Independence Blue Cross

Response To
Public Comments Regarding
IBC Reserves/Surplus Application

October 4, 2004

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On April 15, 2004, Independence Blue Cross filed with the Pennsylvania Insurance Department an application for approval of our reserves and surplus levels. The application conformed fully with the Insurance Department's request for information concerning our reserves, surplus and Social Mission, and we believe it provided the Department with all of the information necessary to determine that our reserves and surplus levels are appropriate in size, and certainly not excessive.

After reviewing the significant amount of public comment filed with the Department in recent weeks, however, IBC realizes that this additional filing is in order, for two reasons: first, to emphasize a number of points we made in our application, and second, to correct and clarify some of the misinformation provided by contributors to the public comment.

First, let us stress two overriding points:

- **IBC's surplus of $840.9 million is not excessive, by any economically responsible measure.** Any decision to arbitrarily force its reduction would endanger IBC's financial commitments to our customers and members, negatively impact our ability to compete in the Southeastern Pennsylvania health insurance market and force the company to reevaluate our ability to carry out a Social Mission.

- **Independence Blue Cross is proud of our Social Mission.** Those who created the not-for-profit Blues in Pennsylvania surely would be pleased with a company that 60 years later, invests more than 200 percent of its tax exemption on Social Mission initiatives. What a cruel irony it would be if those who allegedly represent the interests of the less fortunate would convince the Department to weaken IBC financially – and force us to *reduce* our commitment to the uninsured of Pennsylvania.

Those who filed public comments with the Department over the past six weeks basically fell into two categories:

1. Individuals who are upset about the rising cost of health insurance and who believe that the Blues' surpluses hold the potential to provide significant rate relief.

2. Representatives of special interest groups who are seeking to influence the Department's decision with a variety of analyses and economic arguments – many of which rely on half-truths, rewritten history, questionable economic theory and outright misrepresentations.

IBC's years of experience with the Department's regulators gives us confidence that ultimately, they will take action to ensure that Pennsylvanians will continue to have access to four financially sound Blue Plans. Given the political environment in which this process has been conducted, however, we are providing these responses in the hope that all concerned might

remember that the issue of an insurer's financial stability is a regulatory matter – not a subject for public referendum.

I. We Agree: Health Insurance Is Getting Too Expensive

To all those who wrote to the Department, expressing frustration over the rising cost of health insurance, IBC has this message. We agree. Too many people are finding it more and more difficult – if not impossible – to afford the cost of health insurance, and this is creating a crisis of national proportions. Many of the special interests who filed public comments provided accurate and disturbing statistics concerning the growth of Pennsylvania's uninsured population. They presented compelling arguments that something must be done. We agree.

But IBC's surplus is not the answer.

The fact is this surplus application process has become just the latest chapter in a three-year-old story of misplaced blame. Health insurers are not driving up health insurance premiums—**HEALTH CARE COSTS** are causing premiums to increase. Upset that premium increases are outpacing the overall rate of inflation? Well, take a look at the increase in medical costs in recent years. Those costs also are outpacing the overall rate of inflation. What we have here is a straightforward case of cause and effect.

Only, no one seems interested in tackling the real problem. We can only surmise that it's just too complex – at least to be significantly impacted within one election cycle.

Let's repeat our earlier point. We agree that health insurance is getting too expensive.

The most popular policy we sell at Independence Blue Cross is our Personal Choice PPO family plan. Today it costs over $15,000 per year, including drug coverage. Four years ago, in 2000, the same coverage cost $8,000 per year. That is an increase of almost 90%.

$15,000 per year.

How are employers responding to these increased premiums?

- More and more employers are sharing the cost with their workers.
- More and more employers are buying fewer benefits.
- Some are paying only for their worker's insurance, leaving the employee to pay for the rest of the family – out of pocket, after taxes. That cost, the difference between single and family coverage, is almost $9,000 per year.

