and number of competitors present or that have exited the region.

A.M. Best acknowledges that insuring health care is a local business and that the carrier's market dominance in a state or even in part of a state can be an advantage. In this respect, a small, niche company can succeed by differentiating its provider network and products or by operating in rural areas where managed care is more accepted and where multiregional companies typically don't operate.

A lack of geographic diversity, however, can make a company's business vulnerable to the regulatory constraints of the region; pressure from local competitors with less stringent pricing discipline; the local economy; and exclusion from growth opportunities elsewhere in the country. A.M. Best assesses these factors to determine the strength of the rated entity's market presence.

## Growth Trends

A.M. Best examines the company's strategy for growth and whether it focuses on acquisition or internal growth. The diversity and size of a company's enrollment base are important, because these factors can provide carriers with significant leverage when negotiating

with providers for the discounts that can have a positive impact on operating performance and balance-sheet strength.

Growth is measured in terms of membership and revenue. Because membership drives premiums, a company's growth trend in enrollment, as compared with its competitors, is important. Furthermore, the growth trend must be sustainable. Below-average growth indicates a loss of market share, while too-rapid growth signals a potential for mispricing and future impairment of capital adequacy. Growth is deemed balanced when it mitigates event risk and improves diversity of products, in addition to raising earnings. A decline in membership, especially when part of a retrenchment strategy to enhance profitability, isn't necessarily viewed as a negative, particularly if a sound strategy for future growth is in place and growth can be expected to resume within one or two years.

In evaluating national and multiregional companies, A.M. Best assesses the proportion of organic growth to growth through acquisition. Organic growth generally is viewed as superior. However, a good track record of acquisitions followed by successful integration and strong organic growth at the acquired entities is viewed positively. The strategic fit of the acquisition is critical—particularly its contribution to brand identity, product and geographic diversity or distribution—not merely its contribution to earnings.

### **Business and Product Diversity**

A.M. Best looks at whether the company is an innovator of products or a follower and how close it comes to meeting customers' needs, as well as the strength of each business segment and its contribution to the enterprise.

The health insurance business generally is segmented between commercial and governmental payors. Within commercial lines are managed care, preferred provider organizations (PPOs), full-risk and administrative services only (ASO) plans, which are segmented further as large and small groups and individual plans. Government payors include Medicare and senior-population-related plans, Medicaid and the military. The dominance of large-group business over small-group and government premium payors is viewed positively, but profit margins are narrower. Individual, small and midsize group businesses are con-

sidered more volatile, as they are subject to greater regulatory oversight and restrictions and lower retention rates but generally produce lower medical-cost ratios.

A.M. Best carefully examines a carrier's management of any shifts in its mix of business, such as from managed care to PPO or full risk to ASO. The company's position either behind or ahead of any industrywide shifts toward choice of products and flexibility in payment of premiums can be a critical factor driving future earnings.

### **Provider Relationships**

Provider relationships often make the difference in whether or not a company becomes a "carrier of choice." Important factors in A.M. Best's assessment of provider relationships are the density of the network, particularly the inclusion of major hospital systems; the degree of risk sharing—full risk, shared risk, capitated or mixed—and the balance of negotiating power between the company and providers, as well as the stability of the network.

A.M. Best also assesses the impact of any shift in risk sharing between the carrier and providers, and the ability of the company to sustain profitability during the shift through monitoring of claims costs. The stability of the provider network can be disrupted if carriers overreach with their negotiating power or if medical-malpractice insurance costs are excessive. An exodus of providers from a network or state under these pressures could prompt patients to seek out-of-network care, thereby significantly raising claims costs above pricing assumptions and reducing profits.

### **Distribution**

Market presence can be influenced significantly by the carrier's distribution channels. A.M. Best evaluates how a company serves the needs of its distribution system, especially if a small company faces large, powerful, low-cost competitors. A.M. Best evaluates the strength of the carrier's distribution channels—dependent and/or career or employee distribution—and its use of group discretionary trusts and affiliations with other insurers for marketing complementary products.

### **Not-for-Profit Organizations**

The difference in the evaluation of not-for-profit and for-profit entities isn't signifi-

cant. Generally, not-for-profit companies aren't acquisition oriented, which eliminates one type of risk. Not-for-profit earnings might be lower, although this isn't viewed as a negative as long as capital grows adequately for the company's businesses. However, regulatory pressures can be stronger on these companies, limiting the prospects for

expanding their capital. A.M. Best recognizes the recently improved financial flexibility of small companies and not-for-profits as the result of pooling, whereby separate entities aggregate their debt issuances into a pool, and the various "tranches"—or investment classes—are sold to investors as surplus or trust-preferred securities.

GUIDE TO BEST'S FINANCIAL STRENGTH RATINGS									
<p>A Best's Rating is an independent opinion, based on a comprehensive quantitative and qualitative evaluation, of a company's balance sheet strength, operating performance and business profile. Best's Ratings are not a warranty of a company's financial strength and ability to meet its obligations to policyholders.</p>									
<p><b>Financial Strength Ratings</b></p> <p>A Best's Financial Strength Rating (FSR) is an opinion of an insurer's ability to meet its obligations to policyholders.</p>									
	<b>Rating</b>	<b>Descriptor</b>	<b>Definition</b>						
<b>Secure</b>	A++, A+	Superior	Assigned to companies that have, in our opinion, a superior ability to meet their ongoing obligations to policyholders.						
	A, A-	Excellent	Assigned to companies that have, in our opinion, an excellent ability to meet their ongoing obligations to policyholders.						
	B++, B+	Very Good	Assigned to companies that have, in our opinion, a good ability to meet their ongoing obligations to policyholders.						
<b>Vulnerable</b>	B, B-	Fair	Assigned to companies that have, in our opinion, a fair ability to meet their current obligations to policyholders, but are financially vulnerable to adverse changes in underwriting and economic conditions.						
	C++, C+	Marginal	Assigned to companies that have, in our opinion, a marginal ability to meet their current obligations to policyholders, but are financially vulnerable to adverse changes in underwriting and economic conditions.						
	C, C-	Weak	Assigned to companies that have, in our opinion, a weak ability to meet their current obligations to policyholders and are financially very vulnerable to adverse changes in underwriting and economic conditions.						
	D	Poor	Assigned to companies that, in our opinion, may not have an ability to meet their current obligations to policyholders and are financially extremely vulnerable to adverse changes in underwriting and economic conditions.						
	E	Under Regulatory Supervision	Assigned to companies (and possibly their subsidiaries/affiliates) that have been placed by an insurance regulatory authority under a significant form of supervision, control or restraint whereby they are no longer allowed to conduct normal ongoing insurance operations. This would include conservatorship or rehabilitation, but does not include liquidation. It may also be assigned to companies issued cease and desist orders by regulators outside their home state or country.						
	F	In Liquidation	Assigned to companies that have been placed under an order of liquidation by a court of law or whose owners have voluntarily agreed to liquidate the company. Note: Companies that voluntarily liquidate or dissolve their charters are generally not insolvent.						
	S	Suspended	Assigned to companies that have experienced sudden and significant events affecting their balance sheet strength or operating performance and whose rating implications cannot be evaluated due to a lack of timely or adequate information.						
<p><b>Rating Modifiers and Affiliation Codes</b></p> <p>A rating modifier can be assigned to indicate that a Best's Rating may be subject to near-term change (under review), that a company did not subscribe to Best's interactive rating process (public data) and that the rating is assigned to a syndicate operating at Lloyd's. Affiliation codes (g, p, and r) are added to Best's Ratings to identify companies whose assigned ratings are based on group, pooling or reinsurance affiliation with other insurers.</p>									
	<b>Modifier</b>	<b>Descriptor</b>	<b>Definition</b>						
<b>Rating Modifiers</b>	u	Under Review	A modifier that generally is event-driven (positive, negative or developing) and is assigned to a company whose Best's Rating opinion is under review and may be subject to change in the near-term, generally defined as six months.						
	pd	Public Data	Assigned to insurers that do not subscribe to Best's interactive rating process. Best's "pd" Ratings reflect qualitative and quantitative analyses using public data and information.						
	s	Syndicate	Assigned to syndicates operating at Lloyd's.						
<p><b>Affiliation Codes</b></p> <table border="1"> <tr> <td>g</td> <td>Group</td> <td>p</td> <td>Pooled</td> <td>r</td> <td>Reinsured</td> </tr> </table>				g	Group	p	Pooled	r	Reinsured
g	Group	p	Pooled	r	Reinsured				
<p><b>Not Rated Categories (NR)</b></p> <p>Assigned to companies reported on by A.M. Best, but not assigned a Best's Rating. The five categories are:</p> <table border="1"> <tr> <td>NR-1: Insufficient Data.</td> <td>NR-2: Insufficient Size and/or Operating Experience.</td> <td>NR-3: Rating Procedure Inapplicable.</td> </tr> <tr> <td>NR-4: Company Request.</td> <td>NR-5: Not Formally Followed.</td> <td></td> </tr> </table>				NR-1: Insufficient Data.	NR-2: Insufficient Size and/or Operating Experience.	NR-3: Rating Procedure Inapplicable.	NR-4: Company Request.	NR-5: Not Formally Followed.	
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NR-4: Company Request.	NR-5: Not Formally Followed.								
<p><b>Rating Outlook</b></p> <p>Best's interactive Ratings (A++ to D) are assigned a Rating Outlook that indicates the potential direction of a company's rating for an intermediate period, generally defined as the next 12 to 36 months. Rating Outlooks, which appear in the rating rationale section of the company's Best's Company Report, are as follows:</p> <table border="1"> <tr> <td>Positive</td> <td>Indicates a company's financial/market trends are favorable, relative to its current rating level and, if continued, the company has a good possibility of having its rating upgraded.</td> </tr> <tr> <td>Negative</td> <td>Indicates a company is experiencing unfavorable financial/market trends, relative to its current rating level and, if continued, the company has a good possibility of having its rating downgraded.</td> </tr> <tr> <td>Stable</td> <td>Indicates a company is experiencing stable financial/market trends and there is a low likelihood that its rating will change in the near term.</td> </tr> </table>				Positive	Indicates a company's financial/market trends are favorable, relative to its current rating level and, if continued, the company has a good possibility of having its rating upgraded.	Negative	Indicates a company is experiencing unfavorable financial/market trends, relative to its current rating level and, if continued, the company has a good possibility of having its rating downgraded.	Stable	Indicates a company is experiencing stable financial/market trends and there is a low likelihood that its rating will change in the near term.
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Stable	Indicates a company is experiencing stable financial/market trends and there is a low likelihood that its rating will change in the near term.								
<p>Best's Ratings are distributed via press release and/or the A.M. Best Web site at <a href="http://www.ambest.com">www.ambest.com</a>, and are published in the <i>Rating Monitor</i> section of <i>BestWeek</i>®. Best's Ratings are proprietary and may not be reproduced without permission. Copyright © 2003 by A.M. Best Company, Inc. <span style="float: right;">Version 071503</span></p>									



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**Tab (c)**

The information in this Tab (c) responds to Item (c) of the Notice:

- “(c) identify the Plan’s [Capital BlueCross] funds dedicated, allocated or expended for charitable purposes in 2002 and 2003, and those planned for 2004 through 2006.”

### **CBC's Commitment to its Communities**

In Item (c) of the Notice, the Department asks CBC to identify the amount expended for "charitable purposes" in 2002 and 2003 as well as the amounts to be allocated for such purposes in the next few years. And, in its prior information request on January 5, 2004, the Department earlier sought a description of "social mission" activity in 2002 and 2003. Since CBC is not a charity and the term "charitable" is subject to misinterpretation, and since CBC's enabling act does not include a "social mission," CBC believes the best and most informative approach to these questions is to identify expenses incurred in fulfillment of CBC's statutory responsibilities under its enabling act, the Hospital Plan Corporation Act (40 Pa. C.S.A. § 6101 et seq.).

As a threshold matter, it is important to note that CBC has traditionally and voluntarily engaged in activities intended to benefit the residents of and the communities located within its 21-county service area. As explained in more detail below, we serve as an "insurer" of last resort, and we provide an individual (non-group) program that is not medically underwritten, in a market where few other insurers are even willing to enter. These activities are so much a fundamental part of what we do, that they are embedded in our regular business costs. For this very reason, it is difficult to present a fully comprehensive picture, and because these expenses are part of the fabric of our company, they should be viewed in that broad context.

### **CBC's Mission: Operating a Nonprofit Hospital Plan**

#### ***(i) Some Background***

CBC, like other Blue Cross Plans, was born in the Depression. The Blue Cross movement was grounded in the twin American principles of self-help and pragmatism.

Formed by local area hospitals (the founders included Carlisle Hospital, Harrisburg Hospital and the Harrisburg Polyclinic Hospital), CBC was established as a hospital plan corporation under the Hospital Plan Corporation Act. As such, CBC is engaged in the business of maintaining and offering a "nonprofit hospital plan," which is defined in the Act as:

A plan whereby for prepayment, periodical or lump sum payment hospitalization or related health benefits may be provided to subscribers to such plan. § 6101.

The nonprofit hospital plan serves as a prepayment mechanism for hospital care to mitigate the fear of unexpected hospital expenses for subscribers. Over the years, CBC has successfully provided this service to its communities and fulfilled its statutory purposes and responsibilities.

**(ii) CBC's Nonprofit Hospital Plan**

CBC operates its nonprofit hospital plan in a 21 county service area in Central Pennsylvania and the Lehigh Valley where it is licensed to operate as a Blue Cross plan by the Blue Cross and Blue Shield Association.

In connection with the operation of its nonprofit hospital plan, CBC has voluntarily undertaken activities intended to benefit the residents of its service area.

Among other things, CBC has historically and voluntarily assumed the role of "insurer of last resort" for residents of its service area (well before the advent of HIPAA requirements). That is, CBC has provided pre-paid access to hospitalization benefits (regardless of health status) to the non-group market. Since we began operating as a full-service health plan on April 1, 2002 — without our former business partner — CBC has continued its tradition of serving as "insurer of last resort" in the non-group market in conjunction with its wholly-owned subsidiary, CAIC.

Commercial health insurers have traditionally maintained the profitability of their health insurance in the non-group market by either refusing coverage for those Pennsylvanians with significant pre-existing health problems or charging significantly higher premiums; they have often structured rates in a manner such that they are higher based upon health status or age at the time of enrollment.<sup>22</sup>

CBC, on the other hand, has voluntarily offered coverage in the non-group market that is community rated (with no differential rating due to age or health status) and, through continuous open enrollment, has served all Pennsylvanians in Central Pennsylvania and the Lehigh Valley who desire such coverage.

In evaluating the expenses incurred by CBC in operating a nonprofit hospital plan and in fulfilling its statutory responsibilities, it is important to note that CBC has not generated a profit on any of its underwritten business (i.e., non-group, community rated, and experience rated) for many years. As noted by the President and Chief Executive Officer of CBC in his statement before the Insurance Commissioner on September 4, 2002:

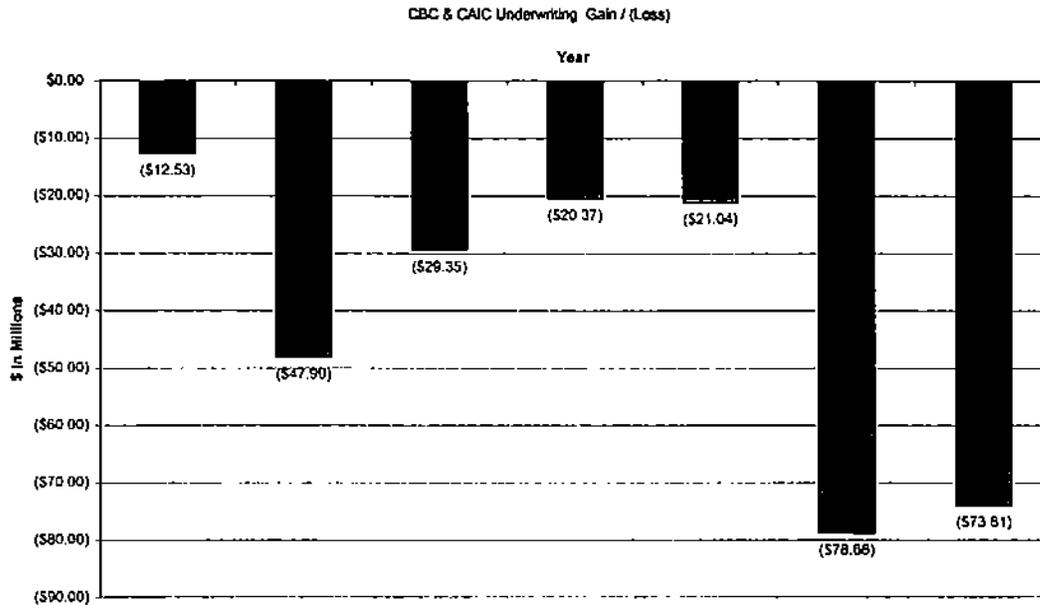
Thus, all unassigned reserves growth can be attributed solely to the earnings from our investment portfolio. Not one penny of premium dollar has gone into our reserves in the past six years.

To illustrate the point, set forth below is a chart (included in our prior filing) showing underwriting results for the past seven years:

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<sup>22</sup> It might be noted that the Department's current proposal for small group reform -- which has been shared with the Legislature -- would give for profit-insurers with less than 10% market share the statutory authority to medically underwrite.

## **Underwriting Losses: Capital BlueCross and Capital Advantage Insurance Company**



Recently, there has been an unprecedented escalation of health care costs nationwide and in Central Pennsylvania and the Lehigh Valley, and competition among payors has intensified. Particularly under these circumstances, CBC felt it was necessary to draw upon its investment income and surplus in an attempt to hold down the level of health care premiums for its subscribers.

In a very real sense, losses resulting from competitive pressures on CBC's nonprofit hospital plan are used in the promotion of health in our service area.

### **(iii) The Individual Market**

CBC's commitment to the individual market includes programs such as Direct Pay, Special Care, AdultBasic and CHIP.

The Direct Pay programs consist of various products offered to individual account subscribers in the non-group market, including Traditional, Comprehensive, Security (Medicare supplemental), HIPAA Eligible Comprehensive, and the Health Care Tax Credit Comprehensive (a program for displaced workers certified to receive certain Trade Adjustment Assistance benefits and for individuals who are receiving benefits from the Pension Benefit Guaranty Corporation).

The Special Care program offers affordable coverage with no deductibles to low-income individuals.

The adultBasic program offers basic insurance benefits to uninsured, low-income adult Pennsylvanians. The adultBasic enrollee is responsible for payment of a very modest premium (and although supported by the Commonwealth, even after government reimbursement, the program still generates a net loss).

The CHIP program offers comprehensive medical benefits (along with dental and vision) to uninsured, low-income children in Pennsylvania.

***(iv) Voluntary Activities***

CBC voluntarily provides financial and other assistance to organizations that promote health such as the Children's Miracle Network, the Salvation Army, Special Olympics, the American Red Cross, the American Diabetes Association, the Susan Byrnes Health Education Center and the United Way—just to name a few.

CBC also provides other voluntary assistance, financial and otherwise, to relieve poverty, advance education and otherwise benefit the community. Examples of these include, contributions to the Boys and Girls Club, the Hemlock Girl Scout Council, the Latin Alliance, the Whitaker Center, the YMCA/YWCA, Channels Food Rescue, the Allied Arts Fund, Big Brothers Big Sisters, Habitat for Humanity, and various colleges and universities.

An added element to our other voluntary activities are the numerous other efforts that we engage in that may relieve poverty, advance education, promote health, government or municipal purposes, and other purposes beneficial to the community that also arguably advance a business interest for CBC. Examples of these include sponsoring events for local Chambers of Commerce (Lancaster County Business Group on Health), partnering with economic development organizations (TeamPA), educational programs ("BrainBusters" and the "Great Teacher Award" program), local hockey and baseball teams, orchestras, theaters, foundations, associations and local public television. This includes assisting in various ways with fundraisers for these organizations.

***(v) Other Contributions to the Commonwealth***

CBC is exempt from payment of local property taxes to the municipalities in which CBC has facilities. Nonetheless, consistent with its voluntary community commitment, and in order to be a "good corporate neighbor" to the communities in which it is headquartered, CBC has voluntarily made payments in lieu of real estate taxes.

When assessing expenditures made by CBC in connection with the operation of its hospital plan, it is important to note that when CBC launched its full-service health plan, after consideration of available alternatives and after consultation with the Department, circumstances dictated that CBC use its existing licensed subsidiary, CAIC, to contract with professional providers and to underwrite medical surgical benefits. CBC's decision to use CAIC was prompted by the Department's traditional position that hospital plans like CBC are prohibited from contracting directly with professional providers and underwriting professional provider services and in light of the time-frames associated with any other alternative. Beginning on April 1, 2002, as a commercial insurer, CAIC began to pay the 2% premium tax on all business that CAIC underwrites. This generates significant amounts of revenue for the Commonwealth. In spite of this, our management and Board of Directors remain committed to ensuring a level of voluntary community commitment consistent with and even exceeding that of prior years.

In addition, CBC' subsidiaries paid various taxes (depending upon the particular subsidiary, capital stock taxes, sales and use taxes, and state income taxes).

(vi) **Expenditures in 2002 and 2003**

Set forth below is a chart of the foregoing expenditures in 2002 and 2003.

We first identify consolidated underwriting losses. We then separately identify those losses incurred for the individual (direct pay) market because of the importance of making quality health insurance available to this segment of our population. We also list amounts spent for voluntary activities undertaken for the benefit of the communities in our service area as well as other contributions made to the Commonwealth.

<b>CBC's Voluntary Community Commitment</b>	<b>Amount Spent 2002</b>	<b>Amount Spent 2003</b>
1. Total Underwriting Losses by CBC and CAIC	(\$78,661,655)	(\$73,810,000)
2. Underwriting Losses in the Individual Market (included in 1 above)	<del>INFORMATION INTENTIONALLY OMITTED</del>	<del>INFORMATION INTENTIONALLY OMITTED</del>
3. Voluntary Activities <sup>23</sup>	(\$1,148,800) <sup>24</sup>	(\$1,168,388)
4. Other Contributions to Commonwealth (State, Federal, Local and Premium Tax) <sup>25</sup>	(\$8,015,112)	(\$24,616,191)

Projections for 2004 through 2006

In the upcoming years, CBC anticipates supporting our past efforts in the individual market, voluntary activities and other contributions to the Commonwealth consistent with and even exceeding our efforts in previous years. In spite of the general economic downturn and in spite of CBC's inability (due to market conditions) to generate underwriting gains, and absent unforeseen circumstances that may warrant a reconsideration, CBC presently plans on increasing our commitment to these voluntary activities by approximately 5% over the next three years (2004, 2005 and 2006).

Further, CBC's management and Board of Directors has under consideration funding a number of special projects that would accomplish significant steps towards the advancement of education and the promotion of health for our communities. The projects under consideration, when finalized, would increase the amount committed to voluntary community education and health-related purposes by well over \$1,000,000.

As indicated in our response to Item (d), the Department's failure to approve increased rates for individual (non-group) programs is resulting in losses of nearly \$1,000,000 per month. Of course, this significantly increases our commitment to the Individual Market. At the same it may require us to reduce expenditures in other areas of benefit to our communities, and it forces us to reduce our surplus at a rate in excess of our prior projections.

<sup>23</sup> Does not include KHPC.

<sup>24</sup> An approximation based upon 2003 activities.

<sup>25</sup> Does not include KHPC.

Our projections for 2004 through 2006 may be re-assessed depending upon the amount of any losses resulting from competitive pressures and increased provider costs facing the operation of CBC's nonprofit hospital plan.

CBC's management and Board of Directors are able to continue these voluntary contributions to our communities during these difficult economic times because we have been strong stewards of our assets over the last 65 years. To a very large extent, our ability to continue these commitments resulted from the decision to build a strong and economically viable company. If for any reason CBC's ability to plan for the future and to control the strategic use of its capital and surplus is restricted by the Department, we could be forced to reduce the scope of these commitments.

**Tab (d)**

The information in this Tab (d) responds to Item (d) of the Notice:

- “(d) provide 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.”

### CBC's Capital and Surplus are Adequate, But Not Excessive

The management and Board of Directors of CBC have concluded that the capital and surplus currently held is adequate, but not excessive, taking into consideration our current obligations, the need for flexibility to meet unforeseen contingencies and future business plans.

We arrived at that conclusion after considering various quantitative and qualitative factors that we believe need to be evaluated as part of a dynamic exercise and taking into consideration the matters more particularly discussed in our response to Item (b) of this Application. In brief summary, such factors include:

- The need for adequate funds to ensure that claims of members, participating providers and vendors are timely paid, particularly considering that CBC is not permitted to participate in the Pennsylvania Guarantee Fund.
- The need for funds to meet unforeseen contingencies such as large, unanticipated increases in utilization of health services arising out of epidemics, terrorist threats and other catastrophes.
- The limited ability on the company's part to access capital markets to fund the growth and development of new products and services, new infrastructure (such as investment in new claims processing, data and telephone systems, and developing new operating facilities).
- The fact that our company can only look internally to meet anticipated capital needs.
- CBC's unique status as the "insurer of last resort" for non-group coverage and the financial consequences of serving in this position.
- The desire on CBC's part to continue offering non-group (direct pay) programs at affordable rates for individual subscribers residing in our service area.
- The failure on CBC's part to generate underwriting profits for the past seven years.
- The new and fiercely competitive level of competition in CBC's market -- competition with CBC's former business partner<sup>26</sup> as well as new, well funded entrants in CBC's service area.

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<sup>26</sup> In a Standard & Poors Ratings Direct Research Report published August 12, 2003, Standard & Poor's rates our former business partner and now competitor and includes the following statement in its description of "Major Rating Factors" notes: "Competition is expected to remain fierce in the region where Highmark and Capital BlueCross have been competing on price." Steven Ader & Jacob L. Schlanger, Research: Summary: Highmark Inc. (d/b/a Highmark BCBS & Highmark Blue Shield), Standard & Poor's Ratings Direct (Aug. 12, 2003).

- The demographics of the market (reflecting an aging population that draws heavily upon health care resources).
- The growing volatility of health care costs.
- A restrictive regulatory environment (which has impeded CBC's ability to flexibly and quickly adjust to changing market conditions).<sup>27</sup>
- The importance the company places on providing continued, uninterrupted coverage to its customers, even in the most turbulent times and even after a catastrophic event.
- A variety of other economic and industry variables.

In further support of this conclusion, we have attached as Exhibit (d)-1 a report prepared by Douglas B. Sherlock, CFA of Sherlock Company, further documenting the particular risks facing CBC and its policyholders and explaining the importance of reserves and surplus for CBC and its policyholders at this point in CBC's history.

As indicated by the President and Chief Executive Officer of CBC in his testimony before the Insurance Commissioner on September 4, 2002:

Pennsylvanians know they can always count on the Blues to be there when they need them. We believe we have an obligation to conduct our affairs in a manner that assures we will never forsake that trust. In essence we must, through good times and bad, ensure that the medical expenses of individuals we insure are covered. We must be able to do this regardless of medical inflation, government mandates, catastrophic events or any of a host of other issues. It is our contractual responsibility and our goal to provide this service year in and year out. Our reserves are one of the prime ways we ensure we will always be able to full our trust with our customers.

#### How our Surplus Developed

Beginning in 1992, CBC began a multi-year effort to rebuild a capital and surplus base that had been severely depleted over the prior half decade. From 1987 through 1991, CBC experienced cumulative underwriting losses of \$178 million. These losses were the result of unprecedented increases in health care costs experienced throughout the

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<sup>27</sup> In a March 1, 2004 article in Business Wire concerning A.M. Best's downgrade of the financial rating of our former business partner and now competitor, one of the reasons given for the downgrade is as follows: "Pennsylvania's insurance regulator will scrutinize Highmark's surplus and reserve levels and quality any excess by mid-2004. Any resulting surplus and claim reserve caps and mandated policy holder refunds could hinder Highmark's -- and the other not-for-profit Blue plans' -- ability to weather any softening of the pricing market for health insurance products, as well as an equity market downturn and/or deterioration in the credit market, should they occur. The regulator's analysis -- and resulting mandate -- would not apply to the commonwealth's for-profit health underwriters, **potentially placing the Blues at a financial strength disadvantage.**" (Emphasis supplied.) A.M. Best Affirms Majority of Highmark's Financial Strength Ratings; Affirms Debt Rating and Revises Both Outlooks to Negative, Business Wire (March 1, 2004).

country as well as the refusal on the part of the Department to approve requested increases in rates to offset these costs.

As a result, at the end of 1991, CBC found itself with only \$124 million of capital and surplus. This amounted to only 1.5 months of claim reserves<sup>28</sup>—a financial position deemed to be precarious and inconsistent with management's and our Board of Director's goal to be a strong and secure financial institution—ready to meet virtually all needs of our subscribers, providers and other stakeholders. At the time we were being formally monitored by both the BCBSA and the Department.

The 1990's brought with it many favorable trends that allowed CBC to build its capital and surplus to a strong and secure position: appropriate rate increases to stem the huge losses we experienced in our direct pay products, a leveling off of the trend in medical costs as the concepts of "managed care," utilization review" and "cost containment" impacted the marketplace, very favorable investment markets that produced historically high returns on our investment portfolio, and a voluntary hold on significant capital investments in systems development and numerous other initiatives while CBC undertook a lengthy and diligent process to determine its long-term future through evaluation of a number of different partnership, merger and acquisition possibilities. After several years, in large part as a result of this process, but also because of the actions of our former business partner, CBC determined to remain independent and to launch a full-service health plan focusing on the needs of Central Pennsylvania and the Lehigh Valley. This decision necessarily took into account the availability of surplus to fund the needed infrastructure investment for our new business enterprise.

The growth in our surplus, however, was not achieved "on the backs" of our subscribers. In fact, since 1991, CBC has had a cumulative underwriting loss of approximately \$40 million. Furthermore, we have had year after year of underwriting losses since 1997, forcing us to draw upon our surplus and investment income. Our losses since our break up with our former business partner have been especially large as we were forced to expedite the development of new systems, products and networks, which had been deferred during the 1990's. In addition, the new millennium brought a resurgence of extraordinary increases in medical costs as managed care and other cost containment activities became less popular at the same time as new (and expensive) technologies became more mainstream as well as huge increases in the cost of pharmaceuticals.

All of these factors have resulted in a significant depletion of our capital and surplus base and are expected to continue to negatively impact our financial position for the next few years.

#### Community Commitment

In CBC's response to Item (c) of this Application, CBC identifies past and projected expenditures for those voluntary activities undertaken for the benefit of the residents of its service area. Increases in such expenditures for the years 2004 through 2005 are not reflected in the confidential Business Plan described below.

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<sup>28</sup> RBC for Health Plans was not introduced until 2000.

It is important to note, in evaluating these types of expenditures that CBC is governed by the Hospital Plan Corporation Act and, under that Act, operates a nonprofit hospital plan. The Act does not include any reference to a "social mission." While CBC's Board of Directors has voluntarily undertaken a number of commitments for the benefit of the residents of and communities located within CBCs' 21-county service area, CBC is not a "charity" and has never operated as such. By law, CBC cannot accept donations, and we must pay taxes – in fact as shown in the chart in the response to Item (c) above, we paid substantial amounts in Federal, State, Local and Premium taxes in the last two years.

#### Confidential Business Plan

When CBC was considering evolving into a full-service, fully integrated health plan in the fall of 2001, the Department requested CBC to submit a business plan. The plan was requested in order to satisfy concerns, repeatedly expressed by the senior members of the Department, that CBC's projected surplus levels would be sufficient for CBC to compete against its former business partner and others in Central Pennsylvania and the Lehigh Valley. The concerns a short two years ago **were not that CBC had too much surplus, but rather, whether it had enough** to effectively compete against its former business partner as well as other strong competitors in Central Pennsylvania and the Lehigh Valley.

We are deeply concerned in that CBC relied on the Department's review of that business plan and its understanding of our business needs going forward. We have already invested significant funds in developing infrastructure and have planned for significant additional expenditures on the assumption that our surplus would be available to fund such expenditures. Indeed, as should be obvious, our very decision in 2001 to **remain an independent health plan and to launch our new business enterprise as a stand-alone, full-service health insurer committed to the residents of Central Pennsylvania and Lehigh Valley as our exclusive focus (rather than merge into a larger, multi-state consolidator) was based upon this assumption.** Continued availability of our surplus is, in fact, essential for successful implementation of the business plan.

Attached as Exhibit (d)-1 is a copy of the confidential business plan submitted in September of 2001.

**CONFIDENTIAL**  
INFORMATION INTENTIONALLY OMITTED

In fact, we believe that the resulting surplus reductions we expect to realize in the next year cannot be sustained and have us remain a competitive force in this marketplace. In selecting carriers, certain major customers in CBC's service area place significant

emphasis on how well carriers have demonstrated financial stability as shown by the ratings published by independent rating agencies such as A.M. Best (indeed, some customers prefer doing business with insurers that have the higher ratings from A.M. Best). This past year we received a public information rating from Best of B++ and, in view of our 2003 operating losses, continuing competitiveness in our marketplace and the poor regulatory environment that exists in Pennsylvania, there could be further downgrade.

We are quickly approaching a point where we will no longer be able to carry the significant underwriting losses we have sustained in the past few years as we are being doubly impacted by not only surplus reductions, but also the loss of related investment income. Further, the Department's refusal to approve requested rate increases for our individual products will only result in much larger increases in the future in order to bring these products up to an acceptable level.<sup>29</sup>

### Conclusions

**First**, CBC does not have excess surplus. CBC has an approximate level of surplus commensurate with prudent management. The Notice only requests a plan for reducing excess surplus to the extent that CBC has excess surplus and, therefore, CBC was not required to submit such a plan and has not submitted such a plan in this Application.

**Second**, we do not believe the Department's authority to regulate surplus gives it the authority to require us to submit a proposed business plan for purposes of distributing any alleged excess surplus to third parties.

**Third**, we do not believe the Department has the authority to distribute or to require us to distribute "excess" surplus, if any, to anyone, including but not limited to plan participants and the Commonwealth's underinsured and uninsured citizens.

**Fourth**, we do not believe surplus can or should be calculated on a static basis by using such formulas as RBC.

**Fifth**, we believe that in the normal course of business, CBC's surplus will be reduced in the near-term.

**Sixth**, CBC has fully explained how its current level of surplus is consistent with both its current requirements and with the plan that it proposed to the Department in 2001 in light of the Department's concerns about the termination of the Joint Operating Agreement. There is no basis on which to conclude that the judgments of the Board of Directors in this regard in 2001 or now and the judgment of the Department in 2001 should be disturbed.

**Seventh**, we do not believe the Department can use RBC to measure excess surplus or to force CBC to select a maximum RBC ratio selected from the range suggested in the Notice.

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<sup>29</sup> Capital calculates that the Department's failure to approve increased rates for individual non-group products is resulting in losses of nearly \$1,000,000 per month.

