



October 8, 2004

The Honorable M. Diane Koken  
Insurance Commissioner  
Commonwealth of Pennsylvania  
1311 Strawberry Square  
Harrisburg, PA 17120

Cc: Stephen J. Johnson  
Deputy Insurance Commissioner

Randolph L. Rohrbaugh  
Deputy Insurance Commissioner

**RE: Highmark Inc.  
Surplus Public Comments**

Dear Commissioner Koken:

During the last several weeks, various organizations and individuals have submitted a large number of comments to you as part of the request for information and review being undertaken with respect to the surplus of Highmark Inc. ("Highmark") and other Blue Plans in Pennsylvania. Highmark believes that a response to some of these comments is appropriate to clarify and, where necessary, correct information provided to you. As a consequence, Highmark respectfully submits these responses to certain of those comments.

While reserving the legal positions described in detail in Highmark's submission of information dated April 15, 2004, Highmark believes that prompt resolution of issues relating to surplus is in the public interest. Highmark has cooperated fully with your office since review began in this matter in mid-2002. We will continue to cooperate with you in the review process. If, as you review the comments submitted by others or responses provided by Highmark, you determine a need to discuss or respond to any specific issues that we may not cover in this letter, please let us know so that we can assist in bringing closure to this long and exhaustive review.

### **Rates**

The majority of commentators are individual or group customers who are asking the Department to order a reduction in surplus as a means of lowering the price they pay for health insurance. Several of the commentators contend that the Blue Plans, including Highmark, should not be using their surplus for charitable purposes, but instead should be using surplus to lower premium rates. Other commentators, most notably our commercial competitors, make the opposite argument, contending that the use of surplus to reduce health insurance premiums would harm these commercial carriers in their competition against Blue insurers. Instead, they maintain that the surplus should be used to increase Highmark's charitable expenditures and expand public programs.

Our commercial competitors would apparently want the public to believe that they exist to serve all of the Commonwealth counties, communities, markets and segments that Highmark serves. As you know, this is not the case. Instead, many commercial carriers engage in patterns of selective marketing to optimize profits, using unregulated rates to attract only the best risk. This form of marketing leaves the remaining high-risk groups without any reasonable option but to seek coverage with the Blue Plans.

The Blue Plans have thus become the de facto high-risk pools of the Commonwealth. We are then faulted for the high premium rates that inevitably reflect the higher utilization and claims experience of such high-risk pools. We are particularly troubled that these competitors continue to hide behind the phrase of “free market” competition. In fact, they are attempting to use the comment period on surplus to further enhance their competitive position against the Blue Plans, while at the same time proposing a prohibition on rate relief that could assist the very groups and risks they avoid in the marketplace.

Highmark, of course, understands that the cost of health insurance is becoming increasingly expensive, and we continue to be committed to finding ways to control increases in claims costs and reduce our administrative costs. The root of the problem and its cure, however, do not lie in our surplus. The root of the problem is the rising cost of health care that is spiraling out of control. Some of the forces driving rising costs present systemic challenges that may not be easily managed in the long run. For example, Pennsylvanians are significantly older, and have more chronic diseases than the national average, and thus finding ways to keep health insurance affordable is a constant challenge. This challenge is compounded by the proliferation of expensive, new medical technology and pharmaceuticals that are fueling consumer demand for more medical services. For these reasons and others, medical expenses are rising three to four times faster than the cost of general inflation, and insurance costs to cover these expenses are continuing to rise concurrently.

Working collaboratively with the business and health care provider communities, Highmark is exploring possible solutions to the issue of escalating costs. In mid-September 2004, Highmark and the RAND Corp. teamed up with key business and provider groups to hold a Health Care Cost Summit in Pittsburgh that explored what the community can do cooperatively to improve health care performance while controlling medical costs.

As noted in Highmark’s filing dated April 15, 2004, Highmark does not believe it has excess surplus. The reasons supporting our position are contained in the filing and the accompanying report from Milliman USA. As stated in that filing, Highmark also takes the position that should it reach a level of excess surplus, it would seek to use the surplus for rate stabilization – returning the surplus in a structured process that would permit a gradual spending down of the surplus through a return to customers. Thus, any needed rate increases would be moderated by the use of a rate stabilization fund. This approach is consistent with the comments from Highmark’s direct pay and group customers who believe that any excess surplus funds should be used to assist them through rate relief. In addition, this approach would also benefit the uninsured, since surplus funds would also be used for rate relief for the programs Highmark offers to lower-income individuals who are unable to afford health insurance.