Is it any wonder why so many workers cannot afford to make up the difference and cover their spouse and children? So what happens to them? They join the growing ranks of the uninsured.

And even more concerning, some employers are no longer providing any coverage at all.

America's Health Insurance Plans (AHIP) calculates that for every 1% that health care costs go up, over 14,000 Pennsylvanians will lose their health insurance coverage over the next five years.

This is a crisis. But it is not a crisis caused by IBC's surplus – or any other insurer's surplus, for that matter.

It is a crisis caused by rising health care costs. Why is that so hard to comprehend?

At Independence Blue Cross, we see what's behind this crisis every day. At IBC, our overall medical costs PER MEMBER, dating back to 2000 when that PPO policy was $8,000, have increased almost 90%. In 2003, we paid out nearly $620 million in claims each and every month of the year. That's right – almost $7.5 billion in a year.

What costs so much? *Everything*.

- In just five years, IBC's payments to hospitals have risen dramatically—by 77%—from $2.1 billion to $3.7 billion. (Appendix, Chart 1)

- Total Physician payments are up 110%. (Appendix, Chart 2)

The reason is simple: Payments to doctors and hospitals have increased due to an increase in the use of services and an increase in the use of more expensive services and technology.

Combine that with another fact:

> **Almost no region in America uses medical services at the rate we do in Southeastern Pennsylvania.**

Consider these numbers:

- Across 34 types of health care services, Philadelphia has the highest average rate of utilization of services in the United States. **The highest**. (Appendix, Chart 3)

- Pennsylvania's rate of hospital inpatient care is 3rd highest in the nation. (Appendix, Chart 4)

- We also have 46% more hospital beds per capita than the national average – and 24% more than the Pennsylvania average. (Appendix, Chart 5)

- We make 35% more visits to physicians (per 1,000 members) than the national average. (Appendix, Chart 6)

- We have higher rates of outpatient surgery than New York, Chicago, Houston Dallas, Boston and lots of other places. (Appendix, Chart 7)

- We are second in the nation for both radiology visits and cardiovascular visits. (Appendix, Charts 8 and 9)

The list goes on and on – for almost every type of medical service Philadelphia ranks higher than the rest of the country.

But let's not limit the cost crisis to medical services. Pharmaceutical costs also have played a major role in driving up the cost of health insurance. Consider:

- In 1999, IBC's pharmacy costs totaled $687 million.

- In 2003, we spent $1.15 billion – **an increase in just four years of 67 percent**. (Appendix Chart 10)

Or consider these statistics:

- In 2000, 188 IBC members had a year's worth of pharmacy claims exceeding $25,000. As a group, the 188 members' claims totaled $7.9 million.

- In 2003, **597** IBC members had a year's worth of claims exceeding $25,000. As a group, their claims totaled **$21.8 million**.

  In just three years, the number of IBC members with more than $25,000 in annual prescription claims increased by 317%. And the costs associated with those claims increased by 276%.

Did our members get that much sicker in three years? Of course not. The drugs just cost more—and we are using more of them. Since the federal government lifted restrictions on direct-to-consumer advertising for pharmaceutical companies, our drug costs have skyrocketed – driven by consumers who demand from their physicians a prescription for the drug they saw on TV last night.

But are we having a serious public discussion about rising pharmaceutical costs? No, we're fixated on the issue of surplus.

The same conclusions can be drawn by looking at the largest medical claims submitted by IBC members since 2001.

- In 2001, 4,105 IBC members submitted a year's worth of medical claims in excess of $50,000.

- Just two years later, 6,494 IBC members submitted a year's worth of claims in excess of $50,000—an increase of 58%.

- The costs associated with those claims increased from $422.3 million in 2001 to $659.3 million in 2003—an increase of 56%.

Those who doubt these facts should check with their local hospital executives or their physician. Ask them what's happening to their costs. Ask them about the impact of new technology, medical malpractice insurance premiums, their practice of defensive medicine and the medical needs of our aging population. And then ask them where they go for an increase to cover those higher costs.