**Economists Report**

# The Challenge of Capital for CBC

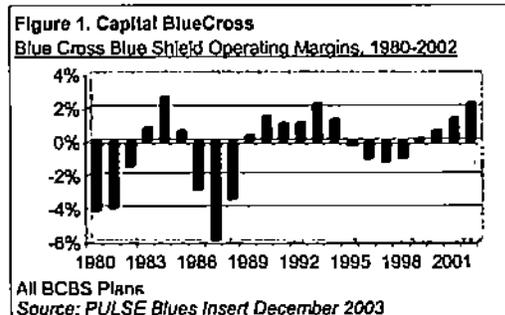
*The amount of capital held should reflect not only the measured amount of risk, but also an adequate "cushion" above that amount to take account of potential uncertainties in risk measurement.*

Supervision and Regulation Letter  
SR 99-18 (SUP)  
July 1, 1999  
Division of Banking  
Supervision and Regulation  
Board of Governors of the Federal Reserve System

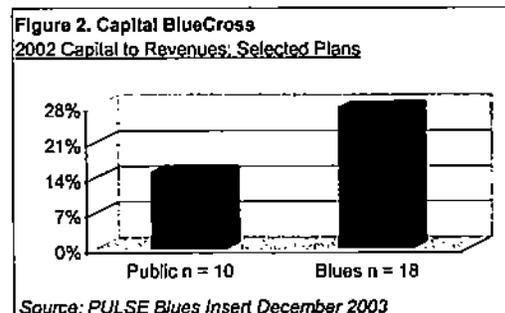
Capital for health plans must be sufficient to operate safely for current members and adequate to support competitive strategies, such as growth, which benefit consumers. Capital BlueCross' (CBC) capital needs are larger because of its non-profit heritage, its status under federal tax law, the riskiness of its business, the highly competitive nature of its market, the presence of new, well-funded entrants and the heightened capital needs in this increasingly information system-intensive industry.

## 1. CBC is non-profit, not owned by investors. Capital is hard to raise and retain for such plans.

CBC is a non-profit health plan, and is not owned by investors. Accordingly, it has less access to capital since equity offerings are unavailable. Moreover, over the longer term, it has less flexibility in its capital structure: Unlike public companies, it is unable to return capital to its owners knowing that, should need arise, it may go back to them to raise more equity.



This means that CBC's only source of equity must come from internal sources, such as profits. Moreover, since profitability trends for health plans are volatile, profits must be stockpiled in profitable years to maintain safe operations in unprofitable years. Figure 1 illustrates the cyclical nature of health plan operations among Blue Cross Blue Shield Plans.



For-profit health plans have strategies available to them that are generally not

available to Blue Cross Blue Shield Plans. As shown in Figure 2, public companies generally operate with far lower levels of equity than their counterpart Blue Cross Blue Shield Plans. In the aggregate for-profit health plans have raised \$4.7 billion in the equity markets since 1987. This is not an alternative available to CBC.

At the local level, this difference is also apparent. In California, a publicly-traded Blue Cross Blue Shield Plan competes with an independent non-profit Blue Cross Blue Shield Plan, providing a unique insight to the differences in capital structure required of these types of Plans, while making it possible to hold constant the effects of the Blue identity.

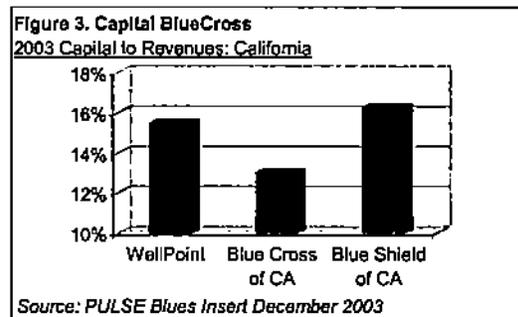
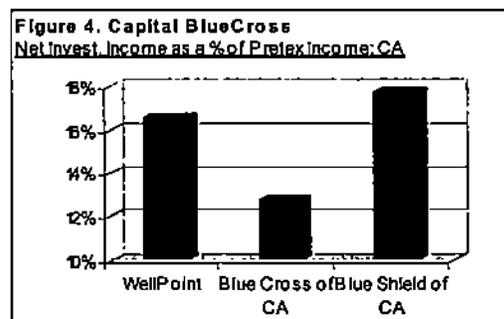


Figure 3 shows that in California, Blue Cross of California, a subsidiary of publicly traded WellPoint, operates with less equity to operating revenues compared to its non-profit competitor Blue Shield of California. The three percentage point difference in this ratio between Blue Cross of California and Blue Shield of California highlights the fact that non-profit health plans must accumulate internally generated equity to a greater extent than that of publicly-traded plans because external financing through capital markets is not an option for non-profit plans. Put a different way, non-profit Blue Shield has 25% more capital per dollar of revenues than for-profit Blue Cross.

The same need to operate at high levels of capital is also apparent in the proportion of income that must be generated from non-profits' investment portfolio. Figure 4 illustrates that the non-profit in California is far more dependent on its investment portfolio than is its for-profit counterpart. For non-profit plans, higher proportions of investment income to pretax income offer protection by providing a significant, stable cash flow stream that can be used to continue operations and sustain capital levels during unprofitable years, especially since external equity financing is unavailable.

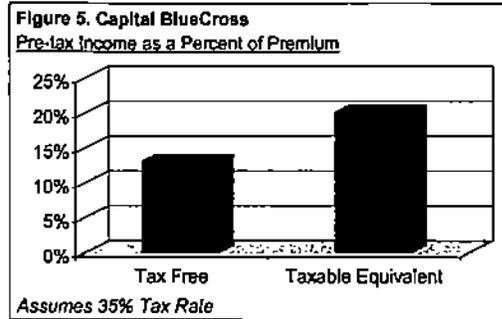


**2. CBC, as a taxable non-profit, has diminished abilities to retain earnings, even when it is profitable.**

Like many Blue Plans, CBC is in a paradoxical situation with respect to its ability to maintain adequate capital. On one hand, as a non-profit, it may not employ the capital markets to raise equity capital. On the other hand, under changes in federal tax laws in the late 1980's, it is effectively fully taxable, like for-profit health plans. In other words,

CBC lacks both the ability to raise capital in the public equity markets, while having diminished ability to retain its earnings because it is subject to federal income taxes.

The implications of this are seen in Figure 5. A health plan in CBC's circumstances must operate at far higher profit margins than would be the case if it were tax exempt. This need is especially critical since the health plan business is highly volatile.



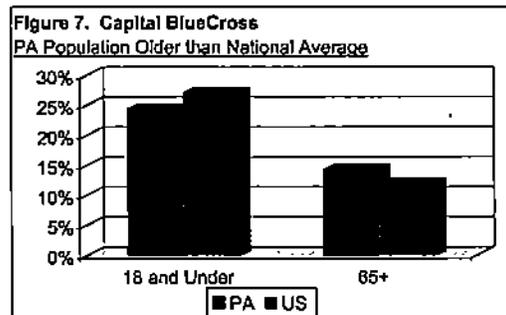
**3. CBC is engaged in an intrinsically risky business, health coverage in Pennsylvania. It is inherently more capital-intensive owing to high and volatile health care costs.**

Health care is more expensive in Pennsylvania. The best available information, from the Kaiser Family Foundation, presented in Figure 6, illustrates that Pennsylvania ranked eighth in the nation in its per capita cost, 11% higher than the U.S. average. Other health care metrics, including admissions per thousand, E/R visits per thousand and prescriptions per capita are also much higher.

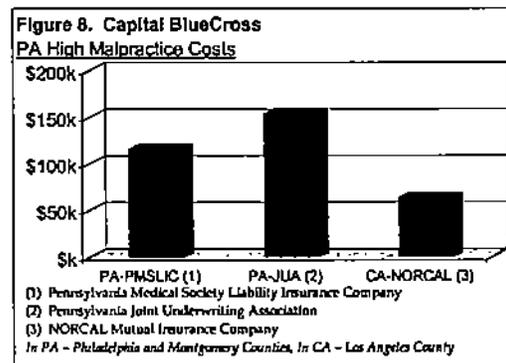
**Figure 6. Capital BlueCross**  
PA Costs Tend to be High

	PA	US	PA Rank
1998 Health Spending per Capita	\$4,168	\$3,759	8
Hospital Admissions/1000	147	119	6
ER Visits / 1,000	396	371	18
Prescriptions per Capita	12.2	10.6	9

Figure 7 illustrates one reason why this is the case. Pennsylvanians are older than most Americans, with a smaller proportion of young people and a larger proportion of seniors than the United States as a whole.



Another factor contributing to high health care costs is malpractice costs. According to the Pennsylvania Medical Society, malpractice insurance premiums average two to three times that of comparable insurance in California. Figure 8 illustrates this. Malpractice premiums understate the effect of high malpractice costs since it is probable that a more aggressive, defensive style of medicine accompanies this insurance environment.



Also, anecdotal evidence suggests that it is more difficult for health plans in

Pennsylvania to negotiate with hospitals than in other markets. This is not only the case in rural hospitals but also in geographically complex markets. This is significant in that the ability of a health plan to reduce the costs of health care is dependent on its bargaining power. To the degree that hospitals possess effective monopoly power, health plans are unable to negotiate lower costs.

Finally, health care inflation is high and volatile. These two factors create an unusually high need for capital to operate safely. Figure 9 shows that health care inflation is higher than inflation for all items in the Consumer Price Index.

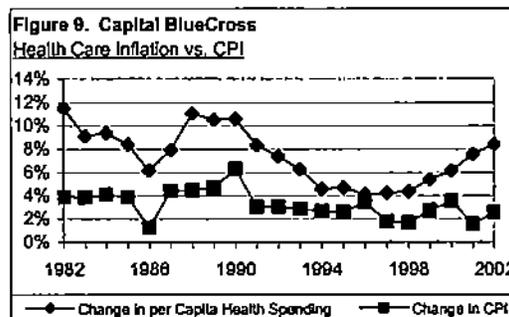
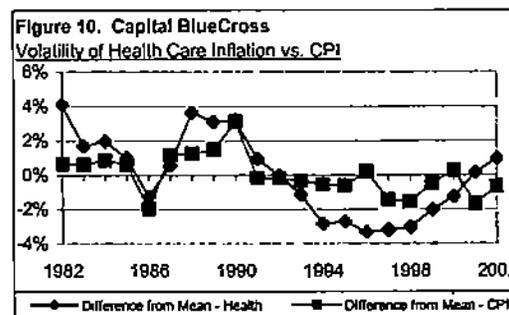


Figure 10 illustrates the volatilities of health care inflation and general inflation: It is not only more volatile but evidently getting more so. In the period from 1982 to 1992 the average spread between the difference from the mean for health care inflation and the difference from the mean for CPI was 1.2 percentage points. After 1992 the average spread widened to 1.9 percentage points.

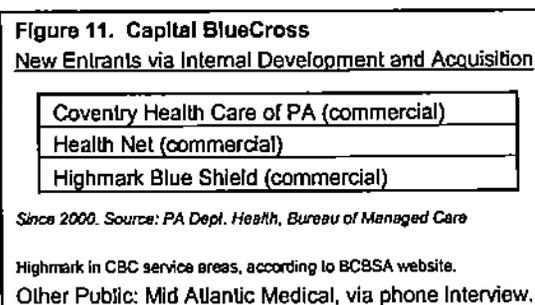
**4. CBC, along with other Blue Cross Blue Shield Plans in Pennsylvania, operates with unique competitive pressures, increasing its need for capital.**



Since, unlike most states, Pennsylvania Blue Plans compete with each other with branded and unbranded products, they lack the valuable differentiating attribute of the exclusive right to employ the Blue name and mark. In other words, while a respected brand, like Blue Cross or Cadillac, would be expected to mute the effects of competitive pressures, this protection is unavailable to CBC since it competes with Highmark Blue Shield in its service area.

**5. CBC faces tough new competition, necessitating more capital.**

In recent years, CBC has faced new competitive challenges. These include new health plans entering CBC's principal service areas in central Pennsylvania and the Lehigh Valley, including both Highmark and public companies.

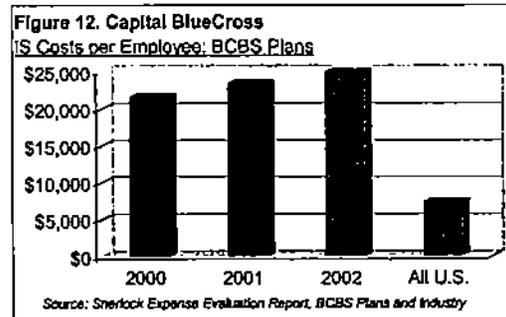


Coventry's success, through both internal growth and acquisition, and the termination

of the Joint Operating Agreement with Highmark are among the most significant changes. CBC operates in one of the few areas nationally in which more than one Blue Plan compete in the same market. Mid Atlantic Medical, recently acquired by the giant UnitedHealth Group system, now offers its products in both York and Harrisburg.

**6. CBC, like other health plans, has significant needs for investment in information systems.**

Blue Cross Blue Shield Plans' average Information Systems (IS) costs of \$24,873 per employee annually, which is over three times as high, as compared with approximately \$7,342 per employee (based on industry sources) for U.S. companies as a whole. The high costs of information systems stem from the intensive transactions and member service requirements of health plans. Consumer-directed health care and other products demanded by consumers require significant investment. In addition, members, employers and providers increasingly demand simplified processing of enrollment, claims and other transactions, often employing internet-based solutions, which requires additional investment.



Investments in information systems costs, while crucial to CBC's long-term success, are frequently expensed because of the hard-to-estimate expected life of these expenditures. Similarly, it is also notable that such investments as are capitalized are of little value for statutory reporting purposes.

Moreover, it appears that information systems expenses are increasing rapidly. Among Blue Cross Blue Shield Plans IS costs per employee increased by 8.61% in 2001, from \$21,525 to \$23,340. Information Systems costs per employee increased 6.39% in 2002 to \$24,874.

**7. A determination of the appropriate amount of capital requires consideration of objective and subjective factors.**

The amount of equity necessary for safe operation and growth depends on the riskiness of the CBC's business. This should be estimated through a variety of quantitative and qualitative means including modeling and or simulation.

*Institutions should be able to demonstrate that their approach to relating capital to risk is conceptually sound and that outputs and results are reasonable. Sensitivity analysis of key inputs and peer analysis could be used by an institution in assessing its approach.*

SR 99-18 (SUP)

**2001 Confidential Business Plan**



# Capital BlueCross

March 22, 2004

Stephen J. Johnson  
Deputy Commissioner  
Office of Corporate and Financial  
Regulation  
Commonwealth of Pennsylvania  
Insurance Department  
1326 Strawberry Square  
Harrisburg, PA 17120

Randolph L. Rohrbaugh  
Deputy Commissioner  
Office of Insurance Product Regulation and  
Market Enforcement  
Commonwealth of Pennsylvania  
Insurance Department  
1326 Strawberry Square  
Harrisburg, PA 17120

Re: Request for Confidential Treatment of Information

Dear Messrs. Johnson and Rohrbaugh:

Attached is one complete copy of Capital BlueCross' response to the January 5, 2004 request by the Pennsylvania Insurance Department ("PID") for certain information, together with one copy redacted to eliminate confidential information. Also attached is an electronic version of the complete and redacted copies of our response.

We are requesting confidential treatment of the chart of losses on page 13. Such information is not publicly available, and its disclosure could be advantageous to competitors.

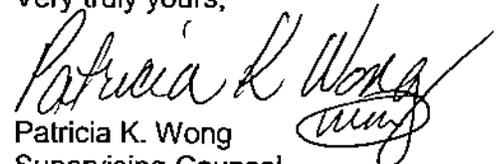
In accordance with the PID's instructions, we have stamped the chart on page 13 as "Confidential;" and we have omitted the text of the chart in the redacted copy (indicating that such information has been intentionally omitted).

You may direct any inquiries regarding the issue of confidential treatment to the undersigned (717-541-7277).

Our separate cover letter indicates that we are submitting our response without waiver of any objection to this proceeding.

Please contact me if you have any questions.

Very truly yours,

  
Patricia K. Wong  
Supervising Counsel

CBC 00093



## Capital BlueCross

REDACTED COPY

March 22, 2004

Stephen J. Johnson  
Deputy Commissioner  
Office of Corporate and Financial  
Regulation  
Commonwealth of Pennsylvania  
Insurance Department  
1326 Strawberry Square  
Harrisburg, PA 17120

Randolph L. Rohrbaugh  
Deputy Commissioner  
Office of Insurance Product Regulation and  
Market Enforcement  
Commonwealth of Pennsylvania  
Insurance Department  
1326 Strawberry Square  
Harrisburg, PA 17120

Dear Messrs. Johnson and Rohrbaugh:

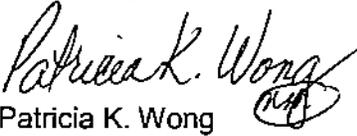
By means of a Notice published in the Pennsylvania Bulletin on January 16, 2004 ("Notice"), the Pennsylvania Insurance Department ("PID") directed Capital BlueCross (sometimes referred to as "Capital" or "CBC") and the other Blue Plans to make application on or before April 15, 2004 for approval of the reserves and surpluses they maintain under their respective enabling acts.

In addition, in a letter dated January 5, 2004 ("Letter") to the President and Chief Executive Officer of Capital BlueCross, the PID requested submission of certain additional information to be provided on or before March 22, 2004.

Without waiver of any objection to this proceeding by Capital (including, without limit, Capital's objection to the use of RBC for purposes of establishing maximum surplus for Capital or that the Notice is a de facto regulation that is invalid since it was not promulgated pursuant to the Commonwealth Documents Law), and in reliance upon the representations made at the March 17, 2004 preliminary injunction hearing by the PID's witness and counsel before the Honorable Dan Pellegrini in the Commonwealth Court of Pennsylvania, Capital submits its response to the Letter. Capital's response to the information requested is set forth in Tabs (a) through (e) that correspond to the Department's lettered requests. This response to the Department's request for information is not intended to be, nor shall it be deemed, an admission that such information is relevant to a determination of excess surplus.

Please contact me if you have any questions.

Very truly yours,

  
Patricia K. Wong  
Supervising Counsel

CBC 00094

**Tab (a)**

The information in this Tab (a) responds to the following request:

- (a) For CBC and each insurance subsidiary, an independent actuarial review and certification of all claims unpaid, accrued medical incentive pool and bonus payments, unpaid claims adjustment expenses, aggregate policy reserve, aggregate claim reserves, and accident and health premiums due and unpaid/premiums received in advance/unearned premiums posted to the companies' statutory annual statements for 2003, and such related accounts on the life and property & casualty annual statement blanks, in order to assess the statement of reserves, surplus and RBC ratios. The independent actuary must be contracted to derive a point estimate for each of these items. The point estimate shall be a "best" estimate. As such, the point estimate is to be neither excessive nor deficient. The independent actuary will be required to document these estimates and findings with a consolidated actuarial report sufficient to allow another actuary to reproduce and verify the conclusions. This consolidated documentation will include and detail, *inter alia*, all data, assumptions, representations and analyses relied upon to derive the point estimate and to conclude that it was a "best estimate." The independent actuary must also find, for each parent and insurance subsidiary, each reinsurance contract transfers risk, and if such contract is with an affiliate, the terms are fair and reasonable. CBC's selection and retention of the independent actuary will be at CBC's expense, and subject to the Department's approval.

Response to Item (a)

As the PID is aware, Capital has engaged John Stenson, a Principal with Deloitte & Touche LLP, to perform an independent actuarial review and issue an opinion on certain balances contained in the December 31, 2003 Annual Statement for Capital, Capital Advantage Insurance Company ("CAIC") and Keystone Health Plan Central ("KHPC"). Specifically, each opinion will address the following items:

- Claims Unpaid (Page 3, Line 1)
- Unpaid Claims Adjustment Expenses (Page 3, Line 3)
- Aggregate Policy Reserves (Page 3, Line 4)

Mr. Stenson will also address the transfer of risk in KHPC's 2003 reinsurance agreement with Highmark Inc. and the fairness and reasonableness of the terms of such agreement.

In addition, we have engaged Ernst & Young LLP to provide an "agreed upon procedures" report that will address the non-actuarial balances specified in Item (a) of the PID's January 5, 2004 letter. Specifically, Ernst & Young LLP will report on the following items included in the December 31, 2003 Annual Statement of each entity:

- Accident and Health Premiums Due and Unpaid (Page 2, Line 12.1)
- Premiums Received in Advance (Page 3, Line 8)

Note that none of the companies carry a balance for the following Annual Statement captions:

- Accrued Medical Incentive Pool and Bonus Payments (Page 3, Line 2)
- Aggregate Claim Reserves (Page 3, Line 7)

Neither Deloitte & Touche LLP nor Ernst & Young LLP have completed the above-mentioned reports. We expect to file these reports with the PID no later than April 15, 2004. However, in the interim, we are submitting on behalf of Capital, CAIC, and KHPC each entity's audited statutory financial statements for the year ended December 31, 2003 and 2002, as well as actuarial opinions issued by Ernst & Young LLP as of December 31, 2003. The foregoing financial statements and actuarial opinions are attached as Exhibits (a)-1, (a)-2 and (a)-3 to this response to Item (a).

Please note that the audited statutory financial statements are consistent with the respective 2003 annual statements filed with the PID on or about March 1, 2004 and specifically state each of the balances enumerated above.

Capital BlueCross

Audited Statutory-Basis Financial Statements  
For the Year Ended December 31, 2003 and 2002  
together with Actuarial Opinion issued by  
Ernst & Young LLP as of December 31, 2003

CAPITAL BLUE CROSS

Statutory-Basis Financial Statements and Supplemental Schedules

Years ended December 31, 2003 and 2002 with Report of Independent Auditors

# Capital Blue Cross

## Statutory-Basis Financial Statements and Supplemental Schedules

Years ended December 31, 2003 and 2002

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## Report of Independent Auditors

Board of Directors  
Capital Blue Cross

We have audited the accompanying statutory-basis balance sheet of Capital Blue Cross (the Company) as of December 31, 2003, and the related statutory-basis statements of operations, changes in unassigned funds and cash flow for the year then ended. These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements based on our audit. The statutory-basis financial statements of the Company for the year ended December 31, 2002 were audited by other auditors whose report dated May 15, 2003 expressed an unqualified opinion on those statements as to a comprehensive basis of accounting other than accounting principles generally accepted in the United States.

We conducted our audit in accordance with auditing standards generally accepted in the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audit provides a reasonable basis for our opinion.

As described in Note 2, the accompanying financial statements have been prepared in conformity with accounting practices prescribed or permitted by the Pennsylvania Insurance Department, which is a comprehensive basis of accounting other than accounting principles generally accepted in the United States.

In our opinion, the 2003 financial statements referred to above present fairly, in all material respects, the financial position of Capital Blue Cross at December 31, 2003 and the results of its operations and its cash flow for the year then ended, in conformity with accounting practices prescribed or permitted by the Pennsylvania Insurance Department.

Our audit was conducted for the purpose of forming an opinion on the December 31, 2003 statutory-basis financial statements taken as a whole. The accompanying summary investment schedule and schedule of investment risk interrogatories are presented to comply with the National Association of Insurance Commissioners' Annual Statement Instructions and the National Association of Insurance Commissioners' Accounting Practices and Procedures Manual and are not a required part of the December 31, 2003 statutory-basis financial statements. Such information has been subjected to the auditing procedures applied in our audit of the December 31, 2003 statutory-basis financial

statements and, in our opinion, is fairly stated in all material respects in relation to the December 31, 2003 statutory-basis financial statements taken as a whole.

This report is intended solely for the information and use of the Company and the Pennsylvania Insurance Department and is not intended to be and should not be used by anyone other than these specified parties.

*Ernst + Young LLP*

March 12, 2004

CBC 00101

## Capital Blue Cross

### Balance Sheets – Statutory Basis

	December 31	
	2003	2002
	<i>(In Thousands)</i>	
<b>Admitted assets</b>		
Cash and short-term investments	\$ 42,103	\$ 74,253
Bonds	332,539	357,475
Preferred stocks	803	4,997
Common stocks—unaffiliated	131,353	106,640
<b>Accounts receivable:</b>		
Accident and health premiums due and unpaid	2,151	4,357
Health care receivables	36,218	42,729
Investment income due and accrued	4,132	4,700
Amounts due from subsidiaries and affiliates	26,018	34,225
Amounts receivable relating to uninsured accident and health plans	5,506	5,490
Due from other plans	19,153	27,154
Premium call receivables	3,427	7,066
<b>Total accounts receivable</b>	<b>96,605</b>	<b>125,721</b>
Investment in subsidiaries and affiliates	64,476	24,760
Investment in joint ventures	21,298	98,514
Other long-term invested assets	158,288	170,482
Net deferred tax asset	—	15,547
Advance deposits	747	1,856
Electronic data processing equipment and software	3,317	4,490
Real estate	28,580	25,200
Goodwill	9,822	—
Other	729	8,413
<b>Total admitted assets</b>	<b>\$ 890,660</b>	<b>\$ 1,018,348</b>

	December 31	
	2003	2002
	<i>(In Thousands)</i>	
<b>Liabilities and unassigned funds</b>		
Liabilities:		
Claims unpaid	\$ 73,597	\$ 198,884
Unpaid claims adjustment expenses	2,206	7,442
Aggregate policy reserves	10,037	39,142
Premiums received in advance	24,533	39,668
General expenses due or accrued	39,988	43,549
Federal income tax payable	43,377	5,526
Amounts withheld or retained for account of others	10,683	9,705
Amounts due to subsidiaries and affiliates	95,235	57,366
Liability for amounts held under uninsured accident and health plans	1,667	10,618
Payments due others	42,846	54,733
National account equalization fund	-	12,630
Other	31,014	20,306
Total liabilities	<u>375,183</u>	<u>499,569</u>
Unassigned funds	515,477	518,779
Total liabilities and unassigned funds	<u>\$ 890,660</u>	<u>\$ 1,018,348</u>

*See accompanying notes.*

## Capital Blue Cross

### Statements of Operations – Statutory Basis

	Year ended December 31	
	2003	2002
	<i>(In Thousands)</i>	
Net premium income	<u>\$ 408,042</u>	<u>\$ 1,029,070</u>
Hospital and medical benefits	281,458	907,261
Claims adjustment expenses	17,262	32,307
General administrative expenses	49,922	126,182
Total underwriting deductions	<u>348,642</u>	<u>1,065,750</u>
Underwriting gain (loss)	59,400	(36,680)
Net investment income earned	18,428	34,106
Net realized capital (losses) gains	(2,474)	6,310
Other income, net	6,333	10,788
Income before federal income taxes	<u>81,687</u>	<u>14,524</u>
Federal income tax expense (benefit) incurred	23,136	(20,340)
Net income	<u>\$ 58,551</u>	<u>\$ 34,864</u>

*See accompanying notes.*

CBC 00104

## Capital Blue Cross

### Statements of Changes in Unassigned Funds – Statutory Basis

	Year ended December 31	
	2003	2002
	<i>(In Thousands)</i>	
Balance of unassigned funds at beginning of year	\$ 518,779	\$ 610,662
Net income	58,551	34,864
Net unrealized capital gains and losses	42,649	(16,839)
Change in net deferred income taxes	41,807	(2,409)
Change in nonadmitted assets	(145,633)	(107,499)
Other	(676)	-
Balance of unassigned funds at end of year	\$ 515,477	\$ 518,779

*See accompanying notes.*

## Capital Blue Cross

### Statements of Cash Flow – Statutory Basis

	<b>Year ended December 31</b>	
	<b>2003</b>	<b>2002</b>
<i>(In Thousands)</i>		
<b>Cash from operations</b>		
Premiums and revenues collected, net of reinsurance	\$ 409,831	\$ 1,058,853
Claims and claims adjustment expenses paid	(429,243)	(1,008,899)
General administrative expenses paid	(53,483)	(124,065)
Cash used by underwriting	(72,895)	(74,111)
Net investment income	16,305	48,097
Other income	6,332	10,788
Federal income taxes recovered (paid)	14,716	(6,877)
Net cash used in operations	<u>(35,542)</u>	<u>(22,103)</u>
<b>Cash from investments</b>		
Proceeds from investments sold, matured or repaid:		
Bonds	858,762	734,512
Stocks	223,139	37,529
Other invested assets	1,000	1,736
Cost of investments acquired:		
Bonds	(826,143)	(508,288)
Stocks	(236,977)	(50,476)
Real estate	(4,704)	(162)
Other invested assets	(107,000)	(225,000)
Net cash used in investments	<u>(91,923)</u>	<u>(10,149)</u>
<b>Cash from miscellaneous sources</b>		
Other cash provided	95,315	24,452
Net decrease in cash and short-term investments	<u>(32,150)</u>	<u>(7,800)</u>
Cash and short-term investments at beginning of year	74,253	82,053
Cash and short-term investments at end of year	<u>\$ 42,103</u>	<u>\$ 74,253</u>

*See accompanying notes.*

CBC 00106

# Capital Blue Cross

## Notes to Statutory-Basis Financial Statements

December 31, 2003  
(Amounts in Thousands)

### 1. Organization and Operations

Capital Blue Cross (the Company) is incorporated as a nonprofit organization in the Commonwealth of Pennsylvania and is subject to regulation by the Commonwealth of Pennsylvania Insurance Department (PID). The Company is an independent licensee of the Blue Cross and Blue Shield Association (BCBSA).

Health care benefits are provided under contracts with subscribers. The Company contracts with providers of health care who are paid under various payment agreements. In addition to servicing its own subscriber base, the Company processes claims for other Blue Cross Plans' subscribers who use providers in the Company's service area. The Company's service area consists of 21 counties within Central Pennsylvania and the Lehigh Valley.

On September 10, 2001, Highmark, Inc. (Highmark) terminated a joint operating agreement to provide health care coverage to consumers in the Company's service area. This resulted in the end of a long-standing relationship between the Company, which provided coverage of hospital services, and Highmark, which provided coverage of physician services. Dissolution of the relationship became effective April 1, 2002. At this time, the Company began underwriting all renewed coverage with medical surgical benefits through its wholly owned subsidiary, Capital Advantage Insurance Company (CAIC).

The Company provides HMO coverage through Keystone Health Plan Central, Inc. (KHPC). KHPC was jointly owned with Highmark in a 50-50 ownership structure. Effective April 1, 2003, through a stock purchase agreement, KHPC became a controlled subsidiary of the Company. Beginning on April 1, 2003, the Company obtained Highmark's full voting proxy with respect to KHPC and began assuming full control and responsibility for the governance, operations and financial results of KHPC. The stock purchase agreement closed on November 26, 2003 and the Company obtained legal ownership of the remaining 50% of KHPC's stock on that date.

The Company also has three other wholly owned subsidiaries: Avalon Health, LTD; Capital Administrative Services, Inc.; and Consolidated Benefits, Inc.

The Company and Highmark are joint owners of Health Benefits Management, Inc. (HBMI), a managed health care service provider. HBMI ceased operations on April 30, 2003. The Company's investment in HBMI as of December 31, 2003 is accounted for under the equity method. A final distribution of the net assets of HBMI will occur during 2004.

## Capital Blue Cross

### Notes to Statutory-Basis Financial Statements (continued)

*(Amounts in Thousands)*

#### 1. Organization and Operations (continued)

As of December 31, 2002, the Company and Highmark were equal members of the Caring Foundation of Central Pennsylvania (the Foundation) a 501(c)(3) organization. The purpose of the Foundation was to administer all outreach, enrollment, financial and reporting activities as required by the Commonwealth of Pennsylvania for the Children's Health Insurance Program. This program provides free or low-cost health insurance to uninsured children from low-income working families. The Company, Highmark, and KHPC underwrite the coverage for these children. The Company's share of the coverage underwritten is reflected in the accompanying financial statements. Effective January 1, 2003, the Foundation ceased operations and the Company and Highmark separately subcontracted with KHPC to provide HMO coverage for children enrolled in the program.

#### 2. Summary of Significant Accounting Policies

##### Basis of Presentation

The Company's statutory-basis financial statements are presented on the basis of accounting practices prescribed or permitted by the PID. The National Association of Insurance Commissioners' (NAIC) Accounting Practices and Procedures has been adopted as a component of prescribed or permitted practices by the Commonwealth of Pennsylvania. The Commonwealth has adopted certain prescribed accounting practices, none of which impact the Company, that differ from those found in NAIC statutory accounting practices (NAIC SAP). In addition, the PID has the right to permit other specific practices that may deviate from prescribed practices. The Company had no such permitted practices during the years ended December 31, 2003 and 2002.

Accounting practices and procedures of the NAIC as prescribed or permitted by the PID comprise a comprehensive basis of accounting other than accounting principles generally accepted in the United States (GAAP). The more significant differences are as follows:

- (a) Investments in bonds are generally carried at amortized cost, while under GAAP, they are carried at either amortized cost or fair value based on their classification according to the Company's ability and intent to hold or trade the securities;
- (b) Investments in common stocks are valued as prescribed by the Securities Valuation Office of the NAIC, while under GAAP, common stocks are reported at market value;

CBC 00108

## Capital Blue Cross

### Notes to Statutory-Basis Financial Statements (continued)

(Amounts in Thousands)

#### 2. Summary of Significant Accounting Policies (continued)

##### Basis of Presentation (continued)

- (c) NAIC SAP requires an amount to be recorded for deferred taxes; however, there are limitations as to the amount of deferred tax assets that may be reported as "admitted assets." The remaining deferred tax assets are nonadmitted. Also, deferred taxes do not include amounts for state income taxes. Under GAAP, state income taxes are included in the computation of deferred taxes, a deferred tax asset is recorded for the amount of gross deferred tax assets expected to be realized in future years, and a valuation allowance is established for deferred tax assets not realizable;
- (d) Assets are reported under NAIC SAP at "admitted-asset" value and "nonadmitted" assets are excluded through a charge against unassigned funds, while under GAAP, "nonadmitted assets" are reinstated to the balance sheet, net of any valuation allowance;
- (e) Comprehensive income and its components are not presented in the statutory financial statements;
- (f) Subsidiaries are included as common stock carried under the equity method (*investment in subsidiaries and affiliates*), with the equity in net income of subsidiaries credited directly to the Company's unassigned funds for NAIC SAP. GAAP requires subsidiaries to either be consolidated or carried under the equity method, depending on certain criteria. Equity in earnings of subsidiaries carried under the equity method for GAAP is included in the income statement.
- (g) In accordance with NAIC SAP, the Company reports the income and claims attributable to administrative services only (ASO) and cost plus customers as components of *general administrative expenses* in the statement of operations – statutory basis.

##### Cash and Short-Term Investments

The Company considers all highly liquid securities with a maturity of three months or less at the date of purchase to be cash equivalents. Short-term investments include money market instruments.