### **The Uninsured**

Some concerned citizens and consumer advocates raise the issue of the medically uninsured, and suggest that we use surplus funds either to assist with adultBasic waiting-list individuals, or to keep our rates more affordable. As part of its corporate mission, Highmark makes contributions to a number of programs and products that help reduce the number of uninsured in the Commonwealth. The April 15, 2004, filing described in detail the ways in which Highmark, historically and currently, has been addressing the uninsured issue.

**Special Care.** We noted in our April 15 filing that we subsidize our individual product rates, particularly a program called Special Care that was initially created in 1992 to provide low-cost coverage for the uninsured. In 2003, Highmark provided an \$11.9 million subsidy for Special Care to help hold down rate increases. Highmark programs, such as Special Care, are one of the reasons why Pennsylvania historically has had one of the lowest rates of uninsured among the 50 states.

We believe that proposed legislation to permit individuals on the adultBasic waiting list to purchase low-cost insurance products, such as Special Care, would do a great deal more to address the uninsured in Pennsylvania than a one-time use of any surplus funds to assist adultBasic. Special Care is a good example of how the private insurance system, working in collaboration with health care providers, can play a key role in providing affordable health coverage for disadvantaged segments of the community. Hospitals and physicians have agreed to accept discounted reimbursement for care they provide to Special Care members.

**AdultBasic.** Highmark and the other Blue Plans have shown a steadfast commitment to assist the uninsured. We were the only insurers to respond to the Insurance Department's request for proposal and to agree to administer the adultBasic program. With limited state funding available, commercial insurers were not attracted to the proposal. In fact, the rates granted have not proved adequate to cover claims costs. In 2003, Highmark incurred \$8.6 million in underwriting losses on the adultBasic program, made up of a \$7.7 million claims expense loss and more than \$800,000 of un-reimbursed administrative costs. Furthermore, during the first six months of 2004, Highmark has incurred \$5.2 million in underwriting losses on the program, made up of a \$5.1 million claims expense loss and a \$96,000 administrative expense loss. Thus, in just one and a half years, Highmark has subsidized the adultBasic program alone by \$13.8 million.

**The Caring Foundation.** Highmark, through the Highmark Caring Foundation, recently assisted individuals on the adultBasic waiting list through the "Waiting List Community Response", the latest in a long line of innovative initiatives launched by the Highmark Caring Foundation. The program offers eligible individuals on the adultBasic waiting list a \$100 voucher for health services at a participating Community Health Center. To date in 2004, more than 6,000 individuals on the waiting list have taken advantage of the voucher program.

### **Charitable Contributions**

When Veritus and Medical Service Association of Pennsylvania consolidated to become Highmark in 1996, then-Commissioner Kaiser issued an Order that established a specific measure for Highmark's social mission activities. Specifically, Condition No. 4 requires Highmark annually to allocate 1.25% of its direct written premiums to charitable and benevolent endeavors and provides a non-exclusive list of programs to which such efforts may be directed. Even though the Commissioner did not identify the authority for the measures in the Order, Highmark has met those measures since 1997, and has filed an annual report of its financial support of social, charitable and health care activities in a form approved by the Department.

Contrary to the assertions of some commentators, the Department approved both the form of the report to be submitted and the sources of financial support for which Highmark would receive credit. Every year, Highmark's support of community charitable and health care endeavors has not only met but also exceeded the required 1.25% of direct written premium. More detail can be found in section III of Highmark's April 15, 2004 filing, posted on the Department's website.

Some commentators contend that Highmark has inappropriately received credit for including its premium subsidy to direct pay programs. We believe that these commentators incorrectly compare our practices to those of commercial insurers.

Highmark's nongroup direct pay subsidies have historically been referred to as "group conversion subsidy." While these subsidized direct pay programs do include group conversion members, the programs are actually guaranteed issue, continuous open enrollment programs available to any individuals in our service area, at any time, regardless of health status. Thus, contrary to some of our critics, this is not ". . . a group subsidy . . . borne by all insurers." Instead, these nongroup direct pay subsidies are a unique undertaking by the Blue Plans in the Commonwealth. Since Highmark provides these direct subsidies to its individual health products, the Department agreed that it was appropriate to treat them as a charitable endeavor for purposes of complying with Condition No. 4.