To the health insurers, of course. Are the dots beginning to connect?

Let's be clear. IBC is not making a case for restricting the rights of physicians and hospitals to request increased reimbursements – or of pharmaceutical companies to increase their prices. But here is the undeniable fact:

> **Every time we increase our payment rates to physicians, to hospitals, to pharmacies, and to any other entity that provides health care to our members, the people who buy our health insurance policies pay for it with higher premiums.**

That is health insurance economics 101. The regulators in the Insurance Department are charged with reviewing the requests we make to raise those premiums, and over the years, their approval of those rate requests has reflected their understanding of this economic reality. Moreover, whenever the regulators consider our requests for higher rates, they know the size of our surplus. It is clear that prior to the start of this process, the Department's regulators had determined that the size of our surplus did not provide any reason at all to deny a rate increase. They knew it was not excessive.

And they clearly understood that our rate increases were necessitated by corresponding increases in our health care expenditures. In fact, Independence Blue Cross spends almost 87 cents out of every premium dollar on health care for our members—more than any of our non-Blue competitors in the Southeastern Pennsylvania health insurance market. Consider the numbers for 2003:

- IBC spent 86.7 cents out of every premium dollar on health care for its members.
- Aetna spent just over 76.6 cents.
- United Healthcare spent 81.4 cents.
- Coventry spent 81.2 cents.
- Oxford spent 79.6 cents.

Clearly, IBC has placed one priority—meeting the healthcare needs of our members—above all others. Meanwhile, our publicly-traded competitors are balancing their subscribers' needs with another (and, for them, more important?) priority—meeting the financial expectations of their shareholders. The evidence is in the margins. Consider:

- For 2003, IBC's margin after taxes was 2.2%.
- Aetna's margin after taxes was 5.2%.
- Coventry was at 5.5%.
- United Healthcare posted 6.3%.
- Oxford posted 6.6%.

These numbers tell an important story. More than any other insurer in the region, IBC is managing its business to maximize our members' access to healthcare. We dedicate more of the premium dollar to healthcare and less to the bottom line. And make no mistake, for a company that must pay nearly $7.5 billion in claims, managing to a margin after taxes of only 2.2% requires a skillful balancing act. A 3% miscalculation in projected claims for 2003 would have landed IBC in the red for the year—and made it necessary for us to draw upon our surplus to meet our financial obligations.

That's what surplus is for, you say, and rightly so. But let's look at one more set of statistics that show why *adequate* surplus is important—and why IBC's surplus is, by no stretch of the responsible imagination, excessive. Consider:

- In 2003, 44,754 IBC members generated "high-cost" claims totaling more than $2.3 billion.
- That means less than 2% of IBC's membership generated nearly one-third of our claims for the year.

Let's repeat that:

> **In 2003, less than 2% of IBC's membership generated nearly $2.3 BILLION in claims—nearly one-third of the total.**

Forget doomsday scenarios that require you to accept the possibility that an anthrax epidemic could affect millions in the Delaware Valley, generating claims that could wipe out our surplus; just consider this:

> **If the number of our high-claims members in 2003 had increased to just 65,000, generating an additional $1 billion in claims, our 2.2% margin—and our entire surplus—could have been wiped out.**

Could that happen? Of course. After all, who would have thought the number of our high-claims pharmacy members would increase by more than 300% in just three years? But they did. And every one of those members has seen first-hand evidence that Independence Blue Cross is living up to the promise we make to each of our nearly 3.5 million members—to be there when they need us.

These are members who understand the value of health insurance, and know—thanks to their unfortunate circumstances—that the unexpected is not just hypothetical, but very, very real. Recall the Northeastern Pennsylvania man who wrote to the Department, recalling that his Blue Plan had fully paid his $400,000 in medical bills. If not for his health insurance, he wrote "we would be financially destitute." Moreover, he asked, how many similar cases would it take to wipe out his Blue Plan's surplus? Is it adequate, he asked, "or should this be increased to accommodate the unexpected?"