CBC 00109

## Capital Blue Cross

### Notes to Statutory-Basis Financial Statements (continued)

*(Amounts in Thousands)*

#### **2. Summary of Significant Accounting Policies (continued)**

##### **Bonds**

Bonds are stated at amortized cost using the interest method or at values prescribed by the NAIC. Interest is recognized on an accrual basis. Realized capital gains and losses are calculated using the specific cost of the investments sold.

##### **Preferred Stocks**

Preferred stocks are stated at cost, lower of cost or amortized cost, or NAIC market values depending on the assigned credit rating and whether the preferred stock has mandatory sinking fund provisions.

##### **Common Stocks**

Common stocks—unaffiliated are carried at market value. The change in the stated value is recorded as a change in net unrealized capital gains and losses, a component of unassigned funds.

Common stocks—affiliated are reported based on underlying statutory equity for insurance company subsidiaries. The Company's wholly owned noninsurance subsidiary, which has significant ongoing operations other than for the Company and its affiliates, is reported at GAAP equity.

##### **Other than Temporary Impairment**

The Company periodically evaluates securities for other than temporary impairment. Factors considered in determining whether declines in fair value are other than temporary include the significance of the decline, the time duration of the decline, current economic conditions and the Company's ability and intent to hold the security until such time that the fair value recovers. At the time a security is determined to be other than temporarily impaired, the Company records a realized loss in the statements of operations. Any subsequent increase or decrease in the security's fair value is reported as an unrealized gain or loss. The Company does not believe that any of its investments are other than temporarily impaired at December 31, 2003 and 2002.

##### **Health Care Receivables**

Health care receivables include advances to providers and pharmaceutical rebates receivable (see Note 12).

## Capital Blue Cross

### Notes to Statutory-Basis Financial Statements (continued)

*(Amounts in Thousands)*

#### **2. Summary of Significant Accounting Policies (continued)**

##### **Real Estate and Equipment**

Real estate is carried at cost less accumulated depreciation. The Company provides for depreciation of real estate using the straight-line method over the estimated useful lives of the assets. Buildings are generally depreciated over 40 years. Leasehold improvements are nonadmitted. The Company provides for amortization of leasehold improvements using the straight-line method over the lesser of the useful life of the asset or the remaining original lease term, excluding options or renewal periods. Leasehold improvements are generally amortized over 3 to 20 years. Furniture and equipment, other than real estate, are fully nonadmitted at December 31, 2003 and 2002 under statutory accounting principles. Depreciation and amortization expense related to furniture and equipment and real estate was approximately \$3,751 and \$4,174 for the years ended December 31, 2003 and 2002, respectively. Maintenance and repairs are charged to expense as incurred.

##### **Electronic Data Processing Equipment and Software**

Electronic data processing (EDP) equipment and operating and nonoperating (a nonadmitted asset) system software are carried at cost less accumulated depreciation. Depreciation expense is computed on the straight-line method over the lesser of the estimated useful life of the related asset or three years for EDP equipment and operating system software. Depreciation expense for nonoperating system software is computed using the straight-line method over the lesser of its estimated useful life or five years. Depreciation expense related to EDP equipment and operating and nonoperating system software was approximately \$3,721 and \$3,110 for the years ended December 31, 2003 and 2002, respectively.

##### **Goodwill**

As a result of the acquisition of the additional interest in KHPC, the excess of the purchase price over the Company's share of KHPC's statutory book value was recorded as goodwill. Goodwill is an admitted asset subject to the following limitation: 10% of the Company's unassigned surplus adjusted to exclude any net positive goodwill, EDP equipment and operating system software, and net deferred tax assets. Goodwill is amortized to unrealized capital gains and losses on investments over a period of 10 years.

CBC 00111

# Capital Blue Cross

## Notes to Statutory-Basis Financial Statements (continued)

*(Amounts in Thousands)*

### **2. Summary of Significant Accounting Policies (continued)**

#### **Claims Unpaid and Unpaid Claims Adjustment Expenses**

Claims unpaid and unpaid claims adjustment expenses include amounts for known reported claims and an amount for claims incurred but not reported. Claims payable is computed in accordance with generally accepted actuarial practices and is based on authorized healthcare services and past payment practices together with current factors that in management's judgment require recognition in the calculation. Such liabilities are necessarily based on assumptions and estimates and while management believes the amounts are adequate, the ultimate liability may be in excess of or less than the amounts provided. The methods for making such estimates and for establishing the resulting liability are continually reviewed and any adjustments are reflected in operations in the period determined. Claim adjustment expenses include cost containment measures such as case management, utilization review, and disease management programs; and other costs incurred in the claim settlement process such as legal fees; outside adjuster fees; and costs to record, process, and adjust claims.

#### **Aggregate Policy Reserves**

Aggregate policy reserves consist of unearned premiums and experience rating credits and refunds. Under the Company's experience rating formula, cumulative excesses of revenue over claims expense and the applicable retention are used to reduce future rates or, for certain types of rating methods, are refunded to customers. The positive balances in rate stabilization funds under the retrospective credit method of rating and the refunds under the retrospective refund method of rating are reflected in this category.

#### **Other Contractual Liabilities**

The Company performs an analysis of contractual obligations and arrangements, including subscriber arrangements, that have either been entered into by the Company or for which the Company is committed to as of the Company's respective fiscal year end. When it is probable that a loss will arise as a result of the contractual obligations and arrangements that have either been entered into or committed to during a fiscal year, the Company records a liability and corresponding charge to income based on a reasonably determined estimate of the expected loss. Estimated losses on committed subscriber contracts consider estimated claims expenses and contract maintenance costs. Contracts are grouped in the manner in which the Company prices its business.

CBC 00112

## Capital Blue Cross

### Notes to Statutory-Basis Financial Statements (continued)

*(Amounts in Thousands)*

#### **2. Summary of Significant Accounting Policies (continued)**

##### **National Account Equalization Fund**

The National Account Equalization Fund represents amounts held for distribution to participating plans that service national accounts and for the stabilization of future premiums. This fund has been eliminated in 2003 as a result of the Company's participation in the BlueCard Program.

##### **Net Premium Income**

Premium income is recognized ratably during the coverage period. The unearned portion of premium income is recorded in the balance sheets – statutory basis as aggregate policy reserves and later reported in the statements of operations – statutory basis as premium income when earned.

The Company participates with other Blue Cross and Blue Shield plans in administering the health care benefit plans of various national accounts. Administrative fees are generally recognized when earned on a monthly basis for the period the participating agreement is in effect and are recorded as a reduction of general and administrative expenses. Network access fees under this arrangement are also recorded as a reduction of general and administrative expenses.

Certain claim payments, premium rates, administrative expense reimbursements and provider discounts are subject to review and potential retroactive adjustment by third parties. Reserves to reduce revenue are established for potential obligations arising from such reviews. While claims for such adjustments have been asserted against the Company, management believes that the resolution of these claims will not be materially different from amounts recorded in the accompanying financial statements.

##### **Hospital and Medical Benefits**

Costs related to hospital and medical benefits are recognized in the period in which members receive medical services. In addition to actual benefits paid, such expense includes the impact of accruals for estimates of reported and unreported claims, which are unpaid as of the balance sheet date.

CBC 00113

## Capital Blue Cross

### Notes to Statutory-Basis Financial Statements (continued)

*(Amounts in Thousands)*

#### 2. Summary of Significant Accounting Policies (continued)

##### **Expense Reimbursement**

Operating expenses are allocated to various lines of business in order to determine the expense reimbursement due from Highmark, other Blue Cross / Blue Shield Plans, and governmental agencies for which the Company performs administrative services. The Company is reimbursed for actual cost incurred or is reimbursed a predetermined amount.

##### **Income Taxes**

The Company is subject to federal income taxes as if it were a stock property and casualty insurance company. As a nonprofit corporation, the Company is exempt from Pennsylvania corporate taxes. All of the Company's subsidiaries are subject to federal and state income or premium taxes. The Company files a consolidated federal income tax return, including all of its wholly owned subsidiaries. Under NAIC SAP, the Company records a provision (credit) for estimated current federal income tax liabilities generated during the reporting period.

##### **Fair Values of Financial Instruments**

The following methods and assumptions were used by the Company in estimating its fair value disclosures for financial instruments:

*Cash and Short-Term Investments and Other Long-Term Invested Assets*—The carrying amounts for these instruments approximate their fair values.

*Bonds*—The fair values for bonds are based on quoted market prices.

*Common Stocks—Unaffiliated*—The fair values for unaffiliated common stocks are based on quoted market prices.

*Preferred Stocks*—The fair values for preferred stocks are based on quoted market prices.

CBC 00114

## Capital Blue Cross

### Notes to Statutory-Basis Financial Statements (continued)

*(Amounts in Thousands)*

#### 2. Summary of Significant Accounting Policies (continued)

##### Use of Estimates

The preparation of financial statements in accordance with NAIC SAP requires management to make estimates and assumptions that affect amounts reported in the financial statements and accompanying notes. Such estimates and assumptions could change in the future as more information becomes known, which could impact the amounts reported and disclosed herein.

#### 3. Investments

The cost or amortized cost and fair value of the Company's investments are as follows:

	Cost or Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
<b>December 31, 2003</b>				
Bonds:				
Government bonds	\$ 141,958	\$ 1,101	\$ (312)	\$ 142,747
States, territories and possessions	3,476	87	(55)	3,508
Special revenue	27,269	398	(77)	27,590
Public utilities	7,941	564	(11)	8,494
Industrial and miscellaneous	151,895	5,889	(657)	157,127
<b>Total bonds</b>	<b>\$ 332,539</b>	<b>\$ 8,039</b>	<b>\$ (1,112)</b>	<b>\$ 339,466</b>
Preferred stocks	\$ 803	\$ 140	\$ —	\$ 943
Common stocks—unaffiliated	\$ 119,774	\$ 12,312	\$ (733)	\$ 131,353

CBC 00115

## Capital Blue Cross

### Notes to Statutory-Basis Financial Statements (continued)

*(Amounts in Thousands)*

#### 3. Investments (continued)

	Cost or Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
<b>December 31, 2002</b>				
Bonds:				
Government bonds	\$ 154,412	\$ 2,689	\$ (8)	\$ 157,093
States, territories and possessions	46,419	20	—	46,439
Special revenue	12,039	334	—	12,373
Public utilities	9,910	707	—	10,617
Industrial and miscellaneous	134,695	4,592	(103)	139,184
<b>Total bonds</b>	<b>\$ 357,475</b>	<b>\$ 8,342</b>	<b>\$ (111)</b>	<b>\$ 365,706</b>
Preferred stocks	\$ 4,997	\$ 28	\$ —	\$ 5,025
Common stocks—unaffiliated	\$ 133,609	\$ 6,255	\$(33,224)	\$ 106,640

The amortized cost and estimated fair value of debt securities at December 31, 2003, by contractual maturity, are shown below. Actual maturities may differ from contractual maturities because borrowers may have the right to call or prepay obligations with or without call or prepayment penalties.

	Amortized Cost	Estimated Fair Value
Due in less than one year	\$ 22,790	\$ 23,006
Due after one year through five years	149,868	153,717
Due after five years through ten years	64,495	66,156
Due after ten years	95,386	96,587
	<b>\$ 332,539</b>	<b>\$ 339,466</b>

CBC 00116

## Capital Blue Cross

### Notes to Statutory-Basis Financial Statements (continued)

*(Amounts in Thousands)*

#### 3. Investments (continued)

Gross realized gains and losses on the sale of investments are as follows:

	<b>Year ended December 31</b>	
	<b>2003</b>	<b>2002</b>
<b>Bonds:</b>		
Realized gains	\$ 9,164	\$ 18,659
Realized losses	(307)	(6,925)
<b>Total bonds</b>	<b>8,857</b>	<b>11,734</b>
<b>Common stocks—unaffiliated:</b>		
Realized gains	2,421	2,696
Realized losses	(13,722)	(8,341)
<b>Total common stocks—unaffiliated</b>	<b>(11,301)</b>	<b>(5,645)</b>
<b>Short-term investments:</b>		
Realized gains	-	221
Realized losses	(30)	-
<b>Total short-term investments</b>	<b>(30)</b>	<b>221</b>
<b>Net realized capital (losses) gains</b>	<b>\$ (2,474)</b>	<b>\$ 6,310</b>

Proceeds from the sale or maturity of bonds were \$858,762 and \$734,512 for the years ended December 31, 2003 and 2002, respectively.

CBC 00117

## Capital Blue Cross

### Notes to Statutory-Basis Financial Statements (continued)

*(Amounts in Thousands)*

#### 4. Claims Unpaid and Unpaid Claims Adjustment Expenses

Activity in the liability for claims unpaid and unpaid claims adjustment expenses is summarized as follows:

	<b>December 31</b>	
	<b>2003</b>	<b>2002</b>
Claims unpaid and unpaid claims adjustment expenses at beginning of year	<b>\$ 206,326</b>	<b>\$ 275,657</b>
Incurred related to:		
Current year	352,935	984,746
Prior years	(54,215)	(45,178)
Total incurred	<b>298,720</b>	<b>939,568</b>
Paid related to:		
Current year	299,286	836,741
Prior years	129,957	172,158
Total paid	<b>429,243</b>	<b>1,008,899</b>
Claims unpaid and unpaid claims adjustment expenses at end of year	<b>\$ 75,803</b>	<b>\$ 206,326</b>

Actual health care trends, as compared to trend assumptions utilized in setting the previous years' claims payable, resulted in overall favorable development. The favorable development was a result of lower than anticipated claims utilization.

Capital Blue Cross

Notes to Statutory-Basis Financial Statements (continued)

(Amounts in Thousands)

**5. Income Taxes**

The components of the current federal income tax expense (benefit) are as follows:

	<b>Year ended December 31</b>	
	<b>2003</b>	<b>2002</b>
Federal	\$ 23,136	\$(20,345)
Foreign	-	5
Federal income tax expense (benefit)	<u>\$ 23,136</u>	<u>\$(20,340)</u>

The components of the net deferred tax (liability) asset recognized are as follows:

	<b>December 31</b>	
	<b>2003</b>	<b>2002</b>
Total deferred tax assets	\$ 160,599	\$ 127,056
Total deferred tax liabilities	(10,813)	(5,454)
Net deferred tax asset	149,786	121,602
Total deferred tax assets nonadmitted	(149,786)	(106,055)
Net admitted deferred tax asset	<u>\$ -</u>	<u>\$ 15,547</u>
Increase in nonadmitted asset	<u>\$ 43,731</u>	<u>\$ 30,003</u>

## Capital Blue Cross

### Notes to Statutory-Basis Financial Statements (continued)

*(Amounts in Thousands)*

#### 5. Income Taxes (continued)

The tax effects of temporary differences that give rise to significant portions of the deferred tax assets and deferred tax liabilities are as follows:

	<b>December 31</b>	
	<b>2003</b>	<b>2002</b>
<b>Deferred tax assets:</b>		
Unrealized loss on investments	\$       —	\$  9,576
Discounting of unpaid claims	13,170	14,366
Benefit plan accruals	20,089	8,884
Rate stabilization reserves	2,774	5,148
Contingent liabilities	5,171	7,193
Other accrued liabilities	2,562	2,999
AMT credits	9,473	2,200
Intangible assets	29,802	32,116
Tax effect for certain nonadmitted assets	75,051	38,678
Other	2,507	5,896
<b>Total deferred tax assets</b>	<b>160,599</b>	<b>127,056</b>
<b>Total deferred tax assets nonadmitted</b>	<b>(149,786)</b>	<b>(106,055)</b>
<b>Admitted deferred tax assets</b>	<b>10,813</b>	<b>21,001</b>
<b>Deferred tax liabilities:</b>		
Unrealized gain on investments	(4,047)	—
Other	(6,766)	(5,454)
<b>Total deferred tax liabilities</b>	<b>(10,813)</b>	<b>(5,454)</b>
<b>Net admitted deferred tax asset</b>	<b>\$       —</b>	<b>\$ 15,547</b>

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## Capital Blue Cross

### Notes to Statutory-Basis Financial Statements (continued)

*(Amounts in Thousands)*

#### 5. Income Taxes (continued)

The change in net deferred income taxes for the year ended December 31, 2003 is composed of the following:

	December 31		Change
	2003	2002	
Total deferred tax assets	\$ 160,599	\$ 127,056	\$ 33,543
Total deferred tax liabilities	(10,813)	(5,454)	(5,359)
Net deferred tax assets	\$ 149,786	\$ 121,602	28,184
Tax effect of unrealized losses			13,623
Change in net deferred income tax			\$ 41,807

A reconciliation of federal tax expense (benefit) and the amount that would have been provided at statutory rates is as follows:

	2003	2002
Provision computed as statutory rate	\$ 28,590	\$ 5,083
Tax-exempt interest	-	(2,157)
Interest income not recognized for statutory purposes	2,637	-
Intangible assets	(2,313)	(14,825)
Liabilities related to postretirement and other benefits	1,021	2,094
Experience rated credits and refunds	(2,374)	(9,584)
Contingent liabilities	(1,769)	-
AMT credits	7,246	(399)
Other	(9,902)	(552)
	\$ 23,136	\$(20,340)

The Company had no capital loss carryforwards. None of the federal income taxes incurred in the current year and the preceding years are available for recoupment in the event of future net losses.

CBC 00121

## Capital Blue Cross

### Notes to Statutory-Basis Financial Statements (continued)

*(Amounts in Thousands)*

#### 6. Pension and Other Benefit Plans

The Company maintains pension and postretirement medical benefit plans for the benefit of substantially all its employees. The following schedules summarize the impact on the balance sheets – statutory basis, as well as benefit obligations, assets, funded status, and rate assumptions associated with the pension and postretirement medical benefit plans.

	Pension Benefits		Other Postretirement Benefits	
	2003	2002	2003	2002
<b>Accumulated benefit obligation</b>	<b>\$ 100,721</b>	<b>\$ 78,441</b>	N/A	N/A
<b>Change in benefit obligation</b>				
Benefit obligation at beginning of year	\$ 122,307	\$ 106,809	\$ 18,491	\$ 15,947
Service cost	8,285	7,346	2,377	1,766
Interest cost	8,471	7,393	1,293	1,102
Change in assumptions and plan amendments	17,628	6,830	–	–
Actuarial loss (gain)	4,409	(576)	1,856	556
Benefits paid	(7,339)	(5,495)	(683)	(880)
Benefit obligation at end of year	<b>\$ 153,761</b>	<b>\$ 122,307</b>	<b>\$ 23,334</b>	<b>\$ 18,491</b>
<b>Change in plan assets</b>				
Fair value of plan assets at beginning of year	\$ 100,876	\$ 108,957	\$ –	\$ –
Actual return on plan assets	17,660	(9,149)	–	–
Company contribution	–	6,563	–	–
Benefits paid	(7,339)	(5,495)	–	–
Fair value of plan assets at end of year	<b>\$ 111,197</b>	<b>\$ 100,876</b>	<b>\$ –</b>	<b>\$ –</b>

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## Capital Blue Cross

### Notes to Statutory-Basis Financial Statements (continued)

*(Amounts in Thousands)*

#### 6. Pension and Other Benefit Plans (continued)

	Pension Benefits		Other Postretirement Benefits	
	2003	2002	2003	2002
Funded status	\$ (42,564)	\$ (21,431)	\$(23,334)	\$(18,491)
Unrecognized prior service cost	274	297	(825)	(917)
Unrecognized actuarial loss (gain)	46,697	35,668	3,472	1,665
Remaining net asset at initial date of application	-	(2,985)	-	-
Prepaid (accrued) benefit cost	\$ 4,407	\$ 11,549	\$(20,687)	\$(17,743)
<b>Benefit obligation for nonvested employees</b>	<b>\$ 3,478</b>	<b>\$ 2,158</b>	<b>\$ 39,638</b>	<b>\$ 31,429</b>
<b>Components of net periodic benefit cost</b>				
Service cost	\$ 8,285	\$ 7,346	\$ 2,377	\$ 1,766
Interest cost	8,471	7,393	1,294	1,102
Expected return on plan assets	(8,412)	(9,181)	-	-
Amortization of unrecognized net loss	-	-	49	-
Amortization of prior costs	1,783	22	(92)	(92)
Net periodic benefit cost	\$ 10,127	\$ 5,580	\$ 3,628	\$ 2,776
<b>Weighted-average assumptions</b>				
Discount rate	6.0%	6.75%	6.0%	6.75%
Expected return on plan assets	8.5%	8.50%	N/A	N/A
Rate of compensation increase	4.5%	5.00%	N/A	N/A

The Company also has a nonqualified supplemental retirement benefit plan covering certain officers, which provide for eligible employees to receive additional benefits based principally on compensation and years of service. This plan provides for incremental benefit payments from the Company's funds so that total benefit payments equal amounts that would have been payable from the Company's principal retirement plans if it were not for limitations imposed by income tax regulations. Total liabilities under this plan were \$3,908 at December 31, 2003, including an additional minimum liability of \$676. Expenses under this plan were \$692 for the year ended December 31, 2003.

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## Capital Blue Cross

### Notes to Statutory-Basis Financial Statements (continued)

*(Amounts in Thousands)*

#### 6. Pension and Other Benefit Plans (continued)

For measurement purposes, a 5.5% annual rate of increase in the per capita cost of covered health care benefits was assumed for 2003.

The postretirement health care benefit plan is subject to revision at the discretion of the Board of Directors. Effective January 1, 1993, the Company contributes 100% toward the cost of postretirement health care benefits beginning at age 62 for current retirees and active employees whose age plus years of service as of this date equaled or exceeded 75. For employees first becoming eligible for benefits on or after January 1, 1993, and whose age plus years of service on that date was less than 75, the Company will contribute toward postretirement health care benefits at age 62 at varying percentages.

Assumed health care cost trend rates have a significant effect on the amounts reported for the health care plan. A one-percentage-point change in the assumed health care cost trend rates would have the following effects:

	<u>1% Increase</u>	<u>1% Decrease</u>
Effect on total of service and interest cost components	\$ 1,747	\$ (1,176)
Effect on postretirement benefit obligation	\$ 14,916	\$(11,427)

On December 8, 2003 the Medicare Prescription Drug Improvement and Modernization Act of 2003 (the Act) was enacted. The Act introduces a prescription drug benefit under Medicare (Medicare Part D) as well as a federal subsidy to sponsors of retiree health care benefit plans that provide a benefit that is at least actuarially equivalent to Medicare Part D. On January 12, 2004 the FASB Issued FSP 106-1, Accounting and Disclosure Requirements Related to the Medicare Prescription Drug, Improvement and Modernization Act of 2003 that permits the sponsor of a postretirement health care plan a one-time election to defer accounting for the effects of the Act. The Company has elected such deferral and thus the benefit obligation and net periodic postretirement benefit costs above do not reflect the potential effects of the Act. Specific authoritative guidance on the accounting for the federal subsidy is pending and that guidance, when issued, could require the Company to change previously reported information.

#### 7. Reimbursements of Operating Expenses

Reimbursements for administrative services performed for Highmark, governmental agencies and other plans amounting to \$17,015 and \$30,183 in 2003 and 2002, respectively, have been offset against general and administrative expenses.

## Capital Blue Cross

### Notes to Statutory-Basis Financial Statements (continued)

*(Amounts in Thousands)*

#### **8. Guarantees to Affiliates**

The Company guarantees all of the contractual and financial obligations of KHPC to its members. There is no limitation to the maximum potential future payments that can be made under this guarantee. This guarantee is based on the estimate of claims outstanding as reported by KHPC on their balance sheet as of December 31, 2003, in the amount of \$60,338.

The Company also guarantees all of the contractual and financial obligations of CAIC to its members. This guarantee is based on the estimate of claims outstanding as reported by CAIC on their balance sheet as of December 31, 2003 in the amount of \$194,671. No payments were made under this guarantee in 2003 or 2002.

These guarantees are required by the BCBSA in order for CAIC and KHPC to use the registered Blue Cross service mark. Payment by the Company would only be required in the event that CAIC or KHPC were not able to meet their financial obligations.

#### **9. Commitments and Contingencies**

##### **Commitments**

The Company has entered into various lease agreements, primarily for computer equipment, in the ordinary course of business. As of December 31, 2003, future minimum rental payments required under operating leases that have initial or remaining noncancelable lease terms in excess of one year are not considered by management to be material. Lease expense was \$6,385 and \$6,482 in 2003 and 2002, respectively.

##### **Line of Credit**

The Company has a line of credit with an area bank in the amount of \$25,000 which expires in 2004. Borrowings under the line of credit bear interest at the 30-day LIBOR rate, plus 120 basis points, and are payable upon demand. As of December 31, 2003 and 2002, no amount was outstanding under this agreement.

##### **Litigation**

The Company is involved in and is subject to claims, contractual disputes, and other uncertainties. In the opinion of management, after consultation with legal counsel, the ultimate disposition of these matters will not have a material adverse effect on the Company's financial condition or results of operations.

## Capital Blue Cross

### Notes to Statutory-Basis Financial Statements (continued)

*(Amounts in Thousands)*

#### 9. Commitments and Contingencies (continued)

##### Regulatory

The Company has been named in a class action lawsuit alleging violation of the Pennsylvania Non-Profit Corporation Law and breach of subscriber contracts by maintaining "excessive" surplus. Based on a decision of the Pennsylvania Commonwealth Court in a similar case filed against another Pennsylvania Blue Cross plan, the lower court dismissed the action against the Company, which dismissal was affirmed by the Commonwealth Court. That decision has been appealed to the Pennsylvania Supreme Court, which has stayed the action against the Company pending disposition of the action against the other Blue Cross plan. Plaintiffs have also filed a complaint with the PID under the Pennsylvania Unfair Insurance Practices Act. In January 2004, the PID published a notice directing each Pennsylvania Blue plan to file an application for approval of the reserves and surplus they maintain based on a range of statutory risk based capital levels as defined under statutory regulations. The Company has challenged the PID's authority to issue this notice. Management is not able to estimate the impact of the outcome of this situation on the Company's statutory-basis financial statements.

The health care and health insurance industries are subject to numerous laws and regulations of federal, state and local governments. These laws and regulations include, but are not necessarily limited to, matters such as licensure, accreditation, government health care program participation requirements, reimbursement for patient services and Medicare and Medicaid fraud and abuse. Government activity has increased with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by health care insurers and providers. Violations of these laws and regulations could result in expulsion from government health care programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed. Management believes that the Company is in compliance with fraud and abuse as well as other applicable government laws and regulations. Compliance with such laws and regulations can be subject to future government review and interpretation as well as regulatory actions unknown or unasserted at this time.

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## Capital Blue Cross

### Notes to Statutory-Basis Financial Statements (continued)

*(Amounts in Thousands)*

#### 10. Related Party Transactions

During the year, the Company incurred certain costs on behalf of CAIC, including costs of salaries, professional fees and other administrative expenses. These amounts were allocated between the companies based on relevant statistical measures. Net charges to CAIC for services performed by the Company were \$141,333 and \$28,779 for 2003 and 2002, respectively.

The following table summarizes the due from/to subsidiaries and affiliates balances:

	December 31			
	2003		2002	
	Due From	Due To	Due From	Due To
KHPC	\$ 1,351	\$ (1,880)	\$ 13,469	\$ (4,670)
Joint programs	1,396	358	18,733	(20,885)
HBMI	-	-	46	-
Avalon Health, LTD	-	-	2	-
Capital Administrative Services, Inc.	471	-	281	-
Consolidated Benefits, Inc.	164	-	117	-
CAIC	22,125	(93,713)	1,361	(31,811)
Caring Foundation of Central Pennsylvania	511	-	216	-
<b>Total</b>	<b>\$ 26,018</b>	<b>\$(95,235)</b>	<b>\$ 34,225</b>	<b>\$(57,366)</b>

#### 11. Gain (Loss) from Uninsured Accident and Health Plans

The gain (loss) from operations from ASC and cost plus uninsured plans was as follows:

	2003	2002
Gross reimbursement for medical costs incurred	\$ 139,706	\$ 295,756
Gross administrative fees accrued	29,976	51,229
Gross expenses incurred (claims and administrative)	(167,628)	(382,545)
<b>Gain (loss) from operations</b>	<b>\$ 2,054</b>	<b>\$ (35,560)</b>

CBC 00127

## Capital Blue Cross

### Notes to Statutory-Basis Financial Statements (continued)

*(Amounts in Thousands)*

#### 12. Pharmaceutical Rebates Receivable

The Company estimates pharmaceutical rebates receivable based upon the following information:

Quarter	Estimated Pharmacy Rebates as Originally Reported on Financial Statements	Pharmacy Rebates as Invoiced/ Confirmed	Actual Rebates Collected Within 90 Days of Invoicing/ Confirmation	Actual Rebates Collected Within 91 to 180 Days of Invoicing/ Confirmation	Actual Rebates Collected More Than 180 Days After Invoicing/ Confirmation
December 31, 2003	\$ 3,157	\$ -	\$ -	\$ -	\$ -
September 30, 2003	2,618	3,584	3,342	-	-
June 30, 2003	3,133	3,261	-	3,261	-
March 31, 2003	2,927	3,276	-	3,276	-
December 31, 2002	\$ 5,130	\$ 4,023	\$ -	\$ 3,674	\$ 349
September 30, 2002	3,649	3,719	3,719	-	284
June 30, 2002	4,379	4,120	4,113	7	287
March 31, 2002	3,836	6,063	4,334	15	1,615

#### 13. Acquisition of KHPC

Effective April 1, 2003, the Company obtained the remaining 50% voting rights, control and financial interest in KHPC. The purchase price consisted of \$29,000 in cash and \$3,000 in assumed post retirement liabilities. In addition, the Company purchased \$7 million of KHPC surplus debentures owned by Highmark at par value. The acquisition was accounted for as a statutory purchase and, accordingly, the 50% additional interest was recorded at cost. The excess of the purchase price over the Company's share of KHPC's statutory book value at April 1, 2003 has been recorded as goodwill in the amount of \$9,822. Statutory earnings in KHPC for the three months ended March 31, 2003 was \$4,533.

CBC 00128

## Capital Blue Cross

### Notes to Statutory-Basis Financial Statements (continued)

*(Amounts in Thousands)*

#### **14. Subsequent Event**

On March 8, 2004, the Company entered into a five-year, \$50,000 secured credit facility. The applicable interest rate will be based on 0.43 percentage points above the monthly LIBOR. The loan is due and payable in full on March 8, 2009. The Company has pledged securities as collateral for this credit facility. The facility contains a number of covenants, representations and events of default typical of a credit facility agreement of this size and nature, including financial covenants requiring the Company to maintain minimum capital requirements.

CBC 00129

# Supplemental Schedules

CBC 00130

Capital Blue Cross

Summary Investment Schedule – Statutory Basis

December 31, 2003

	Gross Investment Holdings*		Admitted Assets as Reported in the Annual Statement	
	Amount	Percentage	Amount	Percentage
	<i>(In Thousands)</i>			
Bonds:				
U.S. Treasury securities	\$ 65,508	6.9%	\$ 65,508	8.6%
U.S. government agency and corporate obligations (excluding mortgage-backed securities):				
Issued by U.S. government agencies	16,795	1.8	16,795	2.2
Issued by U.S. government-sponsored agencies	—	—	—	—
Foreign government (including Canada, excluding mortgage-backed securities)	3,334	0.4	3,334	0.4
Securities issued by states, territories, and possessions and political subdivisions in the U.S.:				
State, territory, and possessions – general obligations	3,476	0.4	3,476	0.5
Political subdivisions of states, territories, and possessions and political subdivisions – general obligations	—	—	—	—
Revenue and assessment obligations	22,631	2.4	22,631	3.0
Industrial development and similar obligations	—	—	—	—
Mortgage-backed securities (includes residential and commercial MBS):				
Pass-through securities:				
Guaranteed by GNMA	14,545	1.5	14,545	1.9
Issued by FNMA and FHLMC	46,413	4.9	46,413	6.1
Privately issued	—	—	—	—
CMOs and REMICs:				
Issued by FNMA and FHLMC	—	—	—	—
Privately issued and collateralized by MBS; issued or guaranteed by GNMA, FMNA, or FHLMC	—	—	—	—
All other privately issued	—	—	—	—
Other debt and other fixed income securities (excluding short term):				
Unaffiliated domestic securities (includes credit tenant loans rated by the SVO)	159,837	16.9	159,837	21.1
Unaffiliated foreign securities	—	—	—	—
Affiliated securities	—	—	—	—

## Capital Blue Cross

### Summary Investment Schedule – Statutory Basis (continued)

December 31, 2003

	Gross Investment Holdings*		Admitted Assets as Reported in the Annual Statement	
	Amount	Percentage	Amount	Percentage
	<i>(In Thousands)</i>			
Equity interests:				
Investments in mutual funds	\$ 85,897	9.0%	\$ 85,897	11.3%
Preferred stocks:				
Affiliated	—	—	—	—
Unaffiliated	803	0.1	803	0.1
Publicly traded equity securities (excluding preferred stocks):				
Affiliated	—	—	—	—
Unaffiliated	43,170	4.6	43,170	5.7
Other equity securities:				
Affiliated	64,476	6.8	64,476	8.5
Unaffiliated	2,386	0.2	2,286	0.3
Other equity interests including tangible personal property under lease:				
Affiliated	—	—	—	—
Unaffiliated	—	—	—	—
Mortgage loans:				
Construction and land development	—	—	—	—
Agricultural	—	—	—	—
Single-family residential properties	—	—	—	—
Multifamily residential properties	—	—	—	—
Commercial loans	—	—	—	—
Real estate investments:				
Property occupied by company	28,991	3.1	28,580	3.8
Property held for sale	—	—	—	—
Collateral loans	—	—	—	—
Policy loans	—	—	—	—
Receivables for securities	—	—	—	—
Cash and short-term investments	42,103	4.4	42,103	5.6
Write-in for invested assets	346,125	36.6	158,288	20.9
<b>Total invested assets</b>	<b>\$ 946,490</b>	<b>100.0%</b>	<b>\$ 758,142</b>	<b>100.0%</b>

\*Gross investment holdings as valued in compliance with *NAIC Accounting Practices and Procedures Manual*.

## Capital Blue Cross

### Investment Risk Interrogatories – Statutory Basis

December 31, 2003  
(Amounts in Thousands)

The Plan's total admitted assets as reported in the balance sheet – statutory basis is \$890,660 at December 31, 2003.