Several commentators further suggested that the 1.25% of direct written premium should be extended to the premiums collected by Highmark's subsidiary insurers. These subsidiaries already pay the same taxes as comparable for-profit entities. From 2001 through the end of 2003, Highmark's subsidiaries paid over \$56 million in state and local taxes in Pennsylvania.

### **Provider Reimbursement**

One provider organization that submitted comments suggests that any surpluses should be used to increase the Medicaid reimbursement levels for professional providers in the Commonwealth. We suggest that this is an inappropriate use of surplus, and that no company should be asked to step in to meet the obligations of state or federal governments in such programs.

### **Blue Cross Blue Shield Association Membership**

Some commentators argue that meeting the licensing and membership standards of the Blue Cross Blue Shield Association ("the BCBSA") is irrelevant to Pennsylvania and should be disregarded by the Commissioner. This argument entirely ignores the key role that nationwide Blue Plans play in providing access to health care to a great number of Pennsylvanians, or employees of Pennsylvania companies. If Highmark were to lose its Blue brand, its customers would lose access to, among other things, the nationwide Blue provider network. This, in turn, would mean that they would lose substantial provider discounts, protections against balance billing, the ability to receive medical services without making up-front payments and a national network of transplant centers. While these advantages of the Blue brand may not be readily apparent to the general public, those who offer the Commissioner proposed expert opinion should certainly be better informed. The value of the protections of the Blue brand to our customers cannot be overstated in this era when a hospital admission can easily run into the tens of thousands of dollars.

The BCBSA provides another important assurance to the Commonwealth. It monitors the financial performance of the Blue Plans and assists them to avoid termination of the Blue Cross Blue Shield license, thereby helping to protect Blue Plan subscribers.

### **Level Of Surplus**

Virtually every commentator has ignored or dismissed the fact that, as a non-profit insurer with unique obligations to make health care coverage available to all segments of the community, Highmark does not have the ability of its for-profit competitors to raise capital.

Many have argued that because Highmark is a nonprofit, it should operate on a much leaner basis, with a much lower surplus. This argument fails to recognize the challenge of building surplus. If Highmark's funds run low, we cannot restore them with quick, short-term fixes. A sudden diminution of surplus could severely harm our ability to operate at safe and solvent levels, and thus endanger the coverage that so many of our members depend upon. It could also, in some instances, require higher customer premiums to help rebuild the surplus to an adequate level to ensure Highmark's continued viability over the long term. It is therefore important to recognize that surplus funds take years to accrue and are not necessarily "renewable resources."

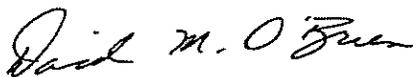
As an illustration of the lack of merit of some comments provided to you, one commentator suggests an approach that utilizes between 53 and 62 days of "Total Underwriting Deductions" (as stated in the Annual Statement to the Department) as a proxy for adequate surplus. The result of using 62 days as a proxy for adequate surplus would leave Highmark with a surplus equal to 198% of risk-based capital, below the state's 200% minimum threshold and potentially causing the loss of the Blue Cross and Blue Shield brands.

Several commentators also made claims of excess surplus based on clear misunderstandings of Highmark's financial reporting to the Insurance Department. These misunderstandings – focusing on the calculation of Highmark's surplus and the impact of a 2001 accounting change affecting financial reporting by Blue Cross Blue Shield companies and other health insurers – underlie the erroneous assertions that Highmark and other Blue Plans have under-reported their actual surplus. The information contained in the April 15 filing reflects the surplus of the combined enterprise, including the parent company (Highmark) and its subsidiaries and affiliate companies.

We have asked Milliman USA, a nationally recognized actuarial firm and Highmark's technical consultant on the surplus matter, to address these financial reporting and accounting issues in greater detail in its report accompanying this response from Highmark. The Milliman report also addresses how certain commentators have distorted the Blue Cross Blue Shield Association's use of risk-based capital as a financial monitoring tool for Blue Plans.

If any further questions remain, please do not hesitate contacting me at (412) 544-5250, or via e-mail at [david.obrien@highmark.com](mailto:david.obrien@highmark.com).

Sincerely,



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