The numbers cited above clearly illustrate IBC's record for managing our business well, and for the benefit of our members. But we also have a clear record that extends beyond the management of our business and into the public discussion of this health care cost crisis.

Barely six months into this three-year-old discussion about our surplus, IBC CEO G. Fred DiBona, Jr., in an OpEd column in The Philadelphia Inquirer, issued an invitation to all of the other parties in the healthcare system to join in serious conversations about how to control health care costs. He is still awaiting the first response.

Since 2003, IBC has been the loudest voice in Harrisburg calling for reform in the small group insurance market. IBC was the last major insurer in Pennsylvania to abandon Community Rating for setting small group rates, and did so only after the competition's use of Demographic Rating and Medical Underwriting began to have a negative impact on IBC's risk pool. Even after switching to Demographic Rating – but not Medical Underwriting – we repeatedly warned in testimony before various legislative committees that these rating practices would cause an increase in the state's uninsured population. We continue to support legislation in Harrisburg that would ban Demographic Rating and Medical Underwriting, and we have pledged to return to Community Rating as soon as our competitors also are required to do so.

Clearly, this is a position that represents the best interests of health insurance purchasers in Pennsylvania. It represents sound public policy. It would make health insurance affordable for more people. And it reflects the mission of a company that seeks to sell health insurance to as many people as possible – unlike our competitors, who seek to insure only those who are least likely to use health care services.

Similarly, IBC has testified before state legislative committees on the need for re-adopting Pennsylvania's Certificate of Need process, which before its elimination in 1996, required health-care providers to justify the need for purchases of major equipment, facility expansion or new services.

The decision to eliminate CON has led to the construction of expensive – and often redundant – medical facilities. And costs have risen steadily.

IBC has lobbied in Washington and Harrisburg for tort reform aimed at providing relief for the state's medical malpractice insurance crisis. Not only has the crisis caused costs to rise – and led to higher IBC reimbursements to providers – but it also has caused the state to lose the services of a significant number of physicians in certain specialties.

All of these efforts and others – including the decision to roll back premiums for Medicare Advantage products following passage of the Medicare Modernization Act – demonstrate IBC's efforts to address the rising costs of health insurance and make it available to as many people as possible.

Sadly, we often find ourselves outnumbered in these public discussions by the special interests who prefer to mislead the public into believing that relieving IBC of its surplus would make health insurance affordable again.

The fact is, it would not. And the numbers clearly prove it.

Let's suppose the Department followed the advice of some public respondents and ordered IBC to reduce its surplus from $840.9 million to the 200 percent RBC level – the minimum required by the state before it begins to monitor the company's affairs. At the end of 2003, the 200 percent RBC level was $430 million. Distributed among IBC's nearly 3.5 million members, that amount would cover far less than a month's premium payment—one time only. And then the surplus would be gone.

Is that a solution to the problem of rising health insurance rates? Certainly not.

Moreover, if the Department were to heed that advice, the Blue Cross Blue Shield Association would be preparing to commence actions to terminate our license to use the Blue brand.

Is that the outcome that best serves the health insurance needs of the residents of Southeastern Pennsylvania? Of course not.

The level of frustration expressed by those looking for relief from rising premiums clearly is running high. The need for action to address that frustration is growing daily.

It has never been more important for the parties in the health care system, together with government, to deal honestly with the causes of this crisis.

It is time to declare that IBC's surplus is in no way excessive—and begin examining the real problem.

II. Never Let The Facts Stand In The Way Of A Good Analysis

From the beginning of this unfortunate chapter in the history of Pennsylvania insurance regulation, misstated numbers have played a key role. Unfortunately, misstating numbers continues to be a favored tactic for many who represent special interests in this matter.

The most frequently misstated numbers involve IBC's Annual Statement for the Year 2003.