1. The 10 largest exposures to a single issuer/borrower/investment, by investment category, excluding: (i) U.S. government, U.S. government agency securities and those U.S. government money market funds listed in the Appendix to the *SVO Purposes and Procedures Manual* as exempt, (ii) property occupied by the Company, and (iii) policy loans at December 31, 2003 are as follows:

Investment	Amount	Percentage of Total Admitted Assets
CAIC Surplus Notes	\$ 144,288	16.200%
KHPC Surplus Notes	14,000	1.572
Vanguard Institutional Index	42,961	4.824
Northern Institutional Funds	42,936	4.821
General Motors Corp.	4,021	.451
British Sky Broadcasting	2,740	.308
Tyco	2,568	.288
Ford	1,999	.224
Allied Waste	1,724	.194
Abitibi Consolidated	1,540	.173

2. The amounts and percentages of the Company's total admitted assets held in bonds and preferred stocks by NAIC rating are as follows:

Bonds	Amount	Percent
NAIC-1	\$ 284,435	31.935%
NAIC-2	54,776	6.150
NAIC-3	22,177	2.490
NAIC-4	10,796	1.212
NAIC-5	–	–
NAIC-6	–	–

CBC 00133

## Capital Blue Cross

### Investment Risk Interrogatories – Statutory Basis (continued)

December 31, 2003  
(Amounts in Thousands)

<b>Preferred Stocks</b>	<b>Amount</b>	<b>Percent</b>
P/RP-1	\$ -	- %
P/RP-2	463	.052
P/RP-3	340	.038
P/RP-4	-	-
P/RP-5	-	-
P/RP-6	-	-

3. The amounts and percentages of the Company's total admitted assets held in foreign investments (regardless of whether there is any foreign currency exposure) and unhedged foreign currency exposure (defined as the statement value of investment denominated in foreign currencies which are not hedged by financial instruments qualifying for hedge), including (i) foreign-currency-denominated investments of \$0 supporting insurance liabilities denominated in that same foreign currency of \$0 and excluding (ii) Canadian investments and currency exposure of \$0 at December 31, 2003 are as follows: None
  
4. The amounts and percentages of the Company's total admitted assets held in Canadian investments and unhedged Canadian currency exposure, including Canadian-currency-denominated investments of \$0 supporting Canadian-denominated insurance liabilities of \$0 at December 31, 2003 are as follows:

<b>Investment</b>	<b>Amount</b>	<b>Percent</b>
Ontario Providence CDA	\$ 846	.0949%

5. The aggregate amounts and percentages of the reporting entity's total admitted assets held in investments with contractual sales restrictions (defined as investments having restrictions that prevent investments from being sold within 90 days at December 31, 2003) are as follows: None

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Capital Blue Cross

Investment Risk Interrogatories – Statutory Basis (continued)

December 31, 2003  
(Amounts in Thousands)

11. The amounts and percentages of the reporting entity's total admitted assets subject to the following types of agreements are as follows:

	Year End Amount	Percentage of Total Admitted Assets	At End of Each Quarter		
			1st Quarter Amount	2nd Quarter Amount	3rd Quarter Amount
Securities lending (do not include assets held as collateral for such transactions)	\$ -	-	\$ -	\$ -	\$ -
Repurchase agreements	-	-	3,026	9,504	-
Reverse repurchase agreements	-	-	-	-	-
Dollar repurchase agreements	-	-	-	-	-
Dollar reverse repurchase agreements	-	-	-	-	-

12. The amounts and percentages of warrants not attached to other financial instruments, options, caps, and floors at December 31, 2003 are as follows: None.
13. The amounts and percentages of potential exposure (*defined as the amount determined in accordance with the NAIC Annual Statement Instructions*) for collars, swaps, and forwards at December 31, 2003 are as follows: None.
14. The amounts and percentages indicated below of potential exposure (*defined as the amount determined in accordance with the NAIC Annual Statement Instructions*) for futures contracts at December 31, 2003 are as follows: None.
15. The amounts and percentages of 10 largest investments included in the Write-ins for Invested Assets category on the Summary Investment Schedule as of December 31, 2003 are as follows:

Investment	Amount	Percentage of Total Admitted Assets
Capital Advantage Insurance Company	\$ 144,288	16.200%
Keystone Health Plan Central	14,000	1.572

CBC 00135

**STATEMENT OF ACTUARIAL OPINION**

February 24, 2004

Board of Directors  
Capital Blue Cross

I, Michael J. Cellini, am a member of the American Academy of Actuaries ("the Academy"), and a Senior Manager and Consulting Actuary with the firm of Ernst & Young LLP. I have been retained by Capital Blue Cross ("the Company") to issue this opinion. I meet the Academy qualification standards for issuing this opinion, and I am familiar with the valuation requirements applicable to the Company.

I have reviewed the actuarial assumptions and actuarial methods used in determining the reserves and related actuarial items listed below and as shown in the Annual Statement of the Company, as prepared by the management of the Company for filing with state regulatory officials, as of December 31, 2003. My responsibility is to express an opinion on these reserves and related actuarial items based on my review. The actuarial methods, considerations and analyses used in forming my opinion conform to the appropriate Actuarial Standards of Practice and Actuarial Compliance Guidelines as promulgated by the Actuarial Standards Board, and form the basis of this statement of opinion.

Annual  
Statement  
Reference  
ItemPage-LineAmount

Claims Unpaid	3-1	\$73,597,432
Unpaid Claims Adjustment Expenses	3-3	\$2,206,041
Aggregate Health Policy Reserves	3-4	\$10,036,906

The reserves and related actuarial items listed above represent the estimates made by management of the Company for all unpaid claims as of December 31, 2003. Considerable uncertainty and variability are inherent in such estimates, and, accordingly, the subsequent development of the unpaid claims liability may not conform to the assumptions used in the determination of the unpaid claims liability and therefore may vary from the amounts in the foregoing table.

I have relied on listings and summaries of claims and other relevant data, and upon management's representations regarding the collectibility of reinsurance recoverable amounts, as expressed in the attached statement. I have relied upon Mr. Joseph N. Romano, Vice President and Chief Actuary, for the accuracy of the data, as expressed in the attached statement.

My review included the identification and evaluation of the effect on the foregoing reserves of capitated risk-sharing contracts with service providers; however, my review of such capitated risk-sharing contracts did not include an assessment of the financial condition of the service providers. As such, the following opinion rests on the assumption that such service providers will fulfill their obligations under their respective contracts with the Company.

In other respects, my examination included such review of the actuarial assumptions and actuarial methods, including comparing prior years' estimates of unpaid claims liabilities to their subsequent development and such other tests of the actuarial calculations, as I considered necessary.

In my opinion, the reserves and related actuarial items identified above:

- (a) Are computed in accordance with presently accepted actuarial standards consistently applied, and are fairly stated in accordance with sound actuarial principles, except that consideration of the adequacy of the Company's reserves and related actuarial items in conjunction with the assets which support them has not been performed;
- (b) Are based on actuarial assumptions relevant to contract provisions and appropriate to the purpose for which the Annual Statement was prepared, and provide for all reasonably anticipated unpaid claims under the contracts;
- (c) Meet the requirements of the insurance laws and regulations of the Commonwealth of Pennsylvania;
- (d) Are computed on the basis of assumptions consistent with those used in computing the corresponding items in the Annual Statement of the preceding year, with any exceptions noted below;
- (e) Include provision for all actuarial reserves and related actuarial items which ought to be established; and,

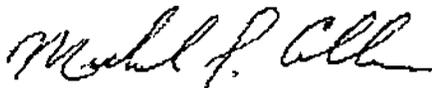
- (f) Make good and sufficient provision for all unpaid claims and other actuarial liabilities of the Company under the terms of its contracts and agreements, by which I mean that the estimated liabilities is an appropriate measure of reasonably anticipated payments on incurred claims under potentially moderately adverse development, although, consistent with the scope of my review, the adequacy of the Company's reserves and related actuarial items in conjunction with the assets which support them has not been considered,

My review did not include asset adequacy analysis, as such analysis is not in the scope of my assignment. I have not reviewed any of the Company's assets and I have not formed any opinion as to their validity or value. My opinion rests on the assumption that the Company's December 31, 2003 statutory-basis unpaid claims liability is funded by valid assets that have suitably scheduled maturities and/or adequate liquidity to meet future cash flow requirements.

The scope of my review did not include preparation of the Underwriting and Investment Exhibit - Part 2B of the Annual Statement. I relied upon Mr. Joseph N. Romano, Vice President and Chief Actuary, regarding the consistency of paid claims data and unpaid claims estimates with the Underwriting and Investment Exhibit. As part of my review, I conducted analysis consistent with Section 3.6, "Follow-Up Studies", contained in ASOP Number 5, "Incurred Health and Disability Claims", adopted by the Actuarial Standards Board in December 2000.

My review relates only to those reserves and related actuarial items identified herein, and I do not express an opinion on the Company's financial statements taken as a whole.

This opinion has been prepared solely for the Board and the management of the Company and for filing with state regulatory officials, and for the Blue Cross and Blue Shield Association, and is not intended for any other purpose.



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Michael J. Cellini, Ph.D., ASA, MAAA  
5 Times Square  
New York, New York 10036-6530  
(212) 773-0873

Capital Advantage Insurance Company

Audited Statutory-Basis Financial Statements  
For the Year Ended December 31, 2003 and 2002  
together with Actuarial Opinion issued by  
Ernst & Young LLP as of December 31, 2003

CAPITAL ADVANTAGE INSURANCE COMPANY

Statutory-Basis Financial Statements and Supplemental Schedules

Years ended December 31, 2003 and 2002 with Report of Independent Auditors

**Capital Advantage Insurance Company**  
**Statutory-Basis Financial Statements and Supplemental Schedules**

Years ended December 31, 2003 and 2002

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## Report of Independent Auditors

Board of Directors  
Capital Advantage Insurance Company

We have audited the accompanying statutory-basis balance sheet of Capital Advantage Insurance Company (the Company) as of December 31, 2003, and the related statutory-basis statements of operations, changes in capital and unassigned funds and cash flow for the year then ended. These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements based on our audit. The statutory-basis financial statements of the Company for the year ended December 31, 2002 were audited by other auditors whose report dated May 15, 2003 expressed an unqualified opinion on those statements as to a comprehensive basis of accounting other than accounting principles generally accepted in the United States.

We conducted our audit in accordance with auditing standards generally accepted in the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audit provides a reasonable basis for our opinion.

As described in Note 2, the accompanying financial statements have been prepared in conformity with accounting practices prescribed or permitted by the Pennsylvania Insurance Department, which is a comprehensive basis of accounting other than accounting principles generally accepted in the United States.

In our opinion, the 2003 financial statements referred to above present fairly, in all material respects, the financial position of Capital Advantage Insurance Company at December 31, 2003 and the results of its operations and its cash flow for the year then ended, in conformity with accounting practices prescribed or permitted by the Pennsylvania Insurance Department.

Our audit was conducted for the purpose of forming an opinion on the December 31, 2003 statutory-basis financial statements taken as a whole. The accompanying summary investment schedule and schedule of investment risk interrogatories are presented to comply with the National Association of Insurance Commissioners' Annual Statement Instructions and the National Association of Insurance Commissioners' Accounting Practices and Procedures Manual and are not a required part of the December 31, 2003 statutory-basis financial statements. Such information has been subjected to the auditing

procedures applied in our audit of the December 31, 2003 statutory-basis financial statements and, in our opinion, is fairly stated in all material respects in relation to the December 31, 2003 statutory-basis financial statements taken as a whole.

This report is intended solely for the information and use of the Company and the Pennsylvania Insurance Department and is not intended to be and should not be used by anyone other than these specified parties.

*Ernst + Young LLP*

March 12, 2004

Capital Advantage Insurance Company

Balance Sheets – Statutory Basis

	December 31	
	2003	2002
<i>(In Thousands)</i>		
<b>Admitted assets</b>		
Cash and short-term investments	\$ 76,668	\$ 180,501
Bonds	260,491	112,504
Accounts receivable:		
Accident and health premiums due and unpaid	7,458	8,999
Investment income due and accrued	2,066	1,316
Amounts due from parent and affiliates	76,241	29,996
Amounts receivable relating to uninsured accident and health plans	356	484
Advances to providers	12,430	-
Premium call receivables	16,415	2,341
Other	452	398
<b>Total accounts receivable</b>	<u>115,418</u>	<u>43,534</u>
Federal income tax recoverable	41,671	6,909
<b>Total admitted assets</b>	<u><u>\$ 494,248</u></u>	<u><u>\$ 343,448</u></u>

	<b>December 31</b>	
	<b>2003</b>	<b>2002</b>
	<i>(In Thousands)</i>	
<b>Liabilities, capital, and unassigned funds</b>		
<b>Liabilities:</b>		
Claims unpaid	<b>\$ 188,454</b>	<b>\$ 107,784</b>
Unpaid claims adjustment expenses	<b>6,217</b>	<b>3,543</b>
Aggregate policy reserves	<b>31,671</b>	<b>18,535</b>
Premiums received in advance	<b>21,582</b>	<b>4,315</b>
General expenses due or accrued	<b>21,855</b>	<b>6,036</b>
Other contractual liabilities	<b>23,236</b>	<b>30,375</b>
Amounts withheld or retained for account of others	<b>309</b>	<b>239</b>
Amounts due to parent	<b>2,859</b>	<b>448</b>
Liability for amounts held under uninsured accident and health plans	<b>157</b>	<b>27</b>
Payments due others	<b>1,171</b>	<b>89</b>
<b>Total liabilities</b>	<b>297,511</b>	<b>171,391</b>
<b>Capital and unassigned funds:</b>		
Capital stock, par value \$750, 1,000 shares authorized, issued and outstanding	<b>750</b>	<b>750</b>
Gross paid in and contributed capital	<b>375</b>	<b>375</b>
Surplus notes	<b>325,625</b>	<b>225,625</b>
Unassigned funds	<b>(130,013)</b>	<b>(54,693)</b>
<b>Total capital and unassigned funds</b>	<b>196,737</b>	<b>172,057</b>
<b>Total liabilities, capital, and unassigned funds</b>	<b>\$ 494,248</b>	<b>\$ 343,448</b>

*See accompanying notes.*

Capital Advantage Insurance Company  
Statements of Operations – Statutory Basis

	Year ended December 31	
	2003	2002
	<i>(In Thousands)</i>	
Net premium income	\$ 921,820	\$ 230,860
Hospital and medical benefits	892,311	232,296
Claims adjustment expenses	52,917	8,574
General administrative expenses	109,802	31,972
Total underwriting deductions	<u>1,055,030</u>	<u>272,842</u>
Underwriting loss	(133,210)	(41,982)
Net investment income earned	7,525	1,391
Net realized capital gains	1,151	131
Change in other contractual liabilities	7,139	(30,375)
Other income, net	1,615	1,702
Loss before federal income taxes	<u>(115,780)</u>	<u>(69,133)</u>
Federal income tax benefit	(41,676)	(6,909)
Net loss	<u>\$ (74,104)</u>	<u>\$ (62,224)</u>

*See accompanying notes.*

Capital Advantage Insurance Company

Statements of Changes in Capital and Unassigned Funds – Statutory Basis

	Year ended December 31	
	2003	2002
	<i>(In Thousands)</i>	
Balance of capital and unassigned funds at beginning of year	\$ 172,057	\$ 9,312
Net loss	(74,104)	(62,224)
Change in net deferred income taxes	1,910	17,858
Change in nonadmitted assets	(3,126)	(17,889)
Change in surplus notes	100,000	225,000
Balance of capital and unassigned funds at end of year	<u>\$ 196,737</u>	<u>\$ 172,057</u>

*See accompanying notes.*

**Capital Advantage Insurance Company**  
**Statements of Cash Flow – Statutory Basis**

	<b>Year ended December 31</b>	
	<b>2003</b>	<b>2002</b>
	<i>(In Thousands)</i>	
<b>Cash from operations</b>		
Premiums and revenues collected, net of reinsurance	\$ 938,078	\$ 196,121
Claims and claims adjustment expenses paid	(861,884)	(129,603)
General administrative expenses paid	(93,982)	(25,960)
Cash from underwriting	(17,788)	40,558
Net investment income	7,926	527
Other income (expenses)	1,616	(28,674)
Federal income taxes recovered (paid)	6,914	(665)
Net cash (used in) provided by operations	(1,332)	11,746
<b>Cash from investments</b>		
Proceeds from bonds sold, matured or repaid	347,187	37,396
Cost of bonds acquired	(495,174)	(143,154)
Net cash used in investments	(147,987)	(105,758)
<b>Cash from financing and miscellaneous sources</b>		
Surplus notes, capital and surplus paid in	100,000	225,000
Other cash (uses) sources	(54,514)	46,553
Net cash provided by financing and miscellaneous sources	45,486	271,553
Net (decrease) increase in cash and short-term investments	(103,833)	177,541
Cash and short-term investments at beginning of year	180,501	2,960
Cash and short-term investments at end of year	\$ 76,668	\$ 180,501

*See accompanying notes.*

# Capital Advantage Insurance Company

## Notes to Statutory-Basis Financial Statements

December 31, 2003  
(Amounts in Thousands)

### 1. Organization and Operations

Capital Advantage Insurance Company (the Company) is incorporated in the Commonwealth of Pennsylvania and is subject to regulation by the Commonwealth of Pennsylvania Insurance Department (PID). All of the outstanding shares of the Company are owned by Capital Blue Cross (CBC), a Pennsylvania non-profit corporation which is organized on a nonstock basis and has no voting securities. The Company has no employees, as all administrative, accounting services, operations, information technology, actuarial, and management duties are provided by the parent company, CBC.

Health care benefits are provided under contracts with subscribers. The Company contracts with providers of health care who are paid under various payment agreements. The Company's service area consists of 21 counties within Central Pennsylvania and the Lehigh Valley.

Prior to April 1, 2002, the Company's activities were confined to issuing and underwriting short-term major-medical insurance policies and providing administrative and marketing services related to stop-loss insurance policies. Effective April 1, 2002, the Company expanded its business to include comprehensive coverage of health care benefits to consumers in the Company's service area. The Company began to provide coverage of physician services under an indemnity program, and hospital and physician services under a preferred provider organization. As a result of this expansion, the Company has experienced significant growth within its subscriber base.

CBC maintains a commitment to support the operations and liquidity of the Company.

### 2. Summary of Significant Accounting Policies

#### Basis of Presentation

The Company's statutory-basis financial statements are presented on the basis of accounting practices prescribed or permitted by the PID. The National Association of Insurance Commissioners' (NAIC) Accounting Practices and Procedures has been adopted as a component of prescribed or permitted practices by the Commonwealth of Pennsylvania. The Commonwealth has adopted certain prescribed accounting practices, none of which impact the Company, that differ from those found in NAIC statutory accounting practices (NAIC SAP). In addition, the PID has the right to permit other specific practices that may deviate from prescribed practices. The Company had no such permitted practices during the years ended December 31, 2003 and 2002.

# Capital Advantage Insurance Company

## Notes to Statutory-Basis Financial Statements (continued)

(Amounts in Thousands)

### 2. Summary of Significant Accounting Policies (continued)

#### Basis of Presentation (continued)

Accounting practices and procedures of the NAIC as prescribed or permitted by the PID comprise a comprehensive basis of accounting other than accounting principles generally accepted in the United States (GAAP). The more significant differences are as follows:

- (a) Investments in bonds are generally carried at amortized cost, while under GAAP, they are carried at either amortized cost or fair value based on their classification according to the Company's ability and intent to hold or trade the securities;
- (b) Investments in common stocks are valued as prescribed by the Securities Valuation Office of the NAIC, while under GAAP, common stocks are reported at market value;
- (c) NAIC SAP requires an amount to be recorded for deferred taxes; however, there are limitations as to the amount of deferred tax assets that may be reported as "admitted assets". The remaining deferred tax assets are nonadmitted. Also, deferred taxes do not include amounts for state income taxes. Under GAAP, state income taxes are included in the computation of deferred taxes, a deferred tax asset is recorded for the amount of gross deferred tax assets expected to be realized in future years, and a valuation allowance is established for deferred tax assets not realizable;
- (d) Assets are reported under NAIC SAP at "admitted-asset" value and "nonadmitted" assets are excluded through a charge against surplus, while under GAAP, "nonadmitted assets" are reinstated to the balance sheet, net of any valuation allowance;
- (e) Comprehensive income and its components are not presented in the statutory financial statements;
- (f) In accordance with NAIC SAP, the Company reports the income and claims attributable to administrative services only (ASO) and cost plus customers as components of *general administrative expenses* in the statement of operations - statutory basis.

# Capital Advantage Insurance Company

## Notes to Statutory-Basis Financial Statements (continued)

*(Amounts in Thousands)*

### **2. Summary of Significant Accounting Policies (continued)**

#### **Cash and Short-Term Investments**

In accordance with the Company's cash management policy of maximizing the amount of funds invested in income-earning assets, the Company routinely anticipates the timing and amount of future cash flow. This policy frequently results in the existence of negative book cash balances.

The Company considers all highly liquid securities with a maturity of three months or less at the date of purchase to be cash equivalents. Short-term investments include money market instruments.

#### **Bonds**

Bonds are stated at amortized cost using the interest method or at values prescribed by the NAIC. Interest is recognized on an accrual basis. Realized capital gains and losses are calculated using the specific cost of the investments sold.

The Company periodically evaluates bonds for other than temporary impairment. Factors considered in determining whether declines in fair value are other than temporary include the significance of the decline, the time duration of the decline, current economic conditions and the Company's ability and intent to hold the security until such time that the fair value recovers. At the time a security is determined to be other than temporarily impaired, the Company records a realized loss in the statement of operations. Any subsequent increase or decrease in the security's fair value is reported as an unrealized gain or loss. The Company does not believe that any of its investments are other than temporarily impaired at December 31, 2003 and 2002.

#### **Claims Unpaid and Unpaid Claims Adjustment Expenses**

Claims unpaid and unpaid claims adjustment expenses include amounts for known reported claims and an amount for claims incurred but not reported. Claims payable is computed in accordance with generally accepted actuarial practices and is based on authorized healthcare services and past payment practices together with current factors that in management's judgment require recognition in the calculation. Such liabilities are necessarily based on assumptions and estimates and while management believes the amounts are adequate, the ultimate liability may be in excess of or less than the amounts provided. The methods for making such estimates and for establishing the resulting

# Capital Advantage Insurance Company

## Notes to Statutory-Basis Financial Statements (continued)

*(Amounts in Thousands)*

### **2. Summary of Significant Accounting Policies (continued)**

#### **Claims Unpaid and Unpaid Claims Adjustment Expenses (continued)**

liability are continually reviewed and any adjustments are reflected in operations in the period determined. Claim adjustment expenses include cost containment measures such as case management, utilization review, and disease management programs; and other costs incurred in the claim settlement process such as legal fees; outside adjuster fees; and costs to record, process, and adjust claims.

#### **Aggregate Policy Reserves**

Aggregate policy reserves consist of unearned premiums and estimated experience rating credits and refunds. Under the Company's experience rating formula, cumulative excesses of revenue over claims expense and the applicable retention are used to reduce future rates or, for certain types of rating methods, are refunded to customers. The positive balances in rate stabilization funds under the retrospective credit method of rating and the refunds under the retrospective refund method of rating are reflected in this category.

#### **Other Contractual Liabilities**

The Company performs an analysis of contractual obligations and arrangements, including subscriber arrangements, that have either been entered into by the Company or for which the Company is committed to as of the Company's respective fiscal year end. When it is probable that a loss will arise as a result of the contractual obligations and arrangements that have either been entered into or committed to during a fiscal year, the Company records a liability and corresponding charge to income based on a reasonably determined estimate of the expected loss. Estimated losses on committed subscriber contracts consider estimated claims expenses and contract maintenance costs. Contracts are grouped in the manner in which the Company prices its business.

#### **Net Premium Income**

Premium income is recognized ratably during the coverage period. The unearned portion of premium income is recorded in the balance sheets – statutory basis as part of aggregate policy reserves and later reported in the statement of operations – statutory basis as premium income when earned.

## Capital Advantage Insurance Company

### Notes to Statutory-Basis Financial Statements (continued)

*(Amounts in Thousands)*

#### **2. Summary of Significant Accounting Policies (continued)**

##### **Net Premium Income (continued)**

Certain claim payments, premium rates, administrative expense reimbursements and provider discounts are subject to review and potential retroactive adjustment by third parties. Reserves to reduce revenue are established for potential obligations arising from such reviews. While claims for such adjustments have been asserted against the Company, management believes that the resolution of these claims will not be materially different from amounts recorded in the accompanying financial statements.

##### **Hospital and Medical Benefits**

Costs related to hospital and medical benefits are recognized in the period in which members receive medical services. In addition to actual benefits paid, such expense includes the impact of accruals for estimates of reported and unreported claims, which are unpaid as of the balance sheet date.

##### **Income Taxes**

The Company is included in a consolidated federal income tax return with CBC and other affiliated companies, including Keystone Health Plan Central. The Company has a written agreement, which sets forth the manner in which the total combined federal income tax is allocated to each entity, which is a party to the consolidated return. Pursuant to this agreement, the Company has the right to recoup federal income taxes paid in prior years in the event of future net losses, which it may incur, or to recoup its net losses carried forward as an offset to future net income subject to federal income taxes. Under NAIC SAP, the Company records a provision (credit) for estimated current federal income tax liabilities generated during the reporting period. The Company is also subject to Commonwealth of Pennsylvania premium taxes.

##### **Fair Values of Financial Instruments**

The following methods and assumptions were used by the Company in estimating its fair value disclosures for financial instruments:

*Cash and Short-Term Investments*—The carrying amounts for these instruments approximate their fair values.

*Bonds*—The fair values for bonds are based on quoted market prices.

## Capital Advantage Insurance Company

### Notes to Statutory-Basis Financial Statements (continued)

*(Amounts in Thousands)*

#### 2. Summary of Significant Accounting Policies (continued)

##### Use of Estimates

The preparation of financial statements in accordance with NAIC SAP requires management to make estimates and assumptions that affect amounts reported in the financial statements and accompanying notes. Such estimates and assumptions could change in the future as more information becomes known, which could impact the amounts reported and disclosed herein.

#### 3. Investments

The cost or amortized cost and fair value of the Company's investments in bonds are as follows:

	Cost or Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
<b>December 31, 2003</b>				
Government bonds	\$ 169,141	\$ 1,053	\$ (121)	\$ 170,073
Special revenue	12,412	39	(113)	12,338
Public utilities	2,310	43	—	2,353
Industrial and miscellaneous	76,628	1,474	(128)	77,974
Total bonds	<u>\$ 260,491</u>	<u>\$ 2,609</u>	<u>\$ (362)</u>	<u>\$ 262,738</u>
<b>December 31, 2002</b>				
Government bonds	\$ 70,327	\$ 1,043	\$ —	\$ 71,370
Special revenue	7,197	68	—	7,265
Public utilities	524	37	—	561
Industrial and miscellaneous	34,456	714	(87)	35,083
Total bonds	<u>\$ 112,504</u>	<u>\$ 1,862</u>	<u>\$ (87)</u>	<u>\$ 114,279</u>

Capital Advantage Insurance Company

Notes to Statutory-Basis Financial Statements (continued)

(Amounts in Thousands)

3. Investments (continued)

The amortized cost and estimated fair value of debt securities at December 31, 2003, by contractual maturity, are shown below. Actual maturities may differ from contractual maturities because borrowers may have the right to call or prepay obligations with or without call or prepayment penalties.

	Amortized Cost	Estimated Fair Value
Due in less than one year	\$ 42,492	\$ 42,627
Due after one year through five years	125,858	127,130
Due after five years through ten years	37,146	37,683
Due after ten years	54,995	55,298
	<u>\$ 260,491</u>	<u>\$ 262,738</u>

Gross realized gains and losses on the sale of investments are as follows:

	Year ended December 31	
	2003	2002
Bonds:		
Realized gains	\$ 2,364	\$ 267
Realized losses	(1,216)	(136)
Total bonds	<u>1,148</u>	<u>131</u>
Short-term investments:		
Realized gains	5	-
Realized losses	(2)	-
Total short-term investments	<u>3</u>	<u>-</u>
Net realized capital gains	<u>\$ 1,151</u>	<u>\$ 131</u>

Proceeds from the sale or maturity of bonds were \$347,187 and \$37,396 for the years ended December 31, 2003 and 2002, respectively.

Capital Advantage Insurance Company

Notes to Statutory-Basis Financial Statements (continued)

(Amounts in Thousands)

**4. Claims Unpaid and Unpaid Claims Adjustment Expenses**

Activity in the liability for claims unpaid and unpaid claims adjustment expenses is summarized as follows:

	<u>2003</u>	<u>2002</u>
Claims unpaid and unpaid claims adjustment expenses at beginning of year	\$ 111,327	\$ 60
Incurred related to:		
Current year	975,961	240,835
Prior years	(30,733)	35
Total incurred	<u>945,228</u>	<u>240,870</u>
Paid related to:		
Current year	783,212	129,509
Prior years	78,672	94
Total paid	<u>861,884</u>	<u>129,603</u>
Claims unpaid and unpaid claims adjustment expenses at end of year	<u>\$ 194,671</u>	<u>\$ 111,327</u>

Actual health care trends, as compared to trend assumptions utilized in setting the previous years' claims payable, resulted in overall favorable development. The favorable development was a result of lower than anticipated claims utilization.

**5. Income Taxes**

The components of the current income tax benefit are as follows:

	<u>December 31</u>	
	<u>2003</u>	<u>2002</u>
Federal income tax benefit	<u>\$(41,676)</u>	<u>\$(6,909)</u>

Capital Advantage Insurance Company

Notes to Statutory-Basis Financial Statements (continued)

(Amounts in Thousands)

5. Income Taxes (continued)

The components of the net deferred tax asset recognized are as follows:

	December 31	
	2003	2002
Total deferred tax assets	\$ 19,771	\$ 17,877
Total deferred tax liabilities	(24)	(40)
Net deferred tax asset	19,747	17,837
Total deferred tax assets nonadmitted	(19,747)	(17,837)
Net admitted deferred tax asset	\$ -	\$ -
Increase in nonadmitted asset	\$ 1,910	\$ 17,837

The tax effects of temporary differences that give rise to significant portions of the deferred tax assets and deferred tax liabilities are as follows:

	December 31	
	2003	2002
Deferred tax assets:		
Unearned premiums	\$ 185	\$ 641
Discounting of unpaid claims	1,594	3,980
Rate stabilization reserves	9,225	2,575
Other contractual liabilities	8,133	10,631
Other	634	50
Total deferred tax assets	19,771	17,877
Total deferred tax assets nonadmitted	(19,747)	(17,837)
Admitted deferred tax assets	24	40
Deferred tax liabilities:		
Bond discount	(24)	(40)
Total deferred tax liabilities	(24)	(40)
Net admitted deferred tax asset	\$ -	\$ -

## Capital Advantage Insurance Company

### Notes to Statutory-Basis Financial Statements (continued)

*(Amounts in Thousands)*

#### 5. Income Taxes (continued)

The change in net deferred income taxes for the year ended December 31, 2003 is composed of the following:

	December 31		
	2003	2002	Change
Total deferred tax assets	\$ 19,771	\$ 17,877	\$ 1,894
Total deferred tax liabilities	(24)	(40)	16
Net deferred tax assets	\$ 19,747	\$ 17,837	\$ 1,910

A reconciliation of federal tax expense (benefit) and the amount that would have been provided at statutory rates is as follows:

	Year ended December 31	
	2003	2002
Provision computed as statutory rate	\$(40,523)	\$(24,197)
Interest expense not recognized for statutory purposes	(2,637)	(552)
Other contractual liabilities	(2,499)	10,632
Claims unpaid	(2,386)	3,981
Experience rated reserves	6,650	2,575
Other	(281)	652
	\$(41,676)	\$ (6,909)

#### 6. Commitments and Contingencies

The Company's parent, CBC, has been named in a class action lawsuit alleging violation of the Pennsylvania Non-Profit Corporation Law and breach of subscriber contracts by maintaining "excessive" surplus. Based on a decision of the Pennsylvania Commonwealth Court in a similar case filed against another Pennsylvania Blue Cross plan, the lower court dismissed the action against CBC, which dismissal was affirmed by the Commonwealth Court. That decision has been appealed to the Pennsylvania Supreme Court, which has stayed the action against CBC pending disposition of the action against the other Blue Cross plan. Plaintiffs have also filed a complaint with the PID under the Pennsylvania Unfair Insurance Practices Act. In January 2004, the PID published a notice directing each Pennsylvania Blue plan to file an application for approval of the reserves

## Capital Advantage Insurance Company

### Notes to Statutory-Basis Financial Statements (continued)

*(Amounts in Thousands)*

#### **6. Commitments and Contingencies (continued)**

and surplus they maintain based on a range of statutory risk based capital levels as defined under statutory regulations. CBC has challenged the PID's authority to issue this notice. Management is not able to estimate the impact of the outcome of this situation on CBC's or the Company's statutory-basis financial statements.

The Company is subject to claims, contractual disputes and other uncertainties. In the opinion of management, after consultation with legal counsel, the ultimate disposition of these matters will not have a material adverse effect on the Company's financial condition or results of operations.

The health care and health insurance industries are subject to numerous laws and regulations of federal, state and local governments. These laws and regulations include, but are not necessarily limited to, matters such as licensure, accreditation, government health care program participation requirements, reimbursement for patient services and Medicare and Medicaid fraud and abuse. Government activity has increased with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by health care insurers and providers. Violations of these laws and regulations could result in expulsion from government health care programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed. Management believes that the Company is in compliance with fraud and abuse as well as other applicable government laws and regulations. Compliance with such laws and regulations can be subject to future government review and interpretation as well as regulatory actions unknown or unasserted at this time.

#### **7. Guarantee from Parent**

The Company has a guarantee from CBC for all contractual and financial obligations to its members. This guarantee is required by the Blue Cross and Blue Shield Association to enable the Company to use the registered Blue Cross and Blue Shield service marks.

## Capital Advantage Insurance Company

### Notes to Statutory-Basis Financial Statements (continued)

*(Amounts in Thousands)*

#### 8. Surplus Debentures

On March 15, 2002, September 13, 2002, December 20, 2002, and December 17, 2003 surplus debentures were issued by the Company to CBC in the amount of \$25,000, \$50,000, \$150,000, and \$100,000, respectively. In addition, the Company had previously issued to CBC a \$625 surplus debenture. The notes bear interest at a rate which is adjusted annually and is based on the five-year U.S. Treasury Bond rate determined for each calendar year, plus 50 basis points. The interest rate was 3.28% and 4.80% for 2003 and 2002, respectively. Interest is due and payable annually on January 15 for interest accrued as of December 31, upon approval by the PID. The Company did not pay any interest in 2003, and paid interest in the amount of \$372 for December 31, 2002. The Company recognizes interest expense on these notes when approved by the PID. The PID did not approve any interest in 2003 and 2002. Total interest contractually accrued but not approved by the PID was \$9,106 at December 31, 2003. These debentures are subordinated to all other indebtedness. The Company may, with the approval of the PID, redeem these debentures at any time, in part or in whole.

#### 9. Related Party Transactions

During the year, CBC incurred certain costs on behalf of the Company, including costs of salaries, professional fees and other administrative expenses. These amounts were allocated between the companies based on relevant statistical measures. Net charges to the Company for services performed by CBC were \$141,333 and \$28,779 for 2003 and 2002, respectively.

The following table summarizes the due from/to parent and affiliates balances:

	December 31			
	2003		2002	
	Due From	Due To	Due From	Due To
CBC	\$ 74,447	\$(2,859)	\$ 29,996	\$(448)
Capital Administrative Services, Inc.	1,794	-	-	-
<b>Total</b>	<b>\$ 76,241</b>	<b>\$(2,859)</b>	<b>\$ 29,996</b>	<b>\$(448)</b>

Capital Advantage Insurance Company

Notes to Statutory-Basis Financial Statements (continued)

*(Amounts in Thousands)*

**10. Loss from Uninsured Accident and Health Plans**

The loss from operations from ASO and cost plus uninsured plans, which is reported as a component of general and administrative expenses, was as follows:

	<u>2003</u>	<u>2002</u>
Gross reimbursement for medical costs incurred	\$ 253,034	\$ 17,215
Gross administrative fees accrued	27,445	(2,973)
Gross expenses incurred (claims and administrative)	<u>(289,847)</u>	<u>(15,226)</u>
Loss from operations	<u>\$ (9,368)</u>	<u>\$ (984)</u>

## Supplemental Schedules

# Capital Advantage Insurance Company

## Summary Investment Schedule – Statutory Basis

December 31, 2003

	Gross Investment Holdings*		Admitted Assets as Reported in the Annual Statement	
	Amount	Percentage	Amount	Percentage
	<i>(In Thousands)</i>			
<b>Bonds:</b>				
U.S. Treasury securities	\$ 113,422	33.6%	\$ 113,422	33.6%
U.S. government agency and corporate obligations (excluding mortgage-backed securities):				
Issued by U.S. government agencies	—	—	—	—
Issued by U.S. government-sponsored agencies	—	—	—	—
Foreign government (including Canada, excluding mortgage-backed securities)	—	—	—	—
Securities issued by states, territories, and possessions and political subdivisions in the U.S.:				
State, territory, and possessions – general obligations	700	0.2	700	0.2
Political subdivisions of states, territories, and possessions and political subdivisions – general obligations	—	—	—	—
Revenue and assessment obligations	—	—	—	—
Industrial development and similar obligations	—	—	—	—
Mortgage-backed securities (includes residential and commercial MBS):				
Pass-through securities:				
Guaranteed by GNMA	17,888	5.3	17,888	5.3
Issued by FNMA and FHLMC	49,543	14.7	49,543	14.7
Privately issued	—	—	—	—
CMOs and REMICs:				
Issued by FNMA and FHLMC	—	—	—	—
Privately issued and collateralized by MBS; issued or guaranteed by GNMA, FMNA, or FHLMC	—	—	—	—
All other privately issued	—	—	—	—
Other debt and other fixed income securities (excluding short term):				
Unaffiliated domestic securities (includes credit tenant loans rated by the SVO)	78,938	23.4	78,938	23.4
Unaffiliated foreign securities	—	—	—	—
Affiliated securities	—	—	—	—

Capital Advantage Insurance Company

Summary Investment Schedule – Statutory Basis (continued)

December 31, 2003

	Gross Investment Holdings*		Admitted Assets as Reported in the Annual Statement	
	Amount	Percentage	Amount	Percentage
	(In Thousands)			
Equity interests:				
Investments in mutual funds	\$ -	- %	\$ -	- %
Preferred stocks:				
Affiliated	-	-	-	-
Unaffiliated	-	-	-	-
Publicly traded equity securities (excluding preferred stocks):				
Affiliated	-	-	-	-
Unaffiliated	-	-	-	-
Other equity securities:				
Affiliated	-	-	-	-
Unaffiliated	-	-	-	-
Other equity interests including tangible personal property under lease:				
Affiliated	-	-	-	-
Unaffiliated	-	-	-	-
Mortgage loans:				
Construction and land development	-	-	-	-
Agricultural	-	-	-	-
Single-family residential properties	-	-	-	-
Multifamily residential properties	-	-	-	-
Commercial loans	-	-	-	-
Real estate investments:				
Property occupied by company	-	-	-	-
Property held for sale	-	-	-	-
Collateral loans	-	-	-	-
Policy loans	-	-	-	-
Receivables for securities	-	-	-	-
Cash and short-term investments	76,668	22.8	76,668	22.8
Write-in for invested assets	-	-	-	-
Total invested assets	\$ 337,159	100.0%	\$ 337,159	100.0%

\*Gross investment holdings as valued in compliance with *NAIC Accounting Practices and Procedures Manual*.

## Capital Advantage Insurance Company

### Investment Risk Interrogatories – Statutory Basis

December 31, 2003  
(Amounts in Thousands)

The Plan's total admitted assets as reported in the balance sheet – statutory basis is \$494,248 at December 31, 2003.

1. The 10 largest exposures to a single issuer/borrower/investment, by investment category, excluding: (i) U.S. government, U.S. government agency securities and those U.S. government money market funds listed in the Appendix to the *SVO Purposes and Procedures Manual* as exempt, (ii) property occupied by the Company, and (iii) policy loans at December 31, 2003 are as follows:

Investment	Amount	Percentage of Total Admitted Assets
General Motors Corp.	\$ 3,929	.795%
Kellogg	1,588	.321
Time Warner Inc.	1,363	.276
Norfolk Southern Corp.	1,221	.247
Walt Disney	1,044	.211
General Mills	1,003	.203
Daimler Chrysler	678	.137
AT&T Broadband	560	.113
Fred Meyer Inc.	554	.112
Lockhead Martin	479	.097

2. The amounts and percentages of the Plan's total admitted assets held in bonds by NAIC rating are as follows:

Bonds	Amount	Percent
NAIC-1	\$ 330,808	66.932%
NAIC-2	15,005	3.036
NAIC-3	—	—
NAIC-4	—	—
NAIC-5	—	—
NAIC-6	—	—

## Capital Advantage Insurance Company

### Investment Risk Interrogatories – Statutory Basis (continued)

December 31, 2003

(Amounts in Thousands)

3. The amounts and percentages of the Plan's total admitted assets held in foreign investments (regardless of whether there is any foreign currency exposure) and unhedged foreign currency exposure (defined as the statement value of investment denominated in foreign currencies which are not hedged by financial instruments qualifying for hedge), including (i) foreign-currency-denominated investments of \$0 supporting insurance liabilities denominated in that same foreign currency of \$0 and excluding (ii) Canadian investments and currency exposure of \$0 at December 31, 2003 are as follows: None
4. The amounts and percentages of the Plan's total admitted assets held in Canadian investments and unhedged Canadian currency exposure, including Canadian-currency-denominated investments of \$0 supporting Canadian-denominated insurance liabilities of \$0 at December 31, 2003 are as follows: None
5. The aggregate amounts and percentages of the reporting entity's total admitted assets held in investments with contractual sales restrictions (defined as investments having restrictions that prevent investments from being sold within 90 days at December 31, 2003) are as follows: None
6. The amounts and percentages of admitted assets held in the largest 10 equity interests (including investments in the shares of mutual funds, preferred stocks, publicly traded equity securities, and other equity securities, and excluding money market and bond mutual funds listed in the Appendix to *SVO Practices and Procedures Manual* as exempt or Class 1) at December 31, 2003 are as follows: None
7. Nonaffiliated, privately placed equities (included in other equity securities) and excluding securities eligible for sale under (i) Securities Exchange Commission (SEC) Rule 144a or (ii) SEC Rule 144 without volume restrictions at December 31, 2003 totaled \$741, which represents 0.15% of total admitted assets.
8. The amounts and percentages of the reporting entity's total admitted assets held in general partnership interests (included in other equity securities) at December 31, 2003 are as follows: None
9. The amounts and percentages of the reporting entity's total admitted assets held in mortgage loans at December 31, 2003 are as follows: None.

Capital Advantage Insurance Company

Investment Risk Interrogatories – Statutory Basis (continued)

December 31, 2003  
(Amounts in Thousands)

10. The amounts and percentages of the reporting entity's total admitted assets held in each of the five largest investments in one parcel or group of contiguous parcels of real estate, excluding property occupied by the Plan at December 31, 2003 are as follows: None
11. The amounts and percentages of the reporting entity's total admitted assets subject to the following types of agreements are as follows:

	Year End Amount	Percentage of Total Admitted Assets	At End of Each Quarter		
			1st Quarter Amount	2nd Quarter Amount	3rd Quarter Amount
Securities lending (do not include assets held as collateral for such transactions)	\$ -	-%	\$ -	\$ -	\$ -
Repurchase agreements	-	-	-	-	-
Reverse repurchase agreements	-	-	-	-	-
Dollar repurchase agreements	-	-	-	-	-
Dollar reverse repurchase agreements	-	-	-	-	-

12. The amounts and percentages of warrants not attached to other financial instruments, options, caps, and floors at December 31, 2003 are as follows: None
13. The amounts and percentages of potential exposure (*defined as the amount determined in accordance with the NAIC Annual Statement Instructions*) for collars, swaps, and forwards at December 31, 2003 are as follows: None
14. The amounts and percentages indicated below of potential exposure (*defined as the amount determined in accordance with the NAIC Annual Statement Instructions*) for futures contracts at December 31, 2003 are as follows: None
15. The amounts and percentages of 10 largest investments included in the Write-ins for Invested Assets category on the Summary Investment Schedule as of December 31, 2003 are as follows: None



STATEMENT OF ACTUARIAL OPINION

February 24, 2004

Board of Directors  
Capital Advantage Insurance Company

I, Michael J. Cellini, am a member of the American Academy of Actuaries ("the Academy"), and a Senior Manager and Consulting Actuary with the firm of Ernst & Young LLP. I have been retained by Capital Advantage Insurance Company ("the Company") to issue this opinion. I meet the Academy qualification standards for issuing this opinion, and I am familiar with the valuation requirements applicable to the Company.

I have reviewed the actuarial assumptions and actuarial methods used in determining the reserves and related actuarial items listed below and as shown in the Annual Statement of the Company, as prepared by the management of the Company for filing with state regulatory officials, as of December 31, 2003. My responsibility is to express an opinion on these reserves and related actuarial items based on my review. The actuarial methods, considerations and analyses used in forming my opinion conform to the appropriate Actuarial Standards of Practice and Actuarial Compliance Guidelines as promulgated by the Actuarial Standards Board, and form the basis of this statement of opinion.

Annual  
Statement  
Reference  
Item

Page-Line

Amount

Claims Unpaid	3-1	\$188,453,689
Unpaid Claims Adjustment Expenses	3-3	\$6,216,742
Aggregate Health Policy Reserves	3-4	\$31,671,039

The reserves and related actuarial items listed above represent the estimates made by management of the Company for all unpaid claims as of December 31, 2003. Considerable uncertainty and variability are inherent in such estimates, and, accordingly, the subsequent development of the unpaid claims liability may not conform to the assumptions used in the determination of the unpaid claims liability and therefore may vary from the amounts in the foregoing table.

I have relied on listings and summaries of claims and other relevant data, and upon management's representations regarding the collectibility of reinsurance recoverable amounts, as expressed in the attached statement. I have relied upon Mr. Joseph N. Romano, Vice President and Chief Actuary, for the accuracy of the data, as expressed in the attached statement.

My review included the identification and evaluation of the effect on the foregoing reserves of capitated risk-sharing contracts with service providers; however, my review of such capitated risk-sharing contracts did not include an assessment of the financial condition of the service providers. As such, the following opinion rests on the assumption that such service providers will fulfill their obligations under their respective contracts with the Company.

In other respects, my examination included such review of the actuarial assumptions and actuarial methods, including comparing prior years' estimates of unpaid claims liabilities to their subsequent development and such other tests of the actuarial calculations, as I considered necessary.

In my opinion, the reserves and related actuarial items identified above:

- (a) Are computed in accordance with presently accepted actuarial standards consistently applied, and are fairly stated in accordance with sound actuarial principles, except that consideration of the adequacy of the Company's reserves and related actuarial items in conjunction with the assets which support them has not been performed;
- (b) Are based on actuarial assumptions relevant to contract provisions and appropriate to the purpose for which the Annual Statement was prepared, and provide for all reasonably anticipated unpaid claims under the contracts;
- (c) Meet the requirements of the insurance laws and regulations of the Commonwealth of Pennsylvania;
- (d) Are computed on the basis of assumptions consistent with those used in computing the corresponding items in the Annual Statement of the preceding year, with any exceptions noted below;
- (e) Include provision for all actuarial reserves and related actuarial items which ought to be established; and,

**ERNST & YOUNG LLP**

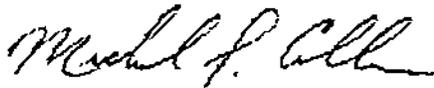
- (f) Make good and sufficient provision for all unpaid claims and other actuarial liabilities of the Company under the terms of its contracts and agreements, by which I mean that the estimated liabilities is an appropriate measure of reasonably anticipated payments on incurred claims under potentially moderately adverse development, although, consistent with the scope of my review, the adequacy of the Company's reserves and related actuarial items in conjunction with the assets which support them has not been considered,

My review did not include asset adequacy analysis, as such analysis is not in the scope of my assignment. I have not reviewed any of the Company's assets and I have not formed any opinion as to their validity or value. My opinion rests on the assumption that the Company's December 31, 2003 statutory-basis unpaid claims liability is funded by valid assets that have suitably scheduled maturities and/or adequate liquidity to meet future cash flow requirements.

The scope of my review did not include preparation of the Underwriting and Investment Exhibit - Part 2B of the Annual Statement. I relied upon Mr. Joseph N. Romano, Vice President and Chief Actuary, regarding the consistency of paid claims data and unpaid claims estimates with the Underwriting and Investment Exhibit. As part of my review, I conducted analysis consistent with Section 3.6, "Follow-Up Studies", contained in ASOP Number 5, "Incurred Health and Disability Claims", adopted by the Actuarial Standards Board in December 2000.

My review relates only to those reserves and related actuarial items identified herein, and I do not express an opinion on the Company's financial statements taken as a whole.

This opinion has been prepared solely for the Board and the management of the Company and for filing with state regulatory officials, and for the Blue Cross and Blue Shield Association, and is not intended for any other purpose.



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Michael J. Cellini, Ph.D., ASA, MAAA  
5 Times Square  
New York, New York 10036-6530  
(212) 773-0873

Keystone Health Plan Central

Audited Statutory-Basis Financial Statements  
For the Year Ended December 31, 2003 and 2002  
together with Actuarial Opinion issued by  
Ernst & Young LLP as of December 31, 2003

KEYSTONE HEALTH PLAN CENTRAL, INC.

Statutory-Basis Financial Statements

Years ended December 31, 2003 and 2002 with Report of Independent Auditors

## REPORT OF INDEPENDENT AUDITORS

Board of Directors  
Keystone Health Plan Central, Inc.

We have audited the accompanying statutory-basis balance sheet of Keystone Health Plan Central, Inc. (the Company) as of December 31, 2003, and the related statutory-basis statements of operations, changes in capital and surplus and cash flow for the year then ended. These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements based on our audits. The statutory-basis financial statements of the Company for the year ended December 31, 2002 were audited by other auditors whose report dated February 28, 2003 expressed an unqualified opinion on those statements as to a comprehensive basis of accounting other than accounting principles generally accepted in the United States.

We conducted our audit in accordance with auditing standards generally accepted in the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audit provides a reasonable basis for our opinion.

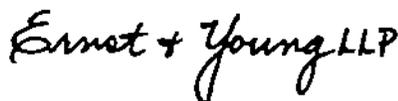
As described in Note 1, the accompanying financial statements have been prepared in conformity with accounting practices prescribed or permitted by the Pennsylvania Insurance Department, which is a comprehensive basis of accounting other than accounting principles generally accepted in the United States.

In our opinion, the 2003 financial statements referred to above present fairly, in all material respects, the financial position of Keystone Health Plan Central, Inc. at December 31, 2003 and the results of its operations and its cash flow for the year then ended, in conformity with accounting practices prescribed or permitted by the Pennsylvania Insurance Department.

As discussed in Notes 1 and 14 to the financial statements, in 2002 the Company changed its method of accounting for pharmacy rebate receivables.

Our audit was conducted for the purpose of forming an opinion on the 2003 statutory-basis financial statements taken as a whole. The accompanying supplemental investment disclosure is presented to comply with the Annual Statement Instructions and the National Association of Insurance Commissioners' Accounting Practices and Procedures Manual and is not a required part of the statutory-basis financial statements. Such information has been subjected to the auditing procedures applied in our audit of the 2003 statutory-basis financial statements and, in our opinion, is fairly stated in all material respects in relation to the 2003 statutory-basis financial statements taken as a whole.

This report is intended solely for the information and use of the Company and the Pennsylvania Insurance Department and is not intended to be and should not be used by anyone other than these specified parties.



February 9, 2004

KEYSTONE HEALTH PLAN CENTRAL, INC.  
 STATUTORY-BASIS BALANCE SHEETS  
 December 31, 2003 and 2002

	2003	2002
<b>ADMITTED ASSETS</b>		
Cash and cash equivalents	\$ 73,158,904	\$ 85,004,025
Short-term investment	-	4,044,936
Investments	79,543,319	50,225,794
Receivables:		
Subscription income	25,830,032	22,922,446
Self - insured groups	12,737,267	17,969,378
Other	2,380,828	592,727
Amounts due from affiliates:		
Capital Blue Cross	1,274,400	1,274,400
Highmark Life Insurance Company	-	374,757
Deferred income tax assets, net	3,680,491	3,419,541
EDP equipment and operating system software (net of accumulated depreciation of \$2,702,909 and \$2,649,686 in 2003 and 2002, respectively)	467,643	561,728
<b>Total admitted assets</b>	<b>\$ 199,072,884</b>	<b>\$ 186,389,732</b>
 <b>LIABILITIES, CAPITAL AND SURPLUS</b>		
<b>Liabilities:</b>		
Claims outstanding	\$ 50,229,316	\$ 52,194,552
Unearned subscription income and advance premium	42,102,040	38,387,302
Accounts payable and accrued expenses	16,761,086	20,018,820
Federal income taxes payable	6,007,490	1,489,276
Amounts due to affiliates:		
Capital Blue Cross	3,215,519	9,081,847
Highmark Inc.	-	1,095,978
Highmark Life Insurance Company	-	113,307
Keystone Health Plan Management Company	202,688	693,985
Amounts held for others	8,343,140	9,528,188
Amounts payable to providers	1,375,164	2,495,372
<b>Total liabilities</b>	<b>128,236,443</b>	<b>135,098,627</b>
<b>Capital and surplus:</b>		
<b>Common stock:</b>		
Class A, \$1 par value, 75,000 shares authorized, 20,000 issued and outstanding	20,000	20,000
Class B, \$1 par value, 75,000 shares authorized, 20,000 issued and outstanding	20,000	20,000
Additional paid-in-capital	1,160,000	1,160,000
Surplus debentures	14,000,000	16,000,000
Unassigned surplus	55,636,441	34,091,105
<b>Total capital and surplus</b>	<b>70,836,441</b>	<b>51,291,105</b>
<b>Total liabilities, capital and surplus</b>	<b>\$ 199,072,884</b>	<b>\$ 186,389,732</b>

The accompanying notes are an integral part of these statutory financial statements

KEYSTONE HEALTH PLAN CENTRAL, INC.  
 STATUTORY-BASIS STATEMENTS OF OPERATIONS  
 for the years ended December 31, 2003 and 2002

	<u>2003</u>	<u>2002</u>
Income:		
Subscription income	\$ 449,094,238	\$ 429,498,124
Investment income	2,733,198	3,390,527
Realized gain (loss) on investments, net	17,672	(832,190)
Other Income	<u>14,058</u>	<u>188,279</u>
	<u>451,859,166</u>	<u>432,244,740</u>
Expenses:		
Hospital and facility expense	199,150,185	194,033,011
Physician and related expense	106,021,491	99,332,932
Capitation expense	37,157,283	39,795,223
Prescription drug expense	32,536,352	34,713,887
Administrative and general expense	46,330,371	46,492,835
Interest expense	<u>1,321,604</u>	<u>1,003,316</u>
	<u>422,517,286</u>	<u>415,371,204</u>
Income before provision for federal income taxes	29,341,880	16,873,536
Provision for federal income taxes	<u>7,688,616</u>	<u>8,194,345</u>
Net income	<u>\$ 21,653,264</u>	<u>\$ 8,679,191</u>

KEYSTONE HEALTH PLAN CENTRAL, INC.  
 STATUTORY-BASIS STATEMENTS OF CHANGES IN CAPITAL AND SURPLUS  
 for the years ended December 31, 2003 and 2002

	Class A & B		Additional	Subordinate	Unassigned	Total
	Shares	Common Stock	Paid-in Capital	and Surplus Debentures	Surplus	
Balance, December 31, 2001	40,000	\$ 40,000	\$ 1,160,000	\$ 18,000,000	\$ 24,211,869	\$ 43,411,869
Decrease in surplus debentures				(2,000,000)		(2,000,000)
Increase in non-admitted assets					(1,178,045)	(1,178,045)
Other capital & surplus adjustments:						
- unrealized gain on equity securities					382,711	382,711
- change in net deferred income tax					1,995,379	1,995,379
Net income					8,679,191	8,679,191
Balance, December 31, 2002	40,000	\$ 40,000	\$ 1,160,000	\$ 16,000,000	\$ 34,091,105	\$ 51,291,105
Decrease in surplus debentures				(2,000,000)		(2,000,000)
Decrease in non-admitted assets					834,552	834,552
Other capital & surplus adjustments:						
- unrealized gain on equity securities					996,906	996,906
- change in net deferred income tax					(1,939,386)	(1,939,386)
Net income					21,653,264	21,653,264
Balance, December 31, 2003	40,000	\$ 40,000	\$ 1,160,000	\$ 14,000,000	\$ 55,636,441	\$ 70,836,441

KEYSTONE HEALTH PLAN CENTRAL, INC.  
 STATUTORY-BASIS STATEMENTS OF CASH FLOWS  
 for the years ended December 31, 2003 and 2002

	2003	2002
Cash flows from operating activities:		
Cash provided by operating activities:		
Premiums and revenues, net of reinsurance	\$ 449,898,160	\$ 432,018,796
Net transfers from affiliates	-	22,766,626
Investment income	3,399,653	3,433,353
Miscellaneous receipts	14,058	188,279
Other cash (used in) provided by operating activities	(5,331,966)	4,862,874
Cash used in operating activities:		
Medical expenses	(376,830,546)	(370,074,338)
Administrative and general expenses	(45,000,377)	(43,745,006)
Net transfers to affiliates	(7,192,153)	-
Federal income taxes paid	(3,170,402)	(8,347,626)
Net cash provided by operating activities	15,786,427	41,102,958
Cash flows from investing activities:		
Payments for purchase of investments	(101,273,141)	(23,860,469)
Proceeds from maturity of investments	22,895,000	14,000,000
Proceeds from sale of investments	49,894,807	-
Payments for acquisition of furniture and equipment	(261,096)	(505,795)
Proceeds from sale of furniture and equipment	-	3,062
Net cash used in investing activities	(28,744,430)	(10,363,202)
Cash flows from financing activities:		
Interest paid	(932,054)	(1,003,316)
Payment of surplus debentures	(2,000,000)	(2,000,000)
Net cash used in financing activities	(2,932,054)	(3,003,316)
Net (decrease) increase in cash, cash equivalents and short-term investments	(15,890,057)	27,736,440
Cash, cash equivalents and short-term investments at beginning of year	89,048,961	61,312,521
Cash, cash equivalents and short-term investments at end of year	\$ 73,158,904	\$ 89,048,961

KEYSTONE HEALTH PLAN CENTRAL, INC.  
NOTES TO STATUTORY-BASIS FINANCIAL STATEMENTS

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1. Summary of significant Accounting Policies:

Description of the Business:

Keystone Health Plan Central, Inc. (the Company) was incorporated in 1985 as a for profit corporation for the purpose of operating as a health maintenance organization (HMO) in Central Pennsylvania. The Company is a wholly-owned subsidiary of Capital Blue Cross (CBC). The Company was previously owned 50% by Highmark Inc. (Highmark) and 50% by CBC. On November 26, 2003, CBC and Highmark finalized a Stock Purchase Agreement in which Highmark sold its 50% ownership interest in the Company to CBC. The Agreement was effective April 1, 2003.

Nature of Operations:

The Company underwrites managed care insurance products and provides administrative services, which include network access, quality management and utilization management, to various self-insured employer groups. All medical loss exposure associated with self-insured contracting activity is retained by the employer groups.

The Company's geographical market area consists of 21 counties within Central Pennsylvania.

Basis of Presentation:

The National Association of Insurance Commissioners' Practices and Procedures Manual (NAIC SAP) has been adopted as a component of prescribed or permitted practices by the Insurance Department. The Insurance Department has adopted certain prescribed accounting practices that differ from those found in NAIC SAP. None of these differences between the Insurance Department's prescribed accounting practices and NAIC SAP had any impact on the Company.

The Company prepares its statutory-basis financial statements in conformity with accounting practices prescribed or permitted by the Insurance Department of the Commonwealth of Pennsylvania (the Insurance Department), which differ from accounting principles generally accepted in the United States (GAAP).

The more significant differences from GAAP are:

*Investments:* Investments in bonds are reported at amortized cost or market value based on their National Association of Insurance Commissioners (NAIC) rating; for GAAP, such fixed maturity investments would be designated at purchase as held-to-maturity, trading or available-for-sale. Held-to-maturity fixed investments would be reported at amortized cost, and the remaining fixed maturity investments would be reported at fair value with unrealized holding gains and losses reported in operations for those designated as trading and as a separate component of shareholders' equity for those designated as available-for-sale.

*Non-admitted Assets:* Certain assets designated as non-admitted, principally prepaid expenses, furniture and equipment, certain receivables greater than 90 days past due and other assets not specifically identified as an admitted asset within the NAIC SAP are excluded from the accompanying balance sheets and are charged directly to unassigned surplus. Under GAAP, such assets are included in the balance sheet.

KEYSTONE HEALTH PLAN CENTRAL, INC.  
NOTES TO STATUTORY-BASIS FINANCIAL STATEMENTS, Continued

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1. Summary of Significant Accounting Policies, continued:

Basis of Presentation, continued:

*Deferred Income Taxes:* Deferred tax assets are limited to 1) the amount of federal income taxes paid in prior years that can be recovered through loss carrybacks for existing temporary differences that reverse by the end of the subsequent calendar year, plus 2) the lesser of the remaining gross deferred tax assets expected to be realized within one year of the balance sheet date or 10% of capital and surplus, excluding any net deferred tax assets, EDP equipment and operating software and any net positive goodwill, plus 3) the amount of remaining gross deferred tax assets that can be offset against existing gross deferred tax liabilities. The remaining deferred tax assets are non-admitted. Deferred taxes do not include amounts for state taxes. Under GAAP, state income taxes are included in the computation of deferred taxes, a deferred tax asset is recorded for the amount of gross deferred tax assets expected to be realized in future years, and a valuation allowance is established for deferred tax assets not realizable.

*Surplus Debentures:* Surplus debentures are reflected in statutory capital and surplus, under GAAP, surplus debentures are reflected as a liability.

Use of Estimates:

The preparation of financial statements of insurance companies requires management to make estimates and assumptions that affect amounts reported in the statutory-basis financial statements and accompanying notes. Such estimates and assumptions could change in the future as more information becomes known, which could impact the amounts reported and disclosed herein.

Cash, Cash Equivalents and Short-Term Investments:

The Company considers all highly liquid debt instruments purchased with a maturity date of three months or less at date of purchase, to be cash equivalents for purposes of the statutory-basis balance sheets and the statements of cash flow. Cash equivalents are carried at cost, which approximates fair value. Short-term investments are securities with a maturity date of one year or less at date of purchase, excluding instruments classified as cash or cash equivalents.

Investments:

The Company's invested assets consist of commercial paper, U.S. Treasury securities, corporate and municipal bonds, other U.S. Government agency debt instruments and certain equity securities. Debt securities are carried at amortized cost and premiums or discounts are amortized using the effective interest method. Marketable equity securities are carried at fair value (using market prices published by the NAIC Securities Valuation Office) and unrealized gains and losses are reported as an adjustment to surplus. Realized gains and losses are calculated based on amortized cost using the specific identification method for calculating these gains and losses.

The Company accounts for its wholly-owned subsidiary, Keystone Health Plan Management Company (KHPMC), using the GAAP equity method. Income is recognized as unrealized gains and losses, which is reported as an adjustment to surplus.

The Company periodically evaluates securities for other than temporary impairment. Factors considered in determining whether declines in fair value are other than temporary include the significance of the decline, the time duration of the decline, current economic conditions and the Company's ability and intent to hold the security until such time that the fair value recovers. At the time a security is determined to be other than temporarily impaired, the Company records a realized loss in the statutory-basis statement of operations.

Continued

KEYSTONE HEALTH PLAN CENTRAL, INC.  
NOTES TO STATUTORY-BASIS FINANCIAL STATEMENTS, Continued

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1. Summary of Significant Accounting Policies, continued:

Investment Income:

All due and accrued investment income was included in the statutory-basis financial statements since no amounts are 90 days past due.

Income Taxes:

The Company and its subsidiary, KHPMC are part of CBC's consolidated federal income tax return. The method of allocation between the companies is subject to written agreement, approved by the Board of Directors. Allocation is based upon separate return calculations with current credit for net losses. Inter-company tax balances are settled within 60 days of statutory due dates.

Claims Outstanding:

The liability for claims outstanding is based on known amounts of reported claims and an estimate for incurred but not reported claims using past experience adjusted for current trends. The methods used to determine this estimate are continually reviewed and any resulting adjustments are included in current operations.

Contract and Premium Deficiency Reserves:

The Company evaluates its various managed care products by contract type to determine if a contract reserve is necessary. Contract reserves are established when a portion of premiums earned in the early periods of a multi year fully insured contract are meant to pay for anticipated increases in claim expenses during the later periods of the contract.

Additionally, the Company evaluates whether a premium deficiency reserve is necessary. Premium deficiency reserves are necessary when future premiums plus claim reserves are insufficient to account for future expected claim payments and expenses. The Company does not take investment income into consideration when making premium deficiency reserve evaluations.

Contract reserves and premium deficiency reserves are included in claims outstanding. At the point in which the Company identifies that a contract or premium deficiency reserve is necessary, the loss is recognized in the statutory-basis statement of operations.

As a result of the Company's periodic evaluation of its various managed care products, the Company has determined that one of its products requires a premium deficiency reserve, as of December 31, 2003 and 2002. Accordingly, the Company recorded premium deficiency reserves of \$282,629 and \$223,290 as of December 31, 2003 and 2002, respectively.

Amounts Held for Others:

Amounts held for others consist of advances from self-insured employer groups for medical costs incurred by the Company on behalf of these groups.

KEYSTONE HEALTH PLAN CENTRAL, INC.  
NOTES TO STATUTORY-BASIS FINANCIAL STATEMENTS, Continued

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1. Summary of Significant Accounting Policies, continued:

Reinsurance:

Through its reinsurance contract, the Company seeks to reduce losses that may arise from risks or occurrences of an unexpected nature that cause adverse underwriting results. Premiums and health care costs are accounted for on bases consistent with those used in accounting for the original policies issued and the terms of the reinsurance contracts.

Subscription Income:

Subscription income is recognized on contracts that contain insurance risk. Subscriber premiums are generally billed in advance of the contractual coverage periods. These premiums are included in income as earned during the coverage period. The unearned portion of premiums is reflected in the statutory-basis balance sheets as unearned subscription income and advance premium.

Administrative Service Revenue:

Administrative service revenue is recognized on contracts that do not contain insurance risk. Administrative services revenue is recorded in the statutory-basis statements of operations in the period that the related services are provided to self-insured employer groups and is recorded as a reduction to administrative and general expense.

Health Care Service Cost Recognition:

The Company contracts with primary care physicians to provide primary health care services to its members. Medical expenses include all amounts incurred by the Company under the aforementioned contracts. The cost of other health care services provided or contracted for is accrued in the period in which the coverage is provided to a member and is based in part on estimates. The methods used to determine these estimates are continually reviewed and any resulting adjustments are included in current operations.

Change in Accounting Principle:

As of January 1, 2002, the Company adopted the provisions of SSAP #84, "Certain Health Care Receivables and Receivables Under Government Insured Plans" regarding admissibility of pharmaceutical rebate receivables.

Reclassifications:

Certain items in the December 31, 2002 statutory-basis financial statements have been reclassified to conform to current year presentation.

KEYSTONE HEALTH PLAN CENTRAL, INC.  
NOTES TO STATUTORY-BASIS FINANCIAL STATEMENTS, Continued

2. Investments:

The amortized cost and fair values of investments in securities at December 31, 2003 and 2002 are as follows:

	2003			
	Amortized Cost or Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
U.S. Treasury securities	\$ 770,692	\$ 1,406	\$ 1,056	\$ 771,042
U.S. Government agencies	30,091,342	113,564	35,629	30,169,277
Municipal bonds	2,082,118	75,051	-	2,157,169
Corporate obligations	<u>42,621,539</u>	<u>536,231</u>	<u>247,218</u>	<u>42,910,552</u>
Total debt securities	75,565,691	726,252	283,903	76,008,040
Marketable equity securities	<u>3,148,747</u>	<u>828,881</u>	<u>-</u>	<u>3,977,628</u>
Total	<u>\$ 78,714,438</u>	<u>\$ 1,555,133</u>	<u>\$ 283,903</u>	<u>\$ 79,985,668</u>

	2002			
	Amortized Cost or Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
U.S. Treasury securities	\$ 1,564,653	\$ 96,886	\$ -	\$ 1,661,539
U.S. Government agencies	20,029,814	365,562	-	20,395,376
Municipal bonds	9,988,009	299,693	-	10,287,702
Corporate obligations	<u>15,514,480</u>	<u>316,765</u>	<u>-</u>	<u>15,831,245</u>
Total debt securities	47,096,956	1,078,906	-	48,175,862
Marketable equity securities	<u>3,128,838</u>	<u>-</u>	<u>-</u>	<u>3,128,838</u>
Total	<u>\$ 50,225,794</u>	<u>\$ 1,078,906</u>	<u>\$ -</u>	<u>\$ 51,304,700</u>

Continued

KEYSTONE HEALTH PLAN CENTRAL, INC.  
 NOTES TO STATUTORY-BASIS FINANCIAL STATEMENTS, Continued

2. Investments, continued:

The amortized cost and fair value of debt securities at December 31, 2003, by contractual maturity, are shown below. Expected maturities could differ from contractual maturities because borrowers may have the right to call or prepay obligations with or without call or prepayment penalties.