For the record, this financial statement is completed in accordance with Pennsylvania statutes. It is completed in accordance with the Department's directions. The form is given to us and we follow directions in filling it out.

Much was made in a number of special interest filings about whether this form captured IBC's Consolidated financial results or not. To be clear, the form captures:

- The entire surplus available to Independence Blue Cross from all of its subsidiaries.
- The claims paid on behalf of members who are covered by products sold by the Independence Blue Cross parent company—which are, in fact, our indemnity products. This form does not direct IBC to record the claims paid on behalf of its other members.

Again, to emphasize, the form captures ALL of the surplus available to IBC. It is a consolidated surplus. The rest of the financial data reported on the form refer only to the parent company, Independence Blue Cross. NAIC/PID forms ask for the information to be provided in this manner.

Those who seek to portray our surplus as excessive routinely have misrepresented the numbers on this form. The first to do so was a group of class action lawyers seeking to gain control of IBC's surplus. In their earliest filings, the class action lawyers divided the claims associated with IBC's indemnity product (which are less than 10% of the company's total claims) into the company's entire 2002 surplus, and concluded that we had enough surplus to cover more than 2 years of claims. At the time, IBC had enough surplus to cover **less than six weeks of claims**.

Despite being alerted to their error, the class action lawyers used the same incorrect data to support its analysis of IBC's surplus application. This time, they went one better – they took the surplus reported in the company's 2002 annual report, and divided it by the company's claims for 2003—but only for the IBC indemnity product—and announced we had enough surplus to pay nearly 2 ½ years of claims.

The magnitude of this misinformation is enormous. Here is a chart that presents the actual 2003 statutory surplus and the total claims paid by IBC and its subsidiaries:

	Class Action Lawyers' Numbers	The REAL Numbers
IBC's 2003 Total Medical and Hospital Expenses	$345,118,574	$7,425,347,000
IBC's Total Surplus	$840,916,844	$840,916,664
Monthly Medical and Hospital Expenses	$28,759,881	$618,779,000
Months of Claims Payments	29.23 months	41 DAYS

	Class Action Lawyers' Numbers	The REAL Numbers
Amount of Surplus Necessary for 3 Months Of Medical and Hospital Expenses	$86,279,643	$1,856,337,000
Excess or Shortage of Surplus Over 3 Months of Medical and Hospital Expenses	$754,637,021	($-1,015,420,336)

Clearly, this misuse of numbers seriously misstates IBC's financial position. It also should call into question any conclusions the class action lawyers draw, based on their incorrect numbers. But their misuse of numbers continued throughout their analysis. Let's take them, one by one:

Surplus Exceeding Four Months of Claims and Expenses

The class action lawyers assert that Highmark suggested during the September 2002 PID hearings that it "established a 'guideline' of 2½ - 4 months of expenses for surplus." The class action lawyers seek to apply this methodology to the other Blue Plans to reveal their allegedly excess surplus.

But once the correct data are applied to the class action lawyers' methodology, IBC clearly demonstrates that it would have no excess surplus. In fact, IBC's surplus would be at a significant deficit. Obviously, the deficit would be even larger than in the 3-month chart on the previous page.

2003 Statutory Financial Statement	Class Action Lawyers' Numbers	The REAL Numbers
Claims Incurred	$345,118,574	$7,425,347,000
Surplus	$840,916,844	$840,916,664
Amount of Surplus Necessary for 4 Months of Claims	$115,039,524	$2,475,116,000
Excess or Shortage	$725,877,140	($-1,634,119,336)

25% of Premium/Revenues Methodology

The class action lawyers assert that Blue Plans outside of Pennsylvania have applied a methodology that assumes that surplus exceeding 25% of Annual Premium/Revenues is excessive. It contends that IBC maintains 202% of revenue as its surplus.

The correct data, however, reveals a different picture entirely. IBC's surplus represents only 9.8% of its revenue – significantly less than the class action lawyers' 25% level.