	2003	
	Amortized Cost	Fair Value
Due within 1 yr. or less	\$ 2,555,902	\$ 2,570,856
Due after 1 yr. through 5 yrs.	\$ 29,531,379	\$ 29,764,850
Due after 5 yr. through 10 yrs.	\$ 22,338,993	\$ 22,243,260
Due after 10 years	21,139,417	21,429,074
Total	\$ 75,565,691	\$ 76,008,040

A bond with a par value of \$100,000 (amortized cost of \$100,154 and \$99,920 as of December 31, 2003 and 2002, respectively) at December 31, 2003 and 2002 was on deposit with the Insurance Department as required by law.

The Company does not own any below investment grade debt securities. Proceeds from the sale of investments were \$49,894,807 and \$0 and gross realized gains were \$17,672 and \$0 in 2003 and 2002, respectively. In addition, the Company recorded a realized loss on marketable equity security investments of \$0 and \$832,190 in 2003 and 2002, respectively, as a result of an other than temporary impairment write-down.

KEYSTONE HEALTH PLAN CENTRAL, INC.  
NOTES TO STATUTORY-BASIS FINANCIAL STATEMENTS, Continued

3. Income Taxes:

The tax effects of temporary differences that give rise to significant portions of deferred tax assets and liabilities are as follows:

	December 31, 2003	December 31, 2002
Deferred tax assets:		
Pension / postretirement benefits	\$ -	\$ 3,011,286
Unearned subscription income	1,724,828	1,531,799
Accrued expenses	2,590,000	2,590,000
Discounting of claims outstanding	469,766	536,792
Difference in investment carrying values	884,984	884,984
Fixed assets	354,148	483,288
Health care receivables	258,956	-
Other	1,310,495	826,027
Total deferred tax assets	<u>7,593,177</u>	<u>9,864,176</u>
Non-admitted deferred tax assets	<u>(3,909,360)</u>	<u>(6,109,696)</u>
Admitted deferred tax assets	3,683,817	3,754,480
Deferred tax liabilities:		
Interest	-	244,601
Other	3,326	90,338
Total deferred tax liabilities	<u>3,326</u>	<u>334,939</u>
Net deferred tax assets	<u>\$ 3,680,491</u>	<u>\$ 3,419,541</u>
Decrease in non-admitted assets	(2,200,336)	

The change in net deferred income taxes is comprised of the following (this analysis is exclusive of non-admitted assets):

	December 31, 2003	December 31, 2002	Change
Total deferred tax assets	\$ 7,593,177	\$ 9,864,176	\$ (2,270,999)
Total deferred tax liabilities	<u>3,326</u>	<u>334,939</u>	<u>(331,613)</u>
Net deferred tax assets	\$ 7,589,851	\$ 9,529,237	(1,939,386)
Tax effect of unrealized gains			-
Change in net deferred income taxes			<u>\$ (1,939,386)</u>

KEYSTONE HEALTH PLAN CENTRAL, INC.  
NOTES TO STATUTORY-BASIS FINANCIAL STATEMENTS, Continued

3. Income Taxes, continued:

The provision for federal income taxes incurred is different from that which would be obtained by applying the statutory Federal income tax rate to income before income taxes. The significant items causing this difference are as follows:

	December 31, 2003	December 31, 2002
Provision computed at statutory rate	\$ 10,381,611	\$ 5,905,738
Tax exempt interest deduction	(138,602)	(102,772)
Temporary differences recorded directly to surplus	(502,477)	359,085
Other	(112,530)	36,915
Total	\$ 9,628,002	\$ 6,198,966
Federal income taxes incurred	\$ 7,688,616	\$ 8,194,345
Change in net deferred income taxes	1,939,386	(1,995,379)
Total statutory income taxes	\$ 9,628,002	\$ 6,198,966

As of December 31, 2003, the Company had state income tax net operating loss carry forwards totaling \$6 million, which will expire by 2007. The Company has not recognized a deferred tax asset for these carry forwards.

The following are income taxes incurred in the current and prior years that will be available for recoupment in the event of future net losses:

2003	\$	8,414,343
2002	\$	7,434,380

4. Transactions with Parents, Subsidiaries and Affiliates:

Highmark provided certain administrative services, including the administration of employee benefits and risk management programs, on behalf of the Company during 2003 and 2002. CBC provided claims processing and certain administrative services on behalf of the Company during 2003 and 2002. Highmark Life Insurance Company, a wholly-owned subsidiary of Highmark, maintained a reinsurance policy for stop-loss coverage on medical claims during 2003 and 2002.

KEYSTONE HEALTH PLAN CENTRAL, INC.  
NOTES TO STATUTORY-BASIS FINANCIAL STATEMENTS, Continued

4. Transactions with Parents, Subsidiaries and Affiliates, continued:

For services received, the Company was charged the following fees from affiliated entities during 2003 and 2002, and are included in hospital and facility expense and administrative and general expense (amounts reported for CBC exclude charges associated with self-insured business):

	<u>2003</u>	<u>2002</u>
Capital Blue Cross	\$ 7,846,389	\$ 7,702,330
Highmark Inc. (A)	2,069,137	2,095,711

In accordance with the Company's reinsurance contract, the following premiums and recoveries were incurred during 2003 and 2002:

	<u>2003</u>	<u>2002</u>
Highmark Life Insurance Company (A)		
Premiums	1,917,059	1,366,841
Recoveries	<u>(670,810)</u>	<u>(882,732)</u>
	<u>\$ 1,246,249</u>	<u>\$ 484,109</u>

(A) As a result of the Stock Purchase Agreement signed by CBC and Highmark, Highmark or any of its subsidiaries are not considered an affiliated entity for 2003.

At December 31, 2003 and 2002, the following amounts due from (to) affiliated entities were outstanding:

	<u>2003</u>	<u>2002</u>
Capital Blue Cross		
Due from	\$ 1,274,400	\$ 1,274,400
Due to	<u>(3,215,519)</u>	<u>(9,081,847)</u>
Due to CBC	<u>\$ (1,941,119)</u>	<u>\$ (7,807,447)</u>
Highmark Inc.		
Due to	<u>\$ -</u>	<u>\$ (1,095,978)</u>
Due to Highmark Inc.	<u>\$ -</u>	<u>\$ (1,095,978)</u>
Highmark Life Insurance Company		
Due from	\$ -	\$ 374,757
Due to	<u>-</u>	<u>(113,307)</u>
Due from Highmark Life Insurance Company	<u>\$ -</u>	<u>\$ 261,450</u>
Due to Keystone Health Plan Management Co.	\$ (202,688)	\$ (693,985)

Continued

KEYSTONE HEALTH PLAN CENTRAL, INC.  
NOTES TO STATUTORY-BASIS FINANCIAL STATEMENTS, Continued

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4. Transactions with Parents, Subsidiaries and Affiliates, continued:

The Company, through its wholly-owned subsidiary KHPMC, provided certain administrative and medical management services to CBC of approximately \$900,000 and \$6,600,000 in 2003 and 2002, respectively.

The Company had a guarantee from CBC and Highmark, to the extent of their ownership interests, for all contractual and financial obligations of the Company through November 26, 2003. Since November 26, 2003, the Company's guarantee has been only from CBC, its sole owner. This guarantee is the result of a requirement by the Blue Cross and Blue Shield Association to enable the Company to use the registered Blue Cross and Blue Shield service marks.

5. Benefit Plans:

The employees of the Company are covered under the retirement plan of Highmark. Accordingly, the Company has been charged \$1,798,007 and \$1,500,705 in 2003 and 2002, respectively, by Highmark for its portion of total pension expense. These amounts are included in the Company's statutory-basis statements of operations.

Highmark also sponsors a post-retirement health benefit plan, which covers eligible employees of the Company. The Company's portion of the total post-retirement health benefit expenses for 2003 and 2002 of \$741,715 and \$487,906, respectively, has been included in the Company's statutory-basis statements of operations based on allocations determined by Highmark.

Additionally, Highmark also sponsors a defined contribution plan that covers eligible employees of the Company. The plan allows participating employees to contribute a percentage of their annual salary subject to current Internal Revenue Service (IRS) limitations. Employee contributions are matched by the Company at various percentages. The Company's contributions were \$398,377 and \$389,899 in 2003 and 2002, respectively.

As a result of the Stock Purchase Agreement, beginning January 1, 2004 the employees of the Company will be covered under CBC's retirement, post-retirement and defined contribution plans.

KEYSTONE HEALTH PLAN CENTRAL, INC.  
NOTES TO STATUTORY-BASIS FINANCIAL STATEMENTS, Continued

6. Surplus Debentures:

The Company had surplus debentures outstanding of \$16,000,000 as of December 31, 2002, of which \$8,000,000 was owed to each CBC and Highmark. As of December 31, 2003, the Company had surplus debentures outstanding of \$14,000,000. As a result of the Stock Purchase Agreement finalized on November 26, 2003 between CBC and Highmark, CBC purchased all surplus debentures that the Company owed to Highmark. As such, \$14,000,000 outstanding at December 31, 2003 was owed entirely to CBC.

Note Number	001	002	003	004	Total
Note Holder	CBC	CBC	CBC	CBC	
Date Issued	12/30/1998	12/30/1998	12/29/2000	12/29/2000	
Par Value (Original amount of Note)	\$ 6,000,000	\$ 6,000,000	\$ 5,000,000	\$ 5,000,000	\$ 22,000,000
Carrying Value	\$ 2,000,000	\$ 2,000,000	\$ 5,000,000	\$ 5,000,000	\$ 14,000,000
Interest Rate	3.71%	3.71%	3.71%	3.71%	
Principal and/or Interest Paid					
Current Year	\$ 1,174,860	\$ 1,174,860	\$ 291,167	\$ 291,167	\$ 2,932,054
Total Principal and/or Interest Paid	\$ 5,222,177	\$ 5,222,177	\$ 664,655	\$ 664,655	\$ 11,773,664
Unapproved Principal / Interest	\$ -	\$ -	\$ -	\$ -	\$ -
Date of Maturity:					
2004	\$ 1,000,000	\$ 1,000,000			\$ 2,000,000
2005	\$ 1,000,000	\$ 1,000,000			\$ 2,000,000
2006	\$ -	\$ -	\$ 1,000,000	\$ 1,000,000	\$ 2,000,000
2007	\$ -	\$ -	\$ 1,000,000	\$ 1,000,000	\$ 2,000,000
2008	\$ -	\$ -	\$ 1,000,000	\$ 1,000,000	\$ 2,000,000
Thereafter	\$ -	\$ -	\$ 2,000,000	\$ 2,000,000	\$ 4,000,000
Total	\$ 2,000,000	\$ 2,000,000	\$ 5,000,000	\$ 5,000,000	\$ 14,000,000

The above referenced surplus debentures were issued in exchange for cash. These surplus debentures bear interest at a rate that is adjusted annually and is based on the five-year U.S. Treasury Bond rate plus 1%. These surplus debentures are subordinated to all other indebtedness and are collateralized by the assets of the Company. The carrying value for the surplus debentures approximate their fair value.

The Company, with the approval of the Insurance Department, may redeem the surplus debentures at any time, in part or in whole. In addition, interest payments and accruals must also be approved by the Insurance Department. Interest expense is not recorded in the statutory statements of operations until approval for accrual has been obtained by the Insurance Department. Interest, which includes prior years' interest, in the amount of \$1,321,604 and \$1,003,316 was approved for accrual or payment in 2003 and 2002, respectively.

KEYSTONE HEALTH PLAN CENTRAL, INC.  
 NOTES TO STATUTORY-BASIS FINANCIAL STATEMENTS, Continued

7. Litigation:

The Company has been named as the defendant in a class action lawsuit regarding changes made between 1997 and 1998 to the premium rates and benefit structure of *SeniorBlue*, the Company's Medicare HMO product. Although efforts are being made to resolve this matter through a negotiated settlement, it is still uncertain as to whether this case will be resolved in the coming year.

The Company is subject to various other legal actions and proceedings that arise in the ordinary course of its business. Due to the complex nature of these actions and proceedings, the timing of the ultimate resolution of these matters is uncertain.

In the opinion of management, based on consultation with legal counsel, adequate provision has been made in the statutory-basis financial statements for the liability with respect to these matters, and the ultimate liability with respect to outstanding litigation could potentially materially affect the statutory financial position of the Company.

8. Leases:

The Company has non-cancelable operating leases for office space and certain equipment, which extend through 2005. The following is a summary of operating lease payments:

	<u>2003</u>	<u>2002</u>
Minimum rentals	\$ 2,540,703	\$ 2,196,466
Sublease income	<u>(224,129)</u>	<u>(42,756)</u>
Net expense	<u>\$ 2,316,574</u>	<u>\$ 2,153,710</u>

Future minimum lease payments under non-cancelable operating leases are as follows:

2004	\$ 1,870,125
2005	<u>52,721</u>
Total	<u>\$ 1,922,846</u>

KEYSTONE HEALTH PLAN CENTRAL, INC.  
NOTES TO STATUTORY-BASIS FINANCIAL STATEMENTS, Continued

9. Uninsured Plans:

The Company provides self-insured contract activities to certain employer groups. The employer group retains all medical loss risk associated with self-insured contracting activities. The following summarizes the Company's self-insured activities during 2003 and 2002:

ASO Uninsured Plans

	2003	2002
Net reimbursement for administrative expenses	\$ (1,309,599)	\$ (1,409,642)
Total other income or expense	-	-
Net loss from operations	\$ (1,309,599)	\$ (1,409,642)
 Total claim payment volume	 \$ 107,610,963	 \$ 106,319,166

10. Reinsurance:

During 2003 and 2002, the Company's reinsurance contract was with Highmark Life Insurance Company. The Company had an unsecured reinsurance recoverable on paid losses from Highmark Life Insurance Company in the amount of \$120,832 and \$374,757 as of December 31, 2003 and 2002, respectively.

11. Changes in Claims Outstanding:

The following is an analysis of the Company's liability for claims outstanding as of December 31, 2003 and 2002:

	2003	2002
Claims outstanding as of January 1	\$ 52,194,552	\$ 53,861,431
Incurred related to:		
Current year	387,977,462	378,401,977
Prior years	(13,112,152)	(10,508,549)
Total incurred	374,865,310	367,893,428
Paid related to:		
Current year	341,937,220	329,231,756
Prior years	34,893,326	40,328,551
Total paid	376,830,546	369,560,307
Claims outstanding as of December 31	\$ 50,229,316	\$ 52,194,552

KEYSTONE HEALTH PLAN CENTRAL, INC.  
NOTES TO STATUTORY-BASIS FINANCIAL STATEMENTS, Continued

11. Changes in Claims Outstanding, continued:

Amounts reported in the analysis of claims outstanding are net of reinsurance. The liability for claims outstanding attributable to insured events of prior years has decreased healthcare service costs by \$13,112,152 and \$10,508,549 in 2003 and 2002, respectively. The decrease is the result of the re-estimation of unpaid losses on the Commercial and Medicare lines of business. This decrease is generally the result of ongoing analysis of recent loss development trends. Original estimates are increased or decreased as additional information becomes known regarding individual losses.

12. Minimum Capital and Surplus:

Under the laws and regulations of the Commonwealth of Pennsylvania, the Company is currently required to maintain minimum capital and surplus equal to the greater of \$1,000,000 or 3 months of uncovered expenditures, for insolvency purposes. As of December 31, 2003 and 2002, the Company met the minimum capital and surplus requirements.

13. EDP Equipment, Operating System Software and Other Depreciable Fixed Assets:

Electronic data processing equipment is carried at cost, less accumulated depreciation. Maintenance, repairs and minor improvements are expensed as incurred. Depreciation is computed under the straight-line method over the estimated useful lives of the related assets. When assets are retired or otherwise disposed of, the cost and related accumulated depreciation are removed from the accounts and any resulting gain or loss is included in operations.

A summary of the major components of depreciable fixed assets at December 31, 2003 is as follows:

	2003		
	Total	Non-admitted	Net
EDP equipment	\$ 3,095,259	\$ -	\$ 3,095,259
Operating system software	\$ 75,293	\$ -	\$ 75,293
Furniture and fixtures	\$ 1,362,362	\$ 1,362,362	\$ -
Non-operating system software	\$ 723,468	\$ 723,468	\$ -
Leasehold improvement and other	\$ 1,667,525	\$ 1,667,525	\$ -
	<u>\$ 6,923,907</u>	<u>\$ 3,753,355</u>	<u>\$ 3,170,552</u>
Less: Accumulated depreciation	<u>(6,132,480)</u>	<u>(3,429,571)</u>	<u>\$ (2,702,909)</u>
Total	<u>\$ 791,427</u>	<u>\$ 323,784</u>	<u>\$ 467,643</u>

Depreciation expense totaled \$760,549 and \$1,020,267 in 2003 and 2002, respectively.

KEYSTONE HEALTH PLAN CENTRAL, INC.  
NOTES TO STATUTORY-BASIS FINANCIAL STATEMENTS, Continued

14. Certain Health Care Receivables:

For periods ending December 31, 2001 and prior, the Company recorded pharmacy rebates as they were received. In 2002, the Company began recording pharmacy rebates on an accrual basis, based on actual scripts filled. The Company admits pharmacy receivables applicable to the quarter ended on the statutory financial statement date.

Quarter	Estimated Pharmacy Rebates Reported on Financial Statements	Pharmacy Rebates as Billed or Otherwise Confirmed	Actual Rebates Received Within 90 Days of Billing	Actual Rebates Received Within 91 to 180 Days of Billing	Actual Rebates Received More Than 180 Days After Billing
12/31/2003	\$ 1,375,528	\$ -	\$ -	\$ -	\$ -
9/30/2003	\$ 1,338,121	\$ 775,096	\$ 775,096	\$ -	\$ -
6/30/2003	\$ 1,377,949	\$ 1,219,968	\$ 593,543	\$ 626,426	\$ -
3/31/2003	\$ 1,340,248	\$ 1,339,901	\$ 619,880	\$ 572,669	\$ 147,352
12/31/2002	\$ 2,005,140	\$ 2,005,140	\$ 2,005,140	\$ -	\$ -
9/30/2002	\$ 1,881,760	\$ 1,881,760	\$ 1,881,760	\$ -	\$ -
6/30/2002	\$ 1,107,841	\$ 1,107,841	\$ 1,107,841	\$ -	\$ -
3/31/2002	\$ 984,252	\$ 984,252	\$ 984,252	\$ -	\$ -
12/31/2001	\$ 1,559,313	\$ 1,559,313	\$ 1,559,313	\$ -	\$ -
9/30/2001	\$ 977,153	\$ 977,153	\$ 977,153	\$ -	\$ -
6/30/2001	\$ 1,620,708	\$ 1,620,708	\$ 1,620,708	\$ -	\$ -
3/31/2001	\$ 965,809	\$ 965,809	\$ 965,809	\$ -	\$ -

15. Risk-Based Capital:

The Company is subject to minimum risk-based capital requirements that were developed by the NAIC. The formulas for determining the amount of risk-based capital specify various weighting factors that are applied to financial balances and various levels of risk activity. Regulatory compliance is determined by a ratio of the Company's total adjusted capital, as defined by the NAIC, to its authorized control level risk-based capital, as defined by the NAIC. Companies below specific ratio thresholds are categorized within certain levels, each of which requires specific corrective action. At December 31, 2003 and 2002, the Company exceeded minimum risk-based capital requirements.

KEYSTONE HEALTH PLAN CENTRAL, INC.  
NOTES TO STATUTORY-BASIS FINANCIAL STATEMENTS, Continued

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16. Stock Purchase Agreement:

On March 26, 2003, the Company's parent companies, CBC and Highmark entered into a Stock Purchase Agreement whereby CBC would acquire Highmark's 50% share of the Company's stock, making CBC the sole owner. This Agreement was subject to certain subsequent conditions, which included Insurance Department approval of grant of irrevocable proxy from Highmark to CBC to vote its shares pending closure of the transaction and of the transaction itself. This proxy was approved and became effective on April 1, 2003, giving CBC effective control of the Company as of that date. The Insurance Department subsequently approved the transaction itself and, after other conditions were met regarding agreements for Highmark to continue certain services to the Company for a period, the transaction closed on November 26, 2003. As part of the transaction, the Company executed a Settlement Agreement and Mutual Release, which released all claims to purchase affiliated managed care organizations, which had been subject of a 1997 arbitration ruling and court order.

KEYSTONE HEALTH PLAN CENTRAL, INC.  
SUMMARY INVESTMENT SCHEDULE  
For the year ended December 31, 2003

Investment Category	Gross Investment Holdings		Admitted Assets as Reported in the Annual Statement	
	Amount	Percentage	Amount	Percentage
<b>Bonds:</b>				
U.S. treasury securities	770,691	0.512%	770,691	0.505%
U.S. government agency and corporate obligations (excluding mortgage-backed securities):				
Issued by U.S. government agencies	-	0.000%	-	0.000%
Issued by U.S. government-sponsored agencies	21,199,137	14.074%	21,199,137	13.883%
Foreign government (including Canada, excluding mortgage-backed securities)	-	0.000%	-	0.000%
Securities issued by states, territories and possessions and political subdivisions of the U.S.:				
State, territory and possession general obligations	2,082,118	1.382%	2,082,118	1.364%
Political subdivisions of states, territories and possessions political subdivisions general obligations	-	0.000%	-	0.000%
Revenue and assessment obligations	10,047,079	6.670%	10,047,079	6.580%
Industrial development and similar obligations	-	0.000%	-	0.000%
Mortgage-backed securities (includes residential and commercial MBS):				
Pass-through securities:				
Guaranteed by GNMA	-	0.000%	-	0.000%
Issued by FNMA and FHLMC	-	0.000%	-	0.000%
Privately issued	-	0.000%	-	0.000%
CMOs and REMICs:				
Issued by FNMA and FHLMC	-	0.000%	-	0.000%
Privately issued and collateralized by MBS issued or guaranteed by GNMA, FMNA and FHLMC	-	0.000%	-	0.000%
All other privately issued	-	0.000%	-	0.000%
Other debt and other fixed income securities (excluding short-term):				
Unaffiliated domestic securities (incl. Credit tenant loans rated by SVO)	41,150,423	27.319%	41,150,423	26.948%
Unaffiliated foreign securities	316,243	0.000%	316,243	0.000%
Affiliated securities	-	0.000%	-	0.000%

Continued

KEYSTONE HEALTH PLAN CENTRAL, INC.  
SUMMARY INVESTMENT SCHEDULE, Continued  
For the year ended December 31, 2003

Investment Category	Gross Investment Holdings		Admitted Assets as Reported in the Annual Statement	
	Amount	Percentage	Amount	Percentage
Equity interests:				
Investment in mutual funds	3,977,628	2.641%	3,977,628	2.605%
Preferred stocks:				
Affiliated	-	0.000%	-	0.000%
Unaffiliated	-	0.000%	-	0.000%
Publicly traded equity interests (excluding preferred stocks):				
Affiliated	-	0.000%	-	0.000%
Unaffiliated	-	0.000%	-	0.000%
Other equity securities:				
Affiliated	(2,070,875)	-1.375%	-	0.000%
Unaffiliated	-	0.000%	-	0.000%
Other equity interests including tangible personal property under lease:				
Affiliated	-	0.000%	-	0.000%
Unaffiliated	-	0.000%	-	0.000%
Mortgage loans:				
Construction and land development	-	0.000%	-	0.000%
Agricultural	-	0.000%	-	0.000%
Single family residential properties	-	0.000%	-	0.000%
Multifamily residential properties	-	0.000%	-	0.000%
Commercial loans	-	0.000%	-	0.000%
Real estate loans:				
Property occupied by company	-	0.000%	-	0.000%
Property held for production of income	-	0.000%	-	0.000%
Property held for sale	-	0.000%	-	0.000%
Collateral loans	-	0.000%	-	0.000%
Policy loans	-	0.000%	-	0.000%
Receivables for securities	-	0.000%	-	0.000%
Cash and short-term investments	73,158,904	48.568%	73,158,904	47.910%
Write-in for invested assets	-	0.000%	-	0.000%
Total invested assets	<u>150,631,348</u>	<u>100.000%</u>	<u>152,702,223</u>	<u>100.000%</u>

KEYSTONE HEALTH PLAN CENTRAL, INC.  
 SUPPLEMENTAL INVESTMENT RISKS INTERROGATORIES  
 For the year ended December 31, 2003

1. State the reporting entity's total admitted assets as reported on page 2 of the Annual Stated - \$199,072,884

2. State by investment category the 10 largest exposures to a single issuer / borrower / investment, excluding U.S. government, U.S. government agency securities and those U.S. government money market funds listed in the appendix to the SVO Purposes and Procedures Manual as exempt, property occupied by the company and policy loans.

	Investment Category	Amount	Percentage of Total Admitted Assets
2.01	Equity: investment in mutual fund	\$ 3,977,628	2.00%
2.02	Bond: industrial & miscellaneous	\$ 1,535,525	0.77%
2.03	Bond: industrial & miscellaneous	\$ 1,514,992	0.76%
2.04	Bond: industrial & miscellaneous	\$ 1,143,447	0.57%
2.05	Bond: special revenue, special assessment	\$ 1,080,105	0.54%
2.06	Bond: industrial & miscellaneous	\$ 1,074,920	0.54%
2.07	Bond: state, territory and possessions	\$ 1,063,475	0.53%
2.08	Bond: industrial & miscellaneous	\$ 1,021,558	0.51%
2.09	Bond: state, territory and possessions	\$ 1,018,643	0.51%
2.10	Bond: industrial & miscellaneous	\$ 999,836	0.50%

3. State the amounts and percentages of the reporting entity's total admitted assets held in bonds and preferred stocks by NAIC rating.

	Bonds	Amount	Percentage of Total Admitted Assets
3.01	NAIC - 1	\$ 61,869,105	31.08%
3.02	NAIC - 2	\$ 13,696,586	6.88%
3.03	NAIC - 3	\$ -	0.00%
3.04	NAIC - 4	\$ -	0.00%
3.05	NAIC - 5	\$ -	0.00%
3.06	NAIC - 6	\$ -	0.00%

KEYSTONE HEALTH PLAN CENTRAL, INC.  
SUPPLEMENTAL INVESTMENT RISKS INTERROGATORIES, Continued  
For the year ended December 31, 2003

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4. State the amounts and percentages of the reporting entity's total admitted assets held in foreign investments (regardless of whether there is any foreign currency exposure) and unhedged foreign currency exposure (defined as the statement value of investments denominated in foreign currencies which are not hedged by financial instruments qualifying for hedge accounting as specified in SSAP No. 31 – Derivative Instruments), including:
  - (4.01) Foreign-currency-denominated investments of - \$0
  - (4.02) Supporting insurance liabilities denominated in that same foreign currency of - \$0
  - (4.03) Canadian investments and currency of - \$0
  - (4.04) Assets held in foreign investments less than 2.5% of the reporting entity's total admitted assets, therefore detail not required for interrogatories 5-10 - **Yes**
  
5. Aggregate foreign investment exposure categorized by NAIC sovereign rating: **Not required**
  
6. Two largest foreign investment exposures to a single country, categorized by the country's NAIC sovereign rating: **Not required**
  
7. Aggregate unhedged foreign currency exposure: **Not required**
  
8. Aggregate unhedged foreign currency exposure categorized by NAIC sovereign rating: **Not required**
  
9. Two largest unhedged foreign currency exposures to a single country, categorized by the country's NAIC sovereign rating: **Not required**
  
10. List the 10 largest non-sovereign (i.e. non-governmental) foreign issues: **Not required**
  
11. State the amount and percentages of the reporting entity's total admitted assets held in Canadian investments and unhedged Canadian currency exposure, including:
  - (11.01) Canadian-currency-denominated investments of - \$0
  - (11.02) Supporting Canadian-denominated insurance liabilities of - \$0
  - (11.03) Assets held in Canadian investments less than 2.5% of the reporting entity's total admitted assets, therefore detail not required for interrogatory 12 - **Yes**

KEYSTONE HEALTH PLAN CENTRAL, INC.  
SUPPLEMENTAL INVESTMENT RISKS INTERROGATORIES, Continued  
For the year ended December 31, 2003

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12. Aggregate Canadian investment exposure: **Not required**

13. State the aggregate amount and percentages of the reporting entity's total admitted assets held in investments with contractual sales restrictions (defined as investments having restrictions that prevent investments from being sold within 90 days) - **\$0, 0.00%**

Assets held in investments with contractual sales restrictions less than 2.5% of the reporting entity's total admitted assets, therefore detail not required for interrogatory 13: **None**

14. State the amounts and percentages of admitted assets held in the largest 10 equity interests (including investments in the shares of mutual funds, preferred stocks, publicly traded equity securities, and other equity securities, and excluding money market and bond mutual funds listed in the Appendix to the SVO Practices and Procedures Manual as exempt or Class 1) - **Mutual Fund: \$3,977,628, 2.00%**

Assets held in equity interests less than 2.5% of the reporting entity's total admitted assets, therefore not required for interrogatory 14: **None**

15. State the amounts and percentages of the reporting entity's total admitted assets held in nonaffiliated, privately placed equities (included in other equity securities) and excluding securities eligible for sale under Securities Exchange Commission (SEC) Rule 144a or SEC Rule 144 without volume restrictions - **\$0, 0.00%**

Assets held in nonaffiliated, privately placed equities less than 2.5% of the reporting entity's total admitted assets, therefore not required for interrogatory 15: **None**

16. State the amounts and percentages of the reporting entity's total admitted assets held in general partnership interests (included in other equity securities) - **\$0, 0.00%**

Assets held in general partnership interests less than 2.5% of the reporting entity's total admitted assets, therefore not required for interrogatory 16: **None**

17. With respect to mortgage loans reported in Schedule B, state the amounts and percentages of the reporting entity's total admitted assets held - **\$0, 0.00%**

Mortgage loans reported in Schedule B less than 2.5% of the reporting entity's admitted assets, therefore not required for interrogatories 17 and 18: **None**

KEYSTONE HEALTH PLAN CENTRAL, INC.  
SUPPLEMENTAL INVESTMENT RISKS INTERROGATORIES, Continued  
For the year ended December 31, 2003

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18. Aggregate mortgage loans having the following loan-to-value ratios as determined from the most current appraisal as of the annual statement date: **Not Applicable**

19. State the amounts and percentages of the reporting entity's total admitted assets held in each of the five largest investments in one parcel or group of continuous parcel of real estate reporting in Schedule A, excluding property occupied by the company - **\$0, 0.00%**

Assets held in each of the five largest investments in once parcel or group of continuous parcels of real estate reported in Schedule A less than 2.5% of the reporting entity's total admitted assets, therefore detail not required for interrogatory 19: **None**

20. State the amounts and percentages of the reporting entity's total admitted assets subject to the following types of agreements:

- (20.01) Securities lending - **\$0, 0.00%**
- (20.02) Repurchase agreements - **\$0, 0.00%**
- (20.03) Reverse repurchase agreements - **\$0, 0.00%**
- (20.04) Dollar repurchase agreements - **\$0, 0.00%**
- (20.05) Dollar reverse repurchase agreements - **\$0, 0.00%**

21. State the amounts and percentages indicated below for warrants not attached to other financial instruments, options, caps and floors: **\$0, 0.00%**

22. State the amount and percentages indicated below of potential exposure (defined as the amount determined in accordance with the NAIC Annual Statement Instructions) for collars, swaps, and forwards: **\$0, 0.00%**

23. State the amounts and percentages indicated below of potential exposure (defined as the amount determined in accordance with the NAIC Annual Statement Instructions) for future contracts: **\$0, 0.00%**

24. State the amounts and percentages of 10 largest investments included in the Write -ins for Invested Assets category included on the Summary Investment Schedule - **\$0, 0.00%**



STATEMENT OF ACTUARIAL OPINION

February 24, 2004

Board of Directors  
Keystone Health Plan Central, Inc.

I, Michael J. Cellini, am a member of the American Academy of Actuaries ("the Academy"), and a Senior Manager and Consulting Actuary with the firm of Ernst & Young LLP. I have been retained by Keystone Health Plan Central ("the Company") to issue this opinion. I meet the Academy qualification standards for issuing this opinion, and I am familiar with the valuation requirements applicable to the Company.

I have reviewed the actuarial assumptions and actuarial methods used in determining the reserves and related actuarial items listed below and as shown in the Annual Statement of the Company, as prepared by the management of the Company for filing with state regulatory officials, as of December 31, 2003. My responsibility is to express an opinion on these reserves and related actuarial items based on my review. The actuarial methods, considerations and analyses used in forming my opinion conform to the appropriate Actuarial Standards of Practice and Actuarial Compliance Guidelines as promulgated by the Actuarial Standards Board, and form the basis of this statement of opinion.

Annual  
Statement  
Reference

<u>Item</u>	<u>Page-Line</u>	<u>Amount</u>
Claims Unpaid	3-1	\$49,946,687
Unpaid Claims Adjustment Expenses	3-3	\$1,741,038
Aggregate Health Policy Reserves	3-4	\$282,629

The reserves and related actuarial items listed above represent the estimates made by management of the Company for all unpaid claims as of December 31, 2003. Considerable uncertainty and variability are inherent in such estimates, and, accordingly, the subsequent development of the unpaid claims liability may not conform to the assumptions used in the determination of the unpaid claims liability and therefore may vary from the amounts in the foregoing table.

I have relied on listings and summaries of claims and other relevant data, and upon management's representations regarding the collectibility of reinsurance recoverable amounts, as expressed in the attached statement. I have relied upon Mr. Brian J. Britt, Vice President of Finance and Chief Financial Officer & Treasurer, for the accuracy of the data, as expressed in the attached statement.

My review included the identification and evaluation of the effect on the foregoing reserves of capitated risk-sharing contracts with service providers; however, my review of such capitated risk-sharing contracts did not include an assessment of the financial condition of the service providers. As such, the following opinion rests on the assumption that such service providers will fulfill their obligations under their respective contracts with the Company.

In other respects, my examination included such review of the actuarial assumptions and actuarial methods, including comparing prior years' estimates of unpaid claims liabilities to their subsequent development and such other tests of the actuarial calculations, as I considered necessary.

In my opinion, the reserves and related actuarial items identified above:

- (a) Are computed in accordance with presently accepted actuarial standards consistently applied, and are fairly stated in accordance with sound actuarial principles, except that consideration of the adequacy of the Company's reserves and related actuarial items in conjunction with the assets which support them has not been performed;
- (b) Are based on actuarial assumptions relevant to contract provisions and appropriate to the purpose for which the Annual Statement was prepared, and provide for all reasonably anticipated unpaid claims under the contracts;
- (c) Meet the requirements of the insurance laws and regulations of the Commonwealth of Pennsylvania;
- (d) Are computed on the basis of assumptions consistent with those used in computing the corresponding items in the Annual Statement of the preceding year, with any exceptions noted below;
- (e) Include provision for all actuarial reserves and related actuarial items which ought to be established; and,

- (f) Make good and sufficient provision for all unpaid claims and other actuarial liabilities of the Company under the terms of its contracts and agreements, by which I mean that the estimated liabilities is an appropriate measure of reasonably anticipated payments on incurred claims under potentially moderately adverse development, although, consistent with the scope of my review, the adequacy of the Company's reserves and related actuarial items in conjunction with the assets which support them has not been considered,

My review did not include asset adequacy analysis, as such analysis is not in the scope of my assignment. I have not reviewed any of the Company's assets and I have not formed any opinion as to their validity or value. My opinion rests on the assumption that the Company's December 31, 2003 statutory-basis unpaid claims liability is funded by valid assets that have suitably scheduled maturities and/or adequate liquidity to meet future cash flow requirements.

The scope of my review did not include preparation of the Underwriting and Investment Exhibit - Part 2B of the Annual Statement. I relied upon Mr. Brian J. Britt, Vice President of Finance and Chief Financial Officer & Treasurer, regarding the consistency of paid claims data and unpaid claims estimates with the Underwriting and Investment Exhibit. As part of my review, I conducted analysis consistent with Section 3.6, "Follow-Up Studies", contained in ASOP Number 5, "Incurred Health and Disability Claims", adopted by the Actuarial Standards Board in December 2000.

My review relates only to those reserves and related actuarial items identified herein, and I do not express an opinion on the Company's financial statements taken as a whole.

This opinion has been prepared solely for the Board and the management of the Company and for filing with state regulatory officials, and for the Blue Cross and Blue Shield Association, and is not intended for any other purpose.



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Michael J. Cellini, Ph.D., ASA, MAAA  
5 Times Square  
New York, New York 10036-6530  
(212) 773-0873

***Tab (b)***

The information in this Tab (b) responds to the following request:

- (b) If the results from (a) above require amendment of an annual statement blank filed by CBC or any of its insurance subsidiaries on or around March 1, 2004, an amended annual statement blank(s) shall be filed within 15 business days of submission of the information herein requested.

Response to Item (b)

No action is required at this time pending the outcome of the reports we intend to file in response to Item (a).

**Tab (c)**

The information in this Tab (c) responds to the following request:

- (c) A description of all affiliated foundations or similar affiliated entities, including charter documents; annual reports of financial condition for 2002 and 2003; financial reports for 2002 and 2003 showing funding from all sources, including but not limited to the parent corporation, governments, and outside sources; a certified statement of federal tax exemption; and a listing of officers, including their positions in the parent corporation or any of the parent's subsidiaries.

### Response to Item (c)

Capital and its former business partner established a non-profit entity, the Caring Foundation of Central Pennsylvania (the "Caring Foundation"). Both Capital and its former business partner served as Members of the Caring Foundation. As Members of the Caring Foundation, Capital and its former business partner each appointed two Directors to serve on the Board of the Directors; the remaining five Directors on the nine person Board were independent.

The Caring Foundation was incorporated on October 15, 1992 and was organized exclusively for charitable, educational, and scientific purposes under Section 501(c)(3) of the Internal Revenue Code. Specifically, the purpose of the Caring Foundation was to "benefit economically disadvantaged children and other members of the Central Pennsylvania Community who do not have access to adequate health care, by providing support to and sponsoring programs designed to improve the availability, quality [sic] and awareness of health care with respect to economically-disadvantaged members of the Central Pennsylvania community."

The Caring Foundation carried out its purpose by administering the Children's Health Insurance Program ("CHIP") on behalf of Capital and its former business partner. CHIP is a health insurance program, providing comprehensive medical benefits (along with dental and vision) for uninsured children from low-income families operated with the benefit of financial support from the Commonwealth. In addition to administering the CHIP program, the Caring Foundation subsidized the premiums certain families paid for CHIP coverage. The Caring Foundation's subsidy of the CHIP program is further described in Capital's response to Item (d) below.

In October and November 2003, respectively, the Caring Foundation's Board of Directors and Members voted to dissolve the Foundation for two reasons. First, Capital's former business partner had previously decided to terminate the joint operating agreement effective April 1, 2002. As a result, when the contract for the CHIP program came up for renewal, the two entities bid for and were selected separately as contractors for the CHIP program as of September 1, 2002, with an effective date for the separate CHIP programs commencing on January 1, 2003. In spite of this separation, the Caring Foundation continued to subsidize the premiums for the separate CHIP programs of Capital and its former business partner from January 1, 2003 through July 2003. Second, the Caring Foundation depleted all of the funds that were available to it to subsidize the CHIP premiums in July 2003.

In response to the PID's request, attached as Exhibits (c)-1, (c)-2, (c)-3 and (c)-4 to this Item (c) are the following documents: (1) Charter Document (Articles of Incorporation); (2) Annual Financial Statements for 2002; Financial Statements for 2002 Required by Office of Management and Budget Circular A-133; and Unaudited Financial Statements for 2003; (3) a Corporate Secretary Certificate and Letter of Federal Tax Exemption; and (4) a Listing of Officers, including their positions in the parent corporation or any of the parent's subsidiaries.

Exhibit (c)-1

Caring Foundation  
Articles of Incorporation

Microfilm Number \_\_\_\_\_

Filed with the Department of State on OCT 15 1992

Entity Number 2129233

[Signature]  
Secretary of the Commonwealth

94

ARTICLES OF INCORPORATION-DOMESTIC NONPROFIT CORPORATION  
DSCB:15-5306 (Rev 90)

In compliance with the requirements of 15 Pa.C.S. § 5306 (relating to articles of incorporation), the undersigned, desiring to incorporate a nonprofit corporation, hereby state(s) that:

1. The name of the corporation is: Caring Foundation of Central Pennsylvania

2. The (a) address of this corporation's initial registered office in this Commonwealth or (b) name of its commercial registered office provider and the county of venue is:

(a) 2500 Elmerton Avenue Harrisburg PA 17110 Dauphin  
Number and Street City State Zip County

(b) c/o: \_\_\_\_\_  
Name of Commercial Registered Office Provider County

For a corporation represented by a commercial registered office provider, the county in (b) shall be deemed the county in which the corporation is located for venue and official publication purposes.

3. The corporation is incorporated under the Nonprofit Corporation Law of 1988 for the following purpose or purposes:  
Please see attached.

4. The corporation does not contemplate pecuniary gain or profit, incidental or otherwise.

5. The corporation is organized upon a nonstock basis.

6. ~~AS TO THE NATURE OF THE BUSINESS OF THE CORPORATION, THE UNDERSIGNED HEREBY CERTIFY THAT:~~

7. ~~AS TO THE NATURE OF THE BUSINESS OF THE CORPORATION, THE UNDERSIGNED HEREBY CERTIFY THAT:~~

~~Business:~~  
~~AS TO THE NATURE OF THE BUSINESS OF THE CORPORATION, THE UNDERSIGNED HEREBY CERTIFY THAT:~~

8. The name and address, including street and number, if any, of each incorporator is:

Name Address  
Capital Blue Cross 2500 Elmerton Avenue, Harrisburg, PA 17110

9. The specified effective date, if any, is: \_\_\_\_\_  
month day year hour, if any

10. Any additional provisions of the articles, if any, attach an 8 1/2 x 11 sheet.

92/10-1412

DSCB:15-6306 (Rev 90)-2

IN TESTIMONY WHEREOF, the Incorporator(s) has (have) signed these Articles of Incorporation this 14th day of October, 1992.

CAPITAL BLUE CROSS

(Signature)

BY: X Michael P. McKinley

(Signature)

(Signature)

92 OCT 15 PM 4:05

PA DEPT. OF STATE

CBC 00209

Attachment to Articles of Incorporation of  
the Caring Foundation of Central Pennsylvania

(1) The Corporation is organized exclusively for charitable, educational and scientific purposes (within the meaning of Section 501(c)(3) of the Internal Revenue Code of 1986, or corresponding section of any future tax code). The Corporation shall be operated exclusively for such charitable, educational and scientific purposes. In carrying out its charitable, educational and scientific purposes, the Corporation shall benefit economically disadvantaged children and other members of the Central Pennsylvania community who do not have access to adequate health care, by providing support to and sponsoring programs designed to improve the availability, quality and awareness of health care with respect to economically-disadvantaged members of the Central Pennsylvania community.

(2) No part of the net earnings of the Corporation shall inure to the benefit of, or be distributable to its members, officers, directors, or other private persons, except that the Corporation shall be authorized and empowered to pay reasonable compensation for services rendered and to make payments in distributions in furtherance of its purposes as indicated in (1) above. No substantial part of the activities of the Corporation shall be the carrying on of propaganda, or otherwise attempting to influence legislation, and the Corporation shall not participate in, or intervene in (including the publishing or distribution of statements) any political campaign on behalf of or in opposition to any candidate for public office. Notwithstanding any other provision of these Articles, the Corporation shall not carry on any other activities not permitted to be carried on (a) by a corporation exempt from federal income tax under Section 501(c)(3) of the Internal Revenue Code, or corresponding section of any future federal tax code, or (b) by a corporation, contributions to which are deductible under Section 170(c)(2) of the Internal Revenue Code, or corresponding section of any future federal tax code.

(3) Upon the dissolution of the Corporation, its assets shall be distributed for one or more exempt purposes within the meaning of Section 501(c)(3) of the Internal Revenue Code, or corresponding section of any future federal tax code, or shall be distributed to the federal government, or to a state or local government, for a public purpose. Any such assets not so disposed of shall be disposed of by the Court of Common Pleas of the county in which the principal office of the Corporation is then located, exclusively for such purposes or to such organization or organizations, as the court shall determine, which are organized and operated exclusively for such purposes as indicated in paragraph (1) above.

Caring Foundation

The Annual Report (Audited) for 2002

Financial statements for 2002 Required by  
Office of Management and Budget Circular A-133

The Annual Report (Unaudited) for 2003

# ***Caring Foundation of Central Pennsylvania***

***Financial Statements for the Years Ended  
December 31, 2002 and 2001, and  
Independent Auditors' Report***

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**Deloitte  
& Touche**

## INDEPENDENT AUDITORS' REPORT

To the Board of Directors  
of the Caring Foundation of Central Pennsylvania

We have audited the accompanying statements of financial position of the Caring Foundation of Central Pennsylvania (the "Foundation") as of December 31, 2002 and 2001, and the related statements of activities and of cash flows for the years then ended. These financial statements are the responsibility of the Foundation's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, such financial statements present fairly, in all material respects, the financial position of the Foundation as of December 31, 2002 and 2001, and the changes in its net assets and its cash flows for the years then ended in conformity with accounting principles generally accepted in the United States of America.

As discussed in Note 1 to the financial statements, as of December 31, 2002, Capital Blue Cross and Pennsylvania Blue Shield mutually agreed to dissolve their joint administration of the children's health insurance program. The Foundation will continue to administer the subsidized program until the funds run out in 2003. The future disposition of the Caring Foundation will be decided during 2003.

As discussed in Note 7 to the financial statements, the accompanying 2001 statement of activities has been restated to include the effects of certain contributed services and outreach administrative expenses for the year ended December 31, 2001.

*Deloitte + Touche LLP*

June 26, 2003

# CARING FOUNDATION OF CENTRAL PENNSYLVANIA

## STATEMENTS OF FINANCIAL POSITION YEARS ENDED DECEMBER 31, 2002 AND 2001

<b>ASSETS</b>	<b>2002</b>	<b>2001</b>
Cash and cash equivalents	\$ 553,070	\$ 2,990,851
Investments	-	201,625
Accrued interest	-	5,253
<b>TOTAL ASSETS</b>	<b>\$ 553,070</b>	<b>\$ 3,197,729</b>
<b>LIABILITIES AND NET ASSETS</b>		
<b>LIABILITIES:</b>		
Accounts payable	\$ 239,592	\$ 2,311,125
<b>NET ASSETS—Unrestricted</b>	<b>313,478</b>	<b>886,604</b>
<b>TOTAL LIABILITIES AND NET ASSETS</b>	<b>\$ 553,070</b>	<b>\$ 3,197,729</b>

See notes to financial statements.

# CARING FOUNDATION OF CENTRAL PENNSYLVANIA

## STATEMENTS OF ACTIVITIES YEARS ENDED DECEMBER 31, 2002 AND 2001

	2002	2001 (As Restated see Note 7)
CHANGES IN UNRESTRICTED NET ASSETS:		
Revenues, gains and other support:		
Grant from Pennsylvania Children's Health Fund	\$ 2,576,083	\$2,336,438
Contributed services	2,896,939	2,373,771
Investment income	<u>13,453</u>	<u>70,389</u>
Total revenues, gains and other support	<u>5,486,475</u>	<u>4,780,598</u>
Expenses:		
Blue Chip of Pennsylvania	5,572,190	4,750,615
Outreach	<u>487,411</u>	<u>437,034</u>
Total expenses	<u>6,059,601</u>	<u>5,187,649</u>
DECREASE IN UNRESTRICTED NET ASSETS	(573,126)	(407,051)
NET ASSETS—UNRESTRICTED, BEGINNING OF YEAR	<u>886,604</u>	<u>1,293,655</u>
NET ASSETS—UNRESTRICTED, END OF YEAR	<u>\$ 313,478</u>	<u>\$ 886,604</u>

See notes to financial statements.

# CARING FOUNDATION OF CENTRAL PENNSYLVANIA

## STATEMENTS OF CASH FLOWS YEARS ENDED DECEMBER 31, 2002 AND 2001

	2002	2001
<b>OPERATING ACTIVITIES:</b>		
Change in net assets	\$ (573,126)	\$ (407,051)
Adjustments to reconcile change in net assets to net cash (used in) provided by operating activities:		
Amortization of premium	(446)	(2,574)
Change in unrealized gains (losses) on investments	5,071	(1,272)
Changes in assets and liabilities which provided (used) cash:		
Accrued interest	5,253	9,849
Accounts payable	<u>(2,071,533)</u>	<u>2,247,956</u>
Net cash provided by (used in) operating activities	<u>(2,634,781)</u>	<u>1,846,908</u>
<b>INVESTING ACTIVITIES:</b>		
Proceeds from maturity of investments	<u>197,000</u>	<u>800,000</u>
Net cash provided by investing activities	<u>197,000</u>	<u>800,000</u>
<b>NET (DECREASE) INCREASE IN CASH AND CASH EQUIVALENTS</b>	<b>(2,437,781)</b>	<b>2,646,908</b>
<b>CASH AND CASH EQUIVALENTS, BEGINNING OF YEAR</b>	<b><u>2,990,851</u></b>	<b><u>343,943</u></b>
<b>CASH AND CASH EQUIVALENTS, END OF YEAR</b>	<b><u>\$ 553,070</u></b>	<b><u>\$ 2,990,851</u></b>

See notes to financial statements.

# CARING FOUNDATION OF CENTRAL PENNSYLVANIA

## NOTES TO FINANCIAL STATEMENTS YEARS ENDED DECEMBER 31, 2002 AND 2001

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### 1. DESCRIPTION OF ENTITY

The Caring Foundation of Central Pennsylvania (the "Foundation") was incorporated in 1992 as a nonprofit membership corporation within the Commonwealth of Pennsylvania under the Nonprofit Corporation Law of 1988. Capital Blue Cross ("CBC") and Pennsylvania Blue Shield ("PBS") (collectively, the "Members") are equal members of the Foundation. The Foundation is an independent licensee of the Blue Cross and Blue Shield Association.

The Foundation was organized to provide and administer fully and partially subsidized health insurance to underprivileged children who reside in the communities serviced by CBC.

The Members have been awarded a grant from the Pennsylvania Children's Health Fund, an agency of the Pennsylvania Insurance Department, to administer the provisions of the Pennsylvania Children's Health Care Act (P.L. 741, No. 113) (the "Act") within the communities serviced by CBC. Under the terms of the grant, the Members provide health insurance coverage, as well as purchase coverage from Keystone Health Plan Central, Inc. ("KHP Central"), and provide administrative services. The Foundation acts as a subcontractor for CBC and PBS to administer the provisions of the Act.

As of December 31, 2002, CBC and PBS mutually agreed to dissolve their joint administration of the children's health insurance program. The Foundation will continue to administer the subsidized program until the funds run out in 2003. The future disposition of the Caring Foundation will be decided during 2003.

### 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

**Cash and Cash Equivalents**—Cash equivalents consist of investments in money market funds and short-term repurchase agreements with financial institutions. These investments are readily convertible into cash and are stated at cost, which approximates fair value.

**Investments**—The Foundation carries investments at fair value. Fair values are based on quoted market prices as of the statement of financial position date. Realized gains and losses on the sale of investments are determined using the specific identification method and recognized as investment income. Realized and unrealized gains and losses are reflected in Investment income in the statements of activities.

**Contributed Services**—For the years ended December 31, 2002 and 2001, the Foundation recognized \$2,896,939 and \$2,373,771, respectively, in contributed services support from the Members. These contributed services consist of salaries and benefits, printing, legal fees and other administrative expenses incurred by the Members in performing administration and outreach activities. The Members' cost is the basis for the estimated fair value of these contributed services (see also Note 7).

**Grant from the Pennsylvania Children's Health Fund**—For the years ended December 31, 2002 and 2001, the Foundation recognized \$2,576,083 and \$2,336,438, respectively, in grant revenue, which represents the amounts of the combined federal and state awards passed through from the Members for administrative services provided by the Foundation.

**Income Taxes**—The Foundation has qualified as a tax-exempt organization under Section 501(c)(3) of the Internal Revenue Code and, accordingly, no provision for income taxes is required.

**Blue Chip of Pennsylvania**—Blue Chip of Pennsylvania represents expenses incurred to operate and administer the activities of the Foundation, and primarily includes administrative costs for intake and retention of children (members), and other related services.

**Estimates**—The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions. These estimates and assumptions affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements. They also affect the reported amounts of revenues and other support and expenses during the reporting period. Actual results could differ from those estimates.

**New Accounting Pronouncements**—In June 1998, the Financial Accounting Standards Board (“FASB”) issued Statement of Financial Accounting Standards (“SFAS”) No. 133, Accounting for Derivative Instruments and Hedging Activities, and in June 1999 and 2000, the FASB issued Statements No. 137, Accounting for Derivative Instruments and Hedging Activities-Deferral of the Effective Date of FASB Statement No. 133, and No. 138, Accounting for Certain Derivative Instruments and Certain Hedging Activities, respectively, all of which became effective January 1, 2001. These statements establish accounting and reporting standards for derivative instruments, including those embedded in other contracts, and for hedging activities. SFAS No. 133 requires recognizing derivatives as assets or liabilities at fair value on the statement of financial position. The adoption of SFAS No. 133 on January 1, 2001 did not have a material effect on the Foundation’s financial position or results of operations.

In November 2002, the FASB issued Interpretation No. 45, *Guarantor’s Accounting and Disclosure requirements for Guarantees, Including Indirect Guarantees of Indebtedness of Others* (“FIN 45”). FIN 45 elaborates on the existing disclosure requirements for most guarantees, including loan guarantees such as standby letters of credit. It also clarifies that at the time a company issues a guarantee, the company must recognize an initial liability for the fair value, or market value, of the obligations it assumes under that guarantee and must disclose that information in its interim and annual financial statements. This guidance does not apply to certain guarantee contracts, such as those issued by insurance companies or for a lessee’s residual value guarantee embedded in a capital lease. The provisions related to recognizing a liability at inception of the guarantee for the fair value of the guarantor’s obligations would not apply to product warranties or to guarantees accounted for as derivatives. The initial recognition and initial measurement provisions of FIN 45 apply on a prospective basis to guarantees issued or modified after December 31, 2002, regardless of the guarantor’s fiscal year-end. The disclosure requirements are effective for financial statements of interim or annual periods ending after December 15, 2002. The Foundation does not expect that the adoption of the initial recognition and initial measurement provisions of FIN 45 will have a material impact on its financial position or results of operations. The adoption of the disclosure requirements of FIN 45 did not have a material impact on the Foundation’s financial statements.

### 3. INVESTMENTS

Investments at December 31, 2001 were as follows:

	2001			Estimated Fair Value
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	
Corporate bonds	<u>\$ 196,554</u>	<u>\$ 5,071</u>	<u>\$ -</u>	<u>\$ 201,625</u>

All of the Foundation's investments that were held at December 31, 2001 matured during 2002. Proceeds received from such maturities amounted to \$197,000 and related reversal of the unrealized gain of \$5,071 was included in Investment income on the Statement of Activities.

### 4. FUNCTIONAL EXPENSES

In 2002 and 2001, the Foundation incurred expenses in connection with the Blue Chip program of \$4,457,838 and \$3,813,866, respectively. Expenses allocated for management and general activities totaled \$1,252,924 and \$936,749 for the Blue Chip program and \$487,411 and \$437,034 for Outreach in 2002 and 2001, respectively.

### 5. REIMBURSEMENTS OF OPERATING EXPENSES

Reimbursements for administrative services performed for CBC amounting to \$138,572 and \$0 in 2002 and 2001, respectively, have been offset against the management and general activities of the Blue Chip program.

### 6. CREDIT RISK

The Foundation maintains all of its cash with one financial institution. Accounts are insured up to \$100,000 by the Federal Deposit Insurance Corporation.

7. **RESTATEMENT OF PRIOR YEAR CONTRIBUTED SERVICES AND OUTREACH ADMINISTRATIVE EXPENSE**

Subsequent to the issuance of the Foundation's 2001 financial statements, it was determined that the Foundation had not properly allocated expenses incurred by CBC for administrative services performed on behalf of the Foundation, resulting in an understatement of outreach expenses for the year ended December 31, 2001. As CBC does not charge the Foundation for these services, the related contributed services from these administrative expenses incurred was similarly understated for the year ended December 31, 2001. The impact of the restatement was to increase both revenues and expenses by \$273,978, therefore there was no impact on Unrestricted Net Assets. As a result, the Statement of Activities for the year ended December 31, 2001 has been restated from the amounts previously reported as follows:

	<u>December 31, 2001</u>	
	As Previously Reported	As Restated
<b>Statement of Activities</b>		
Revenues, gains and other support:		
Contributed services	\$ 2,099,793	\$ 2,373,771
Total revenues, gains and other support	<u>4,506,620</u>	<u>4,780,598</u>
Expenses:		
Outreach	<u>163,056</u>	<u>437,034</u>
Total expenses	<u>4,913,671</u>	<u>5,187,649</u>

\*\*\*\*\*

# ***Caring Foundation of Central Pennsylvania***

*Financial Statements for the Year Ended  
December 31, 2002, Supplemental Schedule  
of Expenditures of Federal Awards for the  
Year Ended December 31, 2002, and  
Independent Auditors' Reports Required by  
Office of Management and Budget Circular A-133*

# CARING FOUNDATION OF CENTRAL PENNSYLVANIA

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& Touche**

## INDEPENDENT AUDITORS' REPORT

To the Board of Directors of the  
Caring Foundation of Central Pennsylvania  
Harrisburg, Pennsylvania

We have audited the accompanying statement of financial position of the Caring Foundation of Central Pennsylvania (the "Foundation") as of December 31, 2002, and the related statements of activities and cash flows for the year then ended. These financial statements are the responsibility of the Foundation's management. Our responsibility is to express an opinion on these financial statements based on our audit.

We conducted our audit in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audit provides a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the Caring Foundation of Central Pennsylvania as of December 31, 2002, and the changes in its net assets and its cash flows for the year then ended in conformity with accounting principles generally accepted in the United States of America.

As discussed in Note 1 to the financial statements, as of December 31, 2002, Capital Blue Cross and Pennsylvania Blue Shield mutually agreed to dissolve their joint administration of the children's health insurance program. The Foundation will continue to administer the subsidized program until the funds run out in 2003. The future disposition of the Caring Foundation will be decided during 2003.

Our audit was performed for the purpose of forming an opinion on the basic financial statements of the Foundation, taken as a whole. The accompanying Supplemental Schedule of Expenditures of Federal Awards for the year ended December 31, 2002, which is the responsibility of management of the Foundation, is presented for purposes of additional analysis as required by the United States Office of Management and Budget Circular A-133, *Audits of States, Local Governments and Non-profit Organizations*, and is not a required part of the basic financial statements. Such information has been subjected to the auditing procedures applied in our audit of the basic financial statements and, in our opinion, is fairly stated, in all material respects, in relation to the basic financial statements taken as a whole.

In accordance with *Government Auditing Standards*, we have also issued our report dated June 26, 2003 on our consideration of the Foundation's internal control over financial reporting and our tests of its compliance with certain provisions of laws, regulations, contracts, and grants. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* and should be read in conjunction with this report in considering the results of our audit.

*Deloitte + Touche LLP*

June 26, 2003

# CARING FOUNDATION OF CENTRAL PENNSYLVANIA

## STATEMENT OF FINANCIAL POSITION DECEMBER 31, 2002

---

### ASSETS

Cash and cash equivalents \$ 553,070

TOTAL ASSETS \$ 553,070

### LIABILITIES AND NET ASSETS

LIABILITIES—Accounts payable \$ 239,592

NET ASSETS—Unrestricted 313,478

TOTAL LIABILITIES AND NET ASSETS \$ 553,070

See notes to financial statements.

# CARING FOUNDATION OF CENTRAL PENNSYLVANIA

## STATEMENT OF ACTIVITIES YEAR ENDED DECEMBER 31, 2002

---

### CHANGES IN UNRESTRICTED NET ASSETS:

Revenues, gains and other support:	
Grant from Pennsylvania Children's Health Fund	\$ 2,576,083
Contributed services	2,896,939
Investment income	<u>13,453</u>
Total revenues, gains and other support	<u>5,486,475</u>
Expenses:	
Blue Chip of Pennsylvania	5,572,190
Outreach	<u>487,411</u>
Total expenses	<u>6,059,601</u>
DECREASE IN UNRESTRICTED NET ASSETS	(573,126)
UNRESTRICTED NET ASSETS—BEGINNING OF YEAR	<u>886,604</u>
UNRESTRICTED NET ASSETS—END OF YEAR	<u>\$ 313,478</u>

See notes to financial statements.

# CARING FOUNDATION OF CENTRAL PENNSYLVANIA

## STATEMENT OF CASH FLOWS YEAR ENDED DECEMBER 31, 2002

---

### OPERATING ACTIVITIES:

Decrease in net assets	\$ (573,126)
Adjustments to reconcile decrease in net assets to net cash provided by operating activities:	
Amortization of premium	(446)
Change in unrealized gains on investments	5,071
Changes in assets and liabilities:	
Accrued interest	5,253
Accounts payable	<u>(2,071,533)</u>
Net cash used in operating activities	<u>(2,634,781)</u>

### INVESTING ACTIVITIES:

Proceeds from maturity of investments	<u>197,000</u>
Net cash provided by investing activities	<u>197,000</u>

NET DECREASE IN CASH AND CASH EQUIVALENTS	(2,437,781)
CASH AND CASH EQUIVALENTS—BEGINNING OF YEAR	<u>2,990,851</u>
CASH AND CASH EQUIVALENTS—END OF YEAR	<u>\$ 553,070</u>

See notes to financial statements.

# CARING FOUNDATION OF CENTRAL PENNSYLVANIA

## NOTES TO FINANCIAL STATEMENTS YEAR ENDED DECEMBER 31, 2002

---

### 1. DESCRIPTION OF ENTITY

The Caring Foundation of Central Pennsylvania (the "Foundation") was incorporated in 1992 as a non-profit membership corporation within the Commonwealth of Pennsylvania under the Non-profit Corporation Law of 1988. Capital Blue Cross ("CBC") and Pennsylvania Blue Shield ("PBS") (collectively, the "Members") are equal members of the Caring Foundation. The Foundation is an independent licensee of the Blue Cross and Blue Shield Association.

The Foundation was organized to provide and administer fully and partially subsidized health insurance to underprivileged children who reside in the communities serviced by CBC.

The Members have been awarded a grant from the Pennsylvania Children's Health Fund, an agency of the Pennsylvania Insurance Department, to administer the provisions of the Pennsylvania Children's Health Care Act (P.L. 741, No. 113) (the "Act") within the communities serviced by CBC. Under the terms of the grant, the Members provide health insurance coverage, as well as purchase coverage from Keystone Health Plan Central, Inc. ("KHP Central") and provide administrative services. The Foundation acts as a subcontractor for CBC and PBS to administer the provisions of the Act.

As of December 31, 2002, CBC and PBS mutually agreed to dissolve their joint administration of the children's health insurance program. The Foundation will continue to administer the subsidized program until the funds run out in 2003. The future disposition of the Caring Foundation will be decided during 2003.

### 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

**Cash and Cash Equivalents**—Cash equivalents consist of investments in money market funds and short term repurchase agreements with financial institutions. These investments are readily convertible into cash and are stated at cost, which approximates fair value.

**Investments**—The Foundation carries investments at fair value. Fair values are based on quoted market prices as of the statement of financial position date. Realized gains and losses on the sale of investments are determined using the specific identification method and recognized as investment income. Realized and unrealized gains and losses are reflected in Investment income in the statement of activities.

All of the Foundation's investments that were held at December 31, 2001 matured during 2002. Proceeds received from such maturities amounted to \$197,000 and related reversal of the unrealized gain of \$5,071 was included in Investment income on the Statement of Activities.

**Contributed Services**—For the year ended December 31, 2002, the Foundation recognized \$2,896,939 in contributed services support from the Members. These contributed services consist of salaries and benefits, printing, legal fees and other administrative expenses incurred by the Members in performing administration and outreach activities. The Members' cost is the basis for the estimated fair value of these contributed services.

*Grant from the Pennsylvania Children's Health Fund*—For the year ended December 31, 2002, the Foundation recognized \$2,576,083 in grant revenue, which represents the amounts of the combined federal and state awards passed through from the Members for administrative services provided by the Foundation.

*Income Taxes*—The Foundation has qualified as a tax-exempt organization under Section 501(c)(3) of the Internal Revenue Code and, accordingly, no provision for income taxes is required.

*Blue Chip of Pennsylvania*—Blue Chip of Pennsylvania represents expenses incurred to operate and administer the activities of the Foundation, and primarily includes administrative costs for intake and retention of members (children), and other related services.

*Estimates*—The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions. These estimates and assumptions affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements. They also affect the reported amounts of revenues and other support and expenses during the reporting period. Actual results could differ from those estimates.

*New Accounting Pronouncements*—In November 2002, the FASB issued Interpretation No. 45, *Guarantor's Accounting and Disclosure requirements for Guarantees, Including Indirect Guarantees of Indebtedness of Others* ("FIN 45"). FIN 45 elaborates on the existing disclosure requirements for most guarantees, including loan guarantees such as standby letters of credit. It also clarifies that at the time a company issues a guarantee, the company must recognize an initial liability for the fair value, or market value, of the obligations it assumes under that guarantee and must disclose that information in its interim and annual financial statements. This guidance does not apply to certain guarantee contracts, such as those issued by insurance companies or for a lessee's residual value guarantee embedded in a capital lease. The provisions related to recognizing a liability at inception of the guarantee for the fair value of the guarantor's obligations would not apply to product warranties or to guarantees accounted for as derivatives. The initial recognition and initial measurement provisions of FIN 45 apply on a prospective basis to guarantees issued or modified after December 31, 2002, regardless of the guarantor's fiscal year-end. The disclosure requirements are effective for financial statements of interim or annual periods ending after December 15, 2002. The Foundation does not expect that the adoption of the initial recognition and initial measurement provisions of FIN 45 will have a material impact on its financial position or results of operations. The adoption of the disclosure requirements of FIN 45 did not have a material impact on the Foundation's financial statements.

### 3. FUNCTIONAL EXPENSES

In 2002, the Foundation incurred program expenses in connection with Blue Chip of \$4,457,838. Expenses allocated for management and general activities totaled \$1,252,924 for Blue Chip and \$487,411 for Outreach in 2002.

### 4. REIMBURSEMENT OF OPERATING EXPENSES

Reimbursements for administrative services performed for CBC amounting to \$138,572 in 2002 have been offset against the management and general activities of Blue Chip.

**5. CREDIT RISK**

The Foundation maintains all of its cash with one financial institution. Accounts are insured up to \$100,000 by the Federal Deposit Insurance Corporation.

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**INDEPENDENT AUDITORS' REPORT ON COMPLIANCE AND ON INTERNAL CONTROL  
OVER FINANCIAL REPORTING BASED UPON THE AUDIT PERFORMED IN  
ACCORDANCE WITH GOVERNMENT AUDITING STANDARDS**

To the Board of Directors of the  
Caring Foundation of Central Pennsylvania  
Harrisburg, Pennsylvania

We have audited the financial statements of the Caring Foundation of Central Pennsylvania (the "Foundation") as of and for the year ended December 31, 2002, and have issued our report thereon dated June 26, 2003. We conducted our audit in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States.

***Compliance***

As part of obtaining reasonable assurance about whether the Foundation's financial statements are free of material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grants, noncompliance with which could have a direct and material effect on the determination of financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance that are required to be reported under *Government Auditing Standards*.

***Internal Control Over Financial Reporting***

In planning and performing our audit, we considered the Foundation's internal control over financial reporting in order to determine our auditing procedures for the purpose of expressing our opinion on the financial statements and not to provide assurance on the internal control over financial reporting. Our consideration of the internal control over financial reporting would not necessarily disclose all matters in the internal control over financial reporting that might be material weaknesses. A material weakness is a condition in which the design or operation of one or more of the internal control components does not reduce to a relatively low level the risk that misstatements in amounts that would be material in relation to the financial statements being audited may occur and not be detected within a timely period by employees in the normal course of performing their assigned functions. We noted no matters involving the internal control over financial reporting and its operation that we consider to be material weaknesses.

This report is intended solely for the information and use of the Board of Directors, management, federal awarding agencies, state funding agencies, and pass-through entities and is not intended to be and should not be used by anyone other than these specified parties.

*Deloitte + Touche LLP*

June 26, 2003



## INDEPENDENT AUDITORS' REPORT ON COMPLIANCE AND INTERNAL CONTROL OVER COMPLIANCE APPLICABLE TO EACH MAJOR FEDERAL AWARD PROGRAM

To the Board of Directors of the  
Caring Foundation of Central Pennsylvania  
Harrisburg, Pennsylvania

### *Compliance*

We have audited the compliance of the Caring Foundation of Central Pennsylvania (the "Foundation") with the types of compliance requirements described in the *U.S. Office of Management and Budget ("OMB") Circular A-133 Compliance Supplement* that are applicable to each of its major federal programs for the year ended December 31, 2002. The Foundation's major federal program is identified in the summary of auditors' results section of the accompanying Schedule of Findings and Questioned Costs. Compliance with the requirements of laws, regulations, contracts, and grants applicable to each of its major federal programs is the responsibility of the Foundation's management. Our responsibility is to express an opinion on the Foundation's compliance based on our audit.

We conducted our audit of compliance in accordance with auditing standards generally accepted in the United States of America, the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States, and OMB Circular A-133, *Audits of States, Local Governments and Non-profit Organizations*. Those standards and OMB Circular A-133 require that we plan and perform the audit to obtain reasonable assurance about whether noncompliance with the types of compliance requirements referred to above that could have a direct and material effect on a major federal program occurred. An audit includes examining, on a test basis, evidence about the Foundation's compliance with those requirements and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion. Our audit does not provide a legal determination on the Foundation's compliance with those requirements.