	Class Action Lawyers' Numbers	The REAL Numbers
12/31/2003 Surplus	$840,916,844	$840,916,664
2003 Revenue	$415,894,165	$8,566,794,000
Surplus Needed for 25% of Revenue	$103,973,541	$2,141,698,500
Excess or Shortage Over 25% of Revenue	$736,943,123	($-1,300,781,836)
Surplus As A Percentage of Revenue	202%	9.8%

Comparing IBC's Surplus, Premium (Revenue) and Claims Experience to Seven Other Blue Plans

The class action lawyers argue that IBC "would have substantially more in surplus in relation to other comparable Blue Cross/Blue Shield Plans even if its surplus was [sic] reduced to 350% of RBC-ACL…"

Using accurate data for IBC, as detailed below, shows that IBC has significantly less surplus relative to each dollar of premium than all of the other Blue plans selected by the class action lawyers for comparison.

	Blue Cross/Blue Shield Plan	Surplus	Premium (Revenue)	Claims Expenses
Class Action Lawyers' Numbers	IBC Statutory Statement	$840,916,664	$415,894,165	$345,118,574
	IBC Surplus at 350% of RBC	$751,672,002	$415,894,165	$345,118,574
The REAL Numbers	IBC	$840,916,664	$8,566,794,000	$7,425,347,000
	IBC Surplus at 350% of RBC	$751,672,002	$8,566,794,000	$7,425,347,000
	Excellus Health Plan	$629,010,742	$3,793,337,037	$3,337,576,998
	Dist. Of Col. BCBS Plan	$392,008,160	$1,891,194,684	$1,674,794,207
	Regence Blue Shield (Wash.)	$501,014,103	$1,660,031,664	$1,342,650,723
	Premera BC (Wash.)	$373,217,439	$2,295,421,096	$1,942,528,319
	Oregon BCBS	$282,399,684	$1,460,858,697	$1,303,637,967
	Carefirst of Md. Inc.	$338,468,658	$1,315,629,257	$1,112,587,924
	Rhode Island BCBS	$261,482,739	$971,002,966	$830,979,202

In all of its filings and in response to any request made by the PID, IBC has consistently provided accurate calculations, information and explanations. While IBC acknowledges that health care financing is a very complicated business with substantial financial risks, any knowledgeable, fair-minded reader would find the class action lawyers' submission, with its incorrect calculations and erroneous conclusions, a poor substitute for the truth and a flimsy foundation for accusations of excessive surplus.

Unfortunately, their calculations have found their way into nearly every one of the special interest submissions received by the Department during this process.

III. Sure, Let's Change the Rules After the Game Begins

Another common theme in the special interest submissions proposed that the current measures for evaluating surplus levels—approved by 50 state insurance commissioners and adopted by 50 state legislatures—should be discarded, undoubtedly because those methods do not support the desired outcome of those special interest groups.

Apparently lost in this process is the importance of surplus to an insurer's financial condition. Surplus serves two principal functions. It is:

- An insurer's safeguard against unforeseen financial difficulties and ultimately, ruin.

- A source of funds that an insurer—especially a non-publicly traded insurer—has available to grow and remain a vital market force.

Surplus provides assurance that an insurer will meet its financial obligations over the long term. This is the essence of insurance and similar financial guarantees—that they will be met when due.

Having said that, it is nothing less than reckless to suggest that the industry's well-established methods for measuring surplus should be discarded. Consider:

1. **Minimum surplus levels are already established by the NAIC and the Commonwealth of Pennsylvania.**

    - In his report prepared for a consortium of special interest groups, Larry Kirsch of IMR Health Economics has turned the world upside down. He has taken what is accepted across the entire health insurance industry as a first alarm bell, designed to warn of an insurer's potential insolvency, and proposed that it become the ceiling. He offers no support, however, for his assertion that 200% of ACL provides a "more than adequate level of 'early warning' protection"—other than his own theoretical observations about the health insurance and Blue plan marketplace. He apparently disregards all of the years of expert analysis performed to create solvency standards, as well as the tests of how well they would work in the actual market.