In our opinion, the Foundation complied, in all material respects, with the requirements referred to above that are applicable to each of its major federal programs for the year ended December 31, 2002.

### *Internal Control Over Compliance*

The management of the Foundation is responsible for establishing and maintaining effective internal control over compliance with requirements of laws, regulations, contracts, and grants applicable to federal programs. In planning and performing our audit, we considered the Foundation's internal control over compliance with requirements that could have a direct and material effect on a major federal program in order to determine our auditing procedures for the purpose of expressing our opinion on compliance and to test and report on internal control over compliance in accordance with OMB Circular A-133.

Our consideration of the Foundation's internal control over compliance would not necessarily disclose all matters in the internal control that might be material weaknesses. A material weakness is a condition in which the design or operation of one or more of the internal control components does not reduce to a relatively low level the risk that noncompliance with applicable requirements of laws, regulations, contracts, and grants that would be material in relation to a major federal program being audited may occur and not be detected within a timely period by employees in the normal course of performing their assigned functions. We noted no matters involving the internal control over compliance and its operation that we consider to be material weaknesses.

This report is intended solely for the information and use of the Board of Directors, management, federal awarding agencies, state funding agencies, and pass-through entities and is not intended to be and should not be used by anyone other than these specified parties.

*Deloitte + Touche LLP*

September 23, 2003

# CARING FOUNDATION OF CENTRAL PENNSYLVANIA

## SUPPLEMENTAL SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS YEAR ENDED DECEMBER 31, 2002

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	Federal CFDA Number	Federal Expenditures
<b>Federal Program/Pass Through Grantor</b>		
Department of Health and Human Services - Children's Health Insurance Program:		
Passed through the Commonwealth of Pennsylvania - Department of Insurance - Pennsylvania Children's Health Fund:		
Capital Blue Cross-claims	93.767	\$ 15,213,444
Caring Foundation-administrative costs	93.767	<u>1,690,383</u>
<b>TOTAL EXPENDITURES OF FEDERAL AWARDS</b>		<b><u>\$ 16,903,827</u></b>

See notes to Supplemental Schedule of Expenditures of Federal Awards.

# CARING FOUNDATION OF CENTRAL PENNSYLVANIA

## NOTES TO SUPPLEMENTAL SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS YEAR ENDED DECEMBER 31, 2002

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### 1. BASIS OF ACCOUNTING

The expenditures included in the accompanying schedule are presented using the accrual basis of accounting. The amounts reported in this schedule as expenditures may differ from certain financial reports submitted to federal funding agencies due to those reports being prepared on either a cash or modified accrual basis of accounting.

### 2. RECONCILIATION OF FEDERAL AWARDS TO FINANCIAL STATEMENTS

The Caring Foundation of Central Pennsylvania (the "Foundation") became a subcontractor for Capital Blue Cross ("CBC") and Pennsylvania Blue Shield to administer the provisions of the Pennsylvania Children's Health Care Act (P.L. 741, No. 113) on September 1, 1999. Under this arrangement, the Foundation receives grant payments directly from the Pennsylvania Department of Insurance, however, ninety percent of the federal award is passed immediately on to CBC for claims payments; the Foundation retains the remaining ten percent of the federal award for administrative services. Since the contractual arrangement for provision of health insurance coverage is between CBC and the Pennsylvania Children's Health Fund, the Foundation only recognizes its ten percent pass through award as grant revenue in its financial statements.

\* \* \* \* \*

# CARING FOUNDATION OF CENTRAL PENNSYLVANIA

## SCHEDULE OF FINDINGS AND QUESTIONED COSTS YEAR ENDED DECEMBER 31, 2002

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### Part I – Summary of Auditors' Results

1. The independent auditors' report on the financial statements expressed an unqualified opinion with an explanatory paragraph.
2. Reportable conditions in the internal control over financial reporting – none reported.
3. Our audit disclosed no matters of noncompliance that are material to the financial statements.
4. Reportable conditions in the internal control over compliance requirements applicable to major federal awards programs – none reported.
5. The independent auditors' report on compliance with requirements applicable to major federal awards programs expressed an unqualified opinion.
6. The audit disclosed no findings which are required to be reported by OMB Circular A-133.
7. The Caring Foundation of Central Pennsylvania's only major program was under the U.S. Department of Health and Human Services, Children's Health Insurance Program CFDA # 93.767.
8. A threshold of \$300,000 was used to distinguish between Type A and Type B programs as those terms are defined in OMB Circular A-133.
9. The Caring Foundation of Central Pennsylvania did qualify as a low-risk auditee as that term is defined in Section .530 of OMB Circular A-133.

### Part II – Financial Statement Findings Section

The audit disclosed no items required to be reported in this section.

### Part III – Federal Award Findings and Questioned Costs Section

The audit disclosed no items required to be reported in this section.

### Part IV – Status of Prior-Year Findings

There were no prior-year findings.

**Caring Foundation of Central Pennsylvania**

**Financial Statements**

**December 31, 2003**

Caring Foundation of Central Pennsylvania  
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December 31, 2003

Financial Statements	Page
Statements of Financial Position as of December 31, 2003 and December 31, 2002	1
Statements of Activities for the Twelve Months Ended December 31, 2003 and December 31, 2002	2
Statement of Functional Expenses for the Twelve Months Ended December 31, 2003	3
Statement of Cash Flows for the Twelve Months Ended December 31, 2003	4

Caring Foundation of Central Pennsylvania  
 Statements of Financial Position  
 As of December 31, 2003 and December 31, 2002

	<u>December 31, 2003</u>	<u>Restated December 31, 2002</u>
<b>ASSETS</b>		
Cash and cash equivalents	<u>\$233,648</u>	<u>\$553,070</u>
<b>TOTAL ASSETS</b>	<u><u>\$233,648</u></u>	<u><u>\$553,070</u></u>
<b>LIABILITIES AND NET ASSETS</b>		
<b>Liabilities:</b>		
Accounts Payable-Capital Blue Cross and PA Blue Shield	<u>\$233,648</u>	<u>\$239,592</u>
Total Liabilities	233,648	239,592
Net Assets - Unrestricted	<u>0</u>	<u>313,478</u>
<b>TOTAL LIABILITIES AND NET ASSETS</b>	<u><u>\$233,648</u></u>	<u><u>\$553,070</u></u>

Caring Foundation of Central Pennsylvania  
 Statements of Activities  
 For the Nine Months Ended December 31, 2003 and December 31, 2002

	<u>December 31, 2003</u>	<u>Restated December 31, 2002</u>
Revenues and other support:		
Contributed services	\$963,425	\$2,896,938
Investment income	<u>2,357</u>	<u>18,525</u>
	965,782	2,915,463
Net assets released from restrictions:		
Satisfaction of grant restriction (Grant from PA Children's Health Care Fund)	<u>108,038</u>	<u>2,576,083</u>
Total unrestricted revenues and other support	<u>1,073,820</u>	<u>5,491,546</u>
Expenses:		
BlueCHIP of Pennsylvania	1,097,799	5,572,190
Outreach	<u>289,499</u>	<u>487,411</u>
Total Expenses	<u>1,387,298</u>	<u>6,059,601</u>
(DECREASE) IN UNRESTRICTED NET ASSETS	(313,478)	(568,055)
NET ASSETS, BEGINNING	<u>313,478</u>	<u>881,533</u>
NET ASSETS, ENDING	<u>\$0</u>	<u>\$313,478</u>

Caring Foundation of Central Pennsylvania  
Statement of Functional Expenses  
For the Nine Months Ended December 31, 2003

Expenses	<u>BlueCHIP</u>	<u>Outreach</u>	<u>Total Expenses</u>
Health Insurance	600,410	0	600,410
Member Administrative Expenses	86,797	0	86,797
Salaries	199,264	148,516	347,780
Fringe Benefits	82,553	69,373	151,926
General Administrative	612	43	655
Outside Services	44,946	7,249	52,195
Depr/C.O.C - F & E	6,407	9,538	15,945
Equipment Use Charge	23,893	22,923	46,816
Magazines	2,869	328	3,197
Insurance	171	184	355
Legal	0	0	0
Office Supplies	2,050	1,282	3,332
Postage	25,163	5,162	30,325
Printing	7,740	2,577	10,317
Rent	20,003	12,488	32,491
Telephone	6,395	9,414	15,809
Travel	1,588	422	2,010
Adult Basic	(13,062)	0	(13,062)
<b>Total Expenses</b>	<u><u>1,097,799</u></u>	<u><u>289,499</u></u>	<u><u>1,387,298</u></u>

Caring Foundation of Central Pennsylvania  
Statement of Cash Flows  
For the Nine Months Ended December 31, 2003

<b>OPERATING ACTIVITIES:</b>	
(Decrease) in unrestricted net assets	(\$313,478)
Adjustments to reconcile the (decrease) in unrestricted net assets to net cash provided (used) by operating activities:	
Increase/(Decrease) in:	
Accounts payable - Capital Blue Cross and PA Blue Shield	<u>(5,944)</u>
<b>NET CASH (USED) BY OPERATING ACTIVITIES</b>	<b>(319,422)</b>
<b>CASH AND CASH EQUIVALENTS, BEGINNING</b>	<u><b>553,070</b></u>
<b>CASH AND CASH EQUIVALENTS, ENDING</b>	<u><u><b>\$233,648</b></u></u>

Caring Foundation of Central Pennsylvania  
Analysis of Contributed Services  
For the Nine Months Ended December 31, 2003

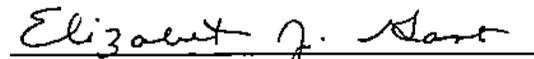
	<u>CBC</u>	<u>PBS</u>	<u>KHP</u>	<u>TOTAL</u>
Contributed Services	\$1,071,463	\$0	\$0	\$1,071,463
Less: Reimbursement from State	<u>(108,038)</u>	<u>0</u>	<u>0</u>	<u>(108,038)</u>
Net Contributed Services	<u>\$963,425</u>	<u>\$0</u>	<u>\$0</u>	<u>\$963,425</u>

Caring Foundation  
Certificate of Federal Tax Exemption

**CERTIFICATE OF CORPORATE SECRETARY**

I, Elizabeth J. Gant, being the Secretary of the Caring Foundation of Central Pennsylvania, duly organized and validly existing under the laws of Pennsylvania, and having a principal place of business at 2500 Elmerton Avenue, Harrisburg, Pennsylvania 17110, hereby certify that the attached letter from the Internal Revenue Service dated April 30, 1997 is a true and correct copy to the best of my knowledge, information, and belief.

In witness whereof, I have hereunto set my hand this 19th day of March 2004.



By: Elizabeth J. Gant

Title: Corporate Secretary

INTERNAL REVENUE SERVICE  
DISTRICT DIRECTOR  
P. O. BOX 2508  
CINCINNATI, OH 45201

DEPARTMENT OF THE TREASURY

Date: APR 30 1997

Employer Identification Number:  
25-1693273

DLN:  
17053096772007

Contact Person:  
D. A. DOWNING  
Contact Telephone Number:  
(513) 241-5199

CARING FOUNDATION OF CENTRAL  
PENNSYLVANIA  
C/O CAPITAL BLUE CROSS  
2500 ELMERTON AVE  
HARRISBURG, PA 17177-9798

Our Letter Dated:  
October, 1992  
Addendum Applies:  
No

Dear Applicant:

This modifies our letter of the above date in which we stated that you would be treated as an organization that is not a private foundation until the expiration of your advance ruling period.

Your exempt status under section 501(a) of the Internal Revenue Code as an organization described in section 501(c)(3) is still in effect. Based on the information you submitted, we have determined that you are not a private foundation within the meaning of section 509(a) of the Code because you are an organization of the type described in section 509(a)(1) and 170(b)(1)(A)(vi).

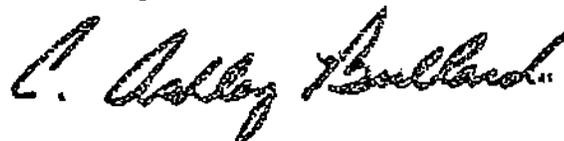
Grantors and contributors may rely on this determination unless the Internal Revenue Service publishes notice to the contrary. However, if you lose your section 509(a)(1) status, a grantor or contributor may not rely on this determination if he or she was in part responsible for, or was aware of, the act or failure to act, or the substantial or material change on the part of the organization that resulted in your loss of such status, or if he or she acquired knowledge that the Internal Revenue Service had given notice that you would no longer be classified as a section 509(a)(1) organization.

If we have indicated in the heading of this letter that an addendum applies, the addendum enclosed is an integral part of this letter.

Because this letter could help resolve any questions about your private foundation status, please keep it in your permanent records.

If you have any questions, please contact the person whose name and telephone number are shown above.

Sincerely yours,



District Director

Letter 1050 (DO/CG)

CBC 00246

Exhibit (c)-4

Caring Foundation

Listing of Officers

**Officers of the Caring Foundation**

Name	Position in Caring Foundation	Position in Parent Company and Subsidiaries
Aaron Walton	Chairman	Highmark, Inc. <sup>1</sup>
James M. Mead	President	President and CEO Capital BlueCross  Chairman and CEO Capital Advantage Insurance Company  Chairman Capital Administrative Services, Inc. d/b/a NCAS-Pennsylvania  Chairman Keystone Health Plan Central  Chairman, President and CEO Avalon Health, Ltd.  Chairman Consolidated Benefits, Inc.  Chairman CBC Insurance Company (a Vermont Corporation)
Lee Van Valkenburgh	Vice President	Vice President, Special Projects Capital BlueCross
Vincent Carocci	Director	Retired Part-time Consultant Capital Blue Cross
Elizabeth Gant	Secretary	Corporate Counsel Capital BlueCross
Carl Buch	Treasurer	Retired Part-time Consultant Capital Blue Cross

<sup>1</sup> Given the fact that Capital and Highmark are now in full competition, Capital does not have access to information regarding Mr. Walton's current position or title.

***Tab (d)***

The information in this Tab (d) responds to the following request:

- (d) A description of all social mission activity in 2002 and 2003 by the parent corporation and all subsidiaries, including, for subsidized products, financial reports documenting the levels of subsidy.

Response to Item (d)

As discussed below, the term "social mission" does not have a statutory basis. The information provided in response to this request describes the activities through which Capital and its subsidiaries meet Capital's responsibilities under the Hospital Plan Corporation Act and the Nonprofit Corporation Law.

***Statutory Differences between Hospital Plan Corporations (such as Capital)  
And Professional Health Services Plan Corporations***

Pennsylvania law prescribes a different set of charitable and benevolent purposes for hospital plan corporations such as Capital BlueCross than for professional health services plan corporations such as Highmark Blue Shield.

A hospital plan corporation is governed by the provisions of the Hospital Plan Corporation Act (40 Pa.C.S.A. § 6101 et seq., and referred to below as the "Hospital Plan Corporation Act" or the "Act").

Under the Act, a hospital plan corporation is defined as a not-for-profit corporation engaged in the business of maintaining and operating a "nonprofit hospital plan." A "nonprofit hospital plan" is defined as:

A plan whereby for prepayment, periodical or lump sum payment hospitalization or related health benefits may be provided to subscribers to such plan. § 6101.

Under Section 6103 of the Hospital Plan Corporation Act, Capital is declared a charitable and benevolent institution for purposes of exempting it from state tax laws. The Act does not include the term "social mission" or any reference to a "social mission." The Nonprofit Corporation Law (15 Pa.C.S.A. § 5101 et seq.) defines "Charitable purposes" very broadly as:

The relief of poverty, the advancement of education, the advancement of religion, the promotion of health, governmental or municipal purposes, and other purposes the accomplishment of which is beneficial to the community. § 5103.

By operating a hospital plan, Capital gives subscribers the means to pay for hospital expenses, assists hospitals and subscribers finance the cost of health care, and thus promotes the health of the residents of its 21 county service area.

Conversely, professional health services plan corporations are governed by the provisions of a separate statute – the Professional Health Services Plan Corporation Act (40 Pa.C.S.A. §6301 et seq.). Unlike the Hospital Plan Corporation Act, the Professional Health Services Plan Corporation Act contains the following "Declaration of necessity:"

Declaration of necessity. -- It is hereby declared that adequate professional health services are essential for the maintenance of the physical and mental health of the residents of this Commonwealth, and that *it is necessary that provision be made for adequate professional*

***health services to persons of low income who are unable to provide such services for themselves or their dependents without depriving themselves or their dependents of such necessities of life as food, clothing and shelter.*** (Emphasis supplied.) § 6303(a).

The requirement of service to “**persons of low income**” is embedded in the very definition of a “nonprofit professional health service plan” (40 C.S.A. § 6302). A similar provision is not contained in the Hospital Plan Corporation Act.

Clearly the legislature set different and separate standards for hospital plan corporations and professional health services plan corporations.

### **How Capital Fulfills its Statutory Responsibilities**

Capital BlueCross has fulfilled and continues to fulfill its statutory responsibilities under the Hospital Plan Corporation Act and the Nonprofit Corporation Law:

- (i) by giving members the means to pay for hospital expenses and by serving as a vehicle to help hospitals and subscribers finance the cost of care – that is, by operating a Nonprofit Hospital Plan (see **Paragraph (i)** below);
- (ii) by offering such programs as CHIP, adultBasic, Special Care and the Health Care Tax Credit Program (see **Paragraph (ii)** below); and
- (iii) by undertaking voluntary activities intended for the benefit of the residents of its 21 county service area (see **Paragraphs (iii) and (iv)** below).

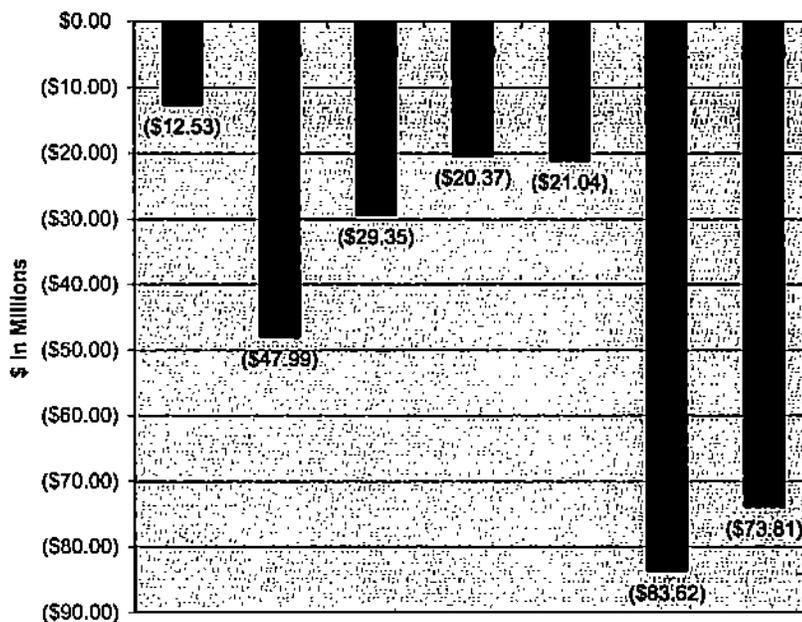
#### **(i) Capital's Nonprofit Hospital Plan**

Capital operates a Nonprofit Hospital Plan in its 21 county service area. As part of that Plan, Capital has traditionally and voluntarily undertaken charitable and community activities intended to benefit the residents of Central Pennsylvania and the Lehigh Valley. Among other things, Capital has historically and voluntarily assumed the role of “insurer of last resort” for residents of its service area. That is, Capital has provided pre-paid access to hospitalization benefits (regardless of health status) to the non-group market. Since we began operating as a full-service health plan on April 1, 2002 without our former business partner, Capital has continued its longstanding tradition of serving as “insurer of last resort” in the non-group market in conjunction with its wholly-owned subsidiary, Capital Advantage Insurance Company.

Commercial health insurers have traditionally maintained the profitability of their health insurance in the non-group market by either refusing coverage for those Pennsylvanians with significant pre-existing health problems or charging significantly higher premiums; they have often structured rates in a manner such that they are higher based upon health status or age at the time of enrollment. Capital, on the other hand, has offered coverage in the non-group market that is community rated (with no differential rating due to age or health status) and, through continuous open enrollment, has served all Pennsylvanians in Central Pennsylvania and the Lehigh Valley who desire such coverage.

As shown by the chart below, Capital has not generated a profit on any of its underwritten business (i.e., non-group, community rated, and experience rated) for over seven years.

**Underwriting Losses: Capital BlueCross and Capital Advantage Insurance Company**



Recently, there has been an unprecedented escalation of health care costs nationwide and in Central Pennsylvania and the Lehigh Valley, and competition among payors has intensified. Particularly under these circumstances, Capital felt it was necessary to draw upon its investment income and surplus in an attempt to hold down the level of health care premiums for its subscribers.

**(ii) The Individual Market**

For the reasons explained above, and due to rate regulation, Capital's premiums charged to subscribers in connection with programs for the non-group market do not cover the actual costs of these programs.

### ***Individual Programs***

These programs include Direct Pay, Special Care, and adultBasic. The Direct Pay programs consist of various products offered to individual account subscribers in the non-group market, including Traditional, Comprehensive, Security (Medicare supplemental), HIPAA Eligible Comprehensive, and Health Care Tax Credit Comprehensive (a program for displaced workers certified to receive certain Trade Adjustment Assistance benefits and for individuals who are receiving benefits from the Pension Benefit Guaranty Corporation). The Special Care program offers affordable coverage with no deductibles to low-income individuals. The adultBasic program offers basic insurance benefits to uninsured, low-income adult Pennsylvanians. The adultBasic enrollee is responsible for payment of a very modest premium (and although supported by the Commonwealth, even after government reimbursement, the program still generates a net loss).

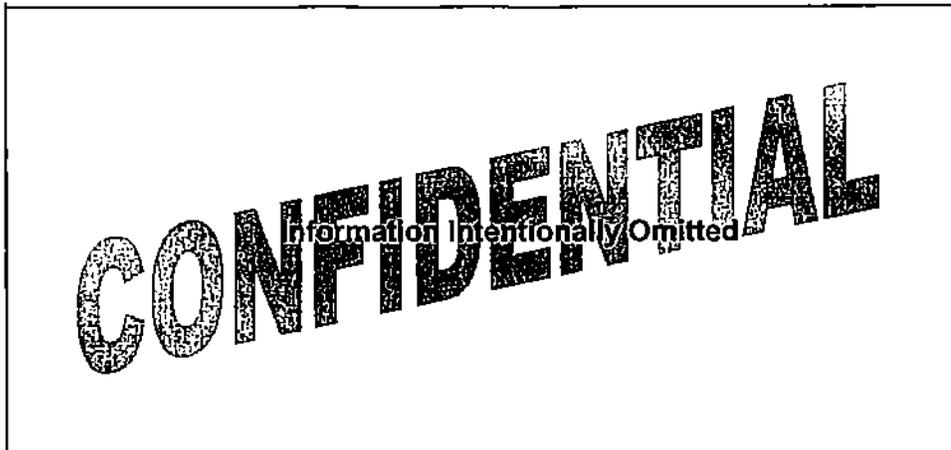
### ***CHIP Program***

The CHIP program offers comprehensive medical benefits (along with dental and vision) to uninsured, low-income children in Pennsylvania. As noted in the chart below, the CHIP program operates at a net loss (after factoring in administrative expense, premium subsidy, and underwriting gains/losses).

Pursuant to the CHIP contract with the Commonwealth, administrative expenses are capped (and expenses incurred above the cap absorbed for the benefit of CHIP enrollees).

In addition, in order to reduce the premiums certain families have to pay for CHIP coverage, either the Caring Foundation or Capital BlueCross has made contributions to the CHIP program to subsidize the families' premiums. The Caring Foundation's contribution from 1999 through July 2003 was derived from an unanticipated profit Capital BlueCross and its former business partner realized on the CHIP program in 1994-1995. Although Capital BlueCross and its former business partner attempted to return these funds to the Commonwealth, the Commonwealth refused to accept them because there was no mechanism under the contract for the Commonwealth to do so. As a result, the Caring Foundation's Board of Directors directed that these funds be used to subsidize the premiums certain families had to pay for CHIP coverage. These funds were depleted in July 2003.

Since that time, Capital has continued to subsidize the premiums from its own surplus so that low-income families can continue to afford quality health insurance coverage for their children, thereby reinforcing our community commitment. Overall, from April 1999 through the present, over 1,500 children have directly benefited from the reduced premiums the families were required to pay for CHIP coverage. Financial reports relating to the Caring Foundation for 2002 and 2003 are included as Exhibit (c)-2 to Capital's response to Item (c).



***(iii) Voluntary Activities***

Capital makes a number of donations and sponsors a number of programs intended to benefit the residents of its 21 county service area.

In terms of donations, Capital makes numerous charitable contributions to benefit organizations that fight disease or offer assistance, such as the Children's Miracle Network, the Salvation Army, Special Olympics, the American Red Cross, the American Diabetes Association, and the United Way. Capital also makes numerous contributions to benefit the community, including the Boys and Girls Club, the Hemlock Girl Scout Council, the Latin Alliance, the Whitaker Center, the YMCA/YWCA, Channels Food Rescue, the Allied Arts Fund, Big Brothers Big Sisters, Habitat for Humanity, and various colleges and universities.

In terms of health education activities, Capital provides a number of services, including such health related services as providing blood pressure and other health screenings, issuing health and wellness materials, and attending/supporting health fairs.

In terms of sponsorships and other activities that serve the general community or support educational activities but also advance Capital's business interests, Capital has made contributions to or sponsored local Chambers of Commerce and economic development agencies, educational programs (including "BrainBusters" and the "Great Teachers Award" program), local hockey and baseball teams, opera houses, orchestras, and theaters, foundations and associations, and local public television.

Because Capital BlueCross is a nonprofit corporation, it is exempt from payment of local property taxes to the municipalities in which Capital BlueCross has facilities. However, consistent with its voluntary charitable and community commitment and in order to be a "good neighbor" to the communities in which it resides, Capital BlueCross voluntarily makes payments in lieu of real estate taxes.

***(iv) Other Contributions to the Commonwealth***

Capital BlueCross itself is exempt from payment of the two percent (2%) tax on insurance premiums. However, in assessing Capital BlueCross' charitable and

community commitments, we note that beginning on April 1, 2002, its subsidiary, Capital Advantage Insurance Company, began to pay the 2% premium tax on all of the business that it underwrites. The payment of the premium tax by Capital Advantage Insurance Company is a significant additional benefit to the Commonwealth on top of our continuing voluntary charitable and community commitments.

In addition, Capital BlueCross' subsidiaries paid various taxes: capital stock taxes – Capital Administrative Services, Inc. d/b/a NCAS® Pennsylvania (“NCAS”) and Consolidated Benefits, Inc. (“CBI”); sales and use taxes – Capital Advantage Insurance Company, Keystone Health Plan Central, NCAS and CBI; and state income taxes – Keystone Health Plan Central, NCAS and CBI.

**Tab (e)**

The information in this Tab (e) responds to the following request:

- (e) An explanation of the role that any for-profit wholly owned subsidiaries have in furtherance of CBC's charitable mission.

## Response to Item (e)

### ***Role of Our Subsidiaries***

The role of Capital's for-profit subsidiaries is: (i) to provide a full array of products in Capital's 21 county service area to better serve our customers and members; and (ii) to enhance Capital's overall financial strength.

For example, when Capital's joint operating agreement was terminated by its former business partner, Capital's commitment to local health care in our communities was at risk (in fact, our survival was in question). As a result, as the PID is aware, Capital determined that in order to remain a viable health insurer in Central Pennsylvania and the Lehigh Valley, Capital needed to evolve into a full-service health insurer capable of providing not only hospitalization, but also professional provider-based medical-surgical and major medical benefits. Given the PID's restrictive interpretation of the Hospital Plan Corporation Act, it became necessary to study alternatives and to select the best and most expeditious vehicle for contracting with professional providers.

After consideration of the available alternatives, and after consultation with the PID concerning the time-frames and the complexity of utilizing a number of other vehicles (including use of a professional health services plan corporation), Capital determined that the best alternative was to utilize Capital Advantage Insurance Company (CAIC) to contract with professional providers. Among other things, CAIC was already capitalized; it was already licensed to use the "Blue Cross" name and logo; and it had the statutory authority to seek and receive PID and DOH authority to offer preferred provider organization arrangements.

Accordingly, CAIC submitted the necessary filings with the PID and the Pennsylvania Department of Health, and after extensive review, CAIC was approved to operate as a preferred provider organization (PPO) and to offer a Gatekeeper PPO/Point-of-Service (POS) managed care program.

In many ways, CAIC simply stepped into the shoes of Capital's former business partner and allowed Capital (i) to continue to offer the same product line as it had offered in the past and (ii) to avoid any disruption to its customer base. So, for example, the "traditional" program, once offered jointly by Capital and its former business partner, is now jointly offered to subscribers by Capital and CAIC; the "traditional" program consists of basic hospitalization benefits offered by Capital and medical-surgical and major medical benefits offered by CAIC.

Capital's individual (direct-pay) products are offered by CAIC, either alone or in conjunction with Capital BlueCross. As one example, our comprehensive program for HIPAA-eligible individuals (which provides coverage on a guaranteed-issue basis without a pre-existing condition exclusion period for HIPAA-eligible individuals) is offered jointly by CAIC and Capital. This coverage, which may be accessed by individuals who cannot obtain benefits elsewhere, is only offered in Pennsylvania by Blue plans like Capital BlueCross.



# Capital BlueCross

RECEIVED CHIEF COUNSEL  
PA INSURANCE DEPT.

2004 MAY 19 PM 11:01

May 17, 2004

Via Fax: 717-772-1969 and  
U.S. First Class Mail

Sandra L. Ykema, Esquire  
Department Counsel  
Commonwealth Of Pennsylvania  
Insurance Department  
1341 Strawberry Square  
Harrisburg, PA 17120

**Re: Notice 2004-01 Application Process**

Dear Ms. Ykema:

This letter is in response to your letter of May 7, 2004 on behalf of the Pennsylvania Insurance Department (the "Department") requesting clarification or an additional submission with regard to the Capital BlueCross ("CBC") March 22, 2004 Submission (the "CBC Submission") in response to the Department's January 5, 2004 Letter.

As you know, I have orally (and, at your request, by e-mail) requested an extension of time for CBC to respond to your May 7, 2004 letter so we could schedule a meeting between our respective actuaries to resolve how CBC can meet the Department's request for an actuarial certification different from that prescribed for annual statements. On Friday afternoon, May 14, 2004, I spoke with your colleague at the Department, Stephen B. Davis, during which he told me that the Department has met with the other Blue Cross Plans to discuss actuarial issues raised by the Department's January 5, 2004 Letter and that the Department is taking our request for an extension under advisement. I look forward to your response regarding the meeting and extension.

Mr. Davis indicated that CBC should respond to the items of the May 7, 2004 letter to the extent CBC is able by today. That is the purpose of this letter. I will address each item in the order presented in your letter.

## **FIRST REQUEST**

Avalon Health Ltd. ("Avalon") is an inactive HMO. No report was made for Avalon because it does not carry any balances pertinent to the Department's request. See, footnote 8 on page 15 of the CBC April 15, 2004 Application.

CBC 00258

## **SECOND REQUEST**

This item will probably be the main topic at the meeting to be scheduled between CBC and the Department. It makes sense, therefore, for CBC to postpone a more detailed response to this part of the Letter of May 7, 2004 until we have held our meeting. That meeting will be attended by CBC's independent actuary, Mr. John Stenson. He is a Fellow of the Society of Actuaries, a Member of the American Academy of Actuaries and is associated with Deloitte Consulting LLP.

Since that meeting may result in additional work being done by our independent actuary, CBC suggests that supplying the underlying documentation from Mr. Stenson be postponed for the time being until we see what can be worked out at that meeting. That said, CBC is willing to provide the underlying documentation for the Statements Of Actuarial Opinion for CBC, for CAIC and for KHPC signed by John Stenson and included in CBC's Application as Exhibit (a)-1 with the Department's assurances that this confidential information will indeed be kept confidential. As you probably know, such items are based on highly confidential claims information which is not shared with the public or competitors. We await your direction on this aspect of our response to your May 7, 2004 letter.

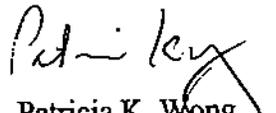
## **THIRD REQUEST**

The CBC April 15, 2004 Application stated in footnote 6 on page 13 that "Aggregate Health Policy Reserves" includes "Unearned Premium Reserves." This presentation is consistent with the instructions for the preparation of our December 31, 2003 Annual Statement. Aggregate Health Policy Reserves were, in turn, opined upon by the independent actuary retained by CBC, John Stenson, for CBC, CAIC and KHPC. See Exhibit (a)-1 to the CBC April 15, 2004 Application. In order to avoid any unnecessary duplication, I incorporate my response to your Second Request herein.

## **FOURTH REQUEST**

Consistent with the statements above, CBC expects to provide the Department with responsive information in electronic form after the meeting to be scheduled.

Very truly yours,

  
Patricia K. Wong  
Supervising Counsel

cc: Connie Foster, Saul Ewing



# Capital BlueCross

2004 JUN 8 PM 4 29  
RECEIVED CHIEF COUNSEL  
PA INSURANCE DEPT.

June 8, 2004

Via Hand Delivery

Sandra L. Ykema, Esquire  
Department Counsel  
Commonwealth Of Pennsylvania  
Insurance Department  
1341 Strawberry Square  
Harrisburg, PA 17120

**Re: Notice 2004-01 Application Process**

Dear Ms. Ykema:

The attached information from John Stenson, FSA, MAAA, Principal of Deloitte Consulting LLP supplements the March 22, 2004 Submission of Capital BlueCross ("CBC") in response to paragraph (a) on page 2 of the January 5, 2004 letter from Stephen J. Johnson and Randolph L. Rohrbaugh of the Pennsylvania Insurance Department to James M. Mead, President and Chief Executive Officer of Capital BlueCross (the "January 5th Letter"). This information is being submitted in express reliance on conversations between counsel for CBC and Counsel for the Pennsylvania Insurance Department (the "Department"), during which the Department's counsel confirmed that information designated as confidential by CBC will be treated as confidential by the Department and not disclosed to the public. If another party should seek disclosure of this information from the Department, the Department will treat the information designated as confidential by CBC as proprietary and confidential information belonging to CBC and shall not disclose it to such third party, except pursuant to Court order. Upon receipt of any request from a third-party for information designated "confidential" by CBC, the Department will notify CBC of such a request to allow CBC to intervene or otherwise seek additional protections from having to disclose such information. The Department may, but does not have to, assist CBC with any efforts to maintain the confidentiality of the information in any Court proceeding.

Very truly yours,

Patricia K. Wong  
Supervising Counsel

CBC 00260