    - Does it not matter that virtually every well-managed insurer in the United States—Blue and non-Blue—is moving toward surplus levels far in excess of the 200% ACL level? And what about the fact that all of the major insurance rating services (whose business is assessing insurers' future prospects) look for surplus well in excess of 200% ACL?

The bottom line: Based on a few theoretical arguments requiring less than a page, Mr. Kirsch would have the PID dispose of all the work that has been performed over many years on minimum and prevailing surplus levels by many reputable organizations and technical experts.

2. **The NAIC directed the analyses that resulted in the calculation of RBC, and benchmarks for appropriate RBC levels.**

   Periodically the NAIC, and the actuarial task forces it appoints, reexamine and update factors and formulas that are used in the RBC calculations. These analyses consider real-world situations and implications of any changes.

   In addition, rating agencies must opine on the financial condition of insurers and healthcare organizations—they put their name and reputation on the line when they provide a rating of an insurer, or any company, for that matter. Their processes for setting and evaluating ratings are well established and continuously updated for new facts and circumstances.

   An important factor in assigning a rating is the insurer's level of surplus—these agencies have developed their own approaches to evaluating surplus levels (which parallel but are not the same as RBC) and some have conducted extensive studies of troubled and failed companies to provide a real-world test of how well their standards work.

   There is no indication that Mr. Kirsch has considered using or has even reviewed any of these available, established processes. His theories and departures from well-established practices seem to be solely his own.

3. **For Blue plans, the BCBSA surplus standards are anything but "excessive," and they cannot be "irrelevant" to a financial inquiry by the PID, as Mr. Kirsch would have us believe.**

   BCBSA has a strong interest in protecting the financial integrity of the Blue Plans. The constituent Blues themselves want assurance that minimum surplus levels are appropriate and are observed so that the entire Blue system works properly.

   The BCBSA's 375% RBC standard is well below the surplus levels that the largest, best managed insurers (both Blue and non-Blue) actually hold. How Mr. Kirsch could construe 375% as having a "conservative bias" is unclear, but this characterization also appears to have little support beyond his own theories and rhetoric.

   Let's be absolutely clear: The Blue license/trademark is invaluable to an individual Blue plan. The loss of the brand could be devastating. Even incurring a *risk* that the trademark could be lost, especially if such a *possibility* were made public, could represent a point of no return for a Blue plan. For starters, the loss of the Blue brand immediately would deprive a Blue Plan of access to the national and international Blue network of hospitals and physicians—thereby making it impossible for the Blue Plan to provide coverage to national and international companies, some of whose employees live outside the Blue Plan's service area. For IBC, this would have a devastating impact, costing the company hundreds of thousands of members.

4. **Mr. Kirsch's discussion of maximum surplus levels relies solely on his own theories.**

   His proposed "Framework for Analysis" proposes an "alternative" underwriting risk model that would be run with his own assumption set. This is a shallow "alternative" that Mr. Kirsch suggests. First, such a model represents only one of the factors to be considered in setting target surplus. Second, his assumption set is highly suspect. Third, even for this very limited suggestion, Mr. Kirsch offers no real-world support. How well would his analysis have worked in the past? What issues would it create today? Could any insurer using such an "alternative" be perceived as financially solid, highly rated, or acceptable to its national association?

5. **Here are important considerations that should be made in evaluating surplus levels.**

   Given the importance of the conclusions, the analyses should be thorough and steps should not be skipped. Some of these considerations include:

   a. <u>What are the lowest possible levels of surplus that can reasonably be held to avoid the risk of adverse market reaction?</u> This should include consideration of the practical impact of RBC surplus and standards such as that of BCBSA. How close should an entity allow itself to come to such minimum levels and what happens when there are adverse trends in that direction? What has been the effect of surplus deterioration on thinly margined organizations in the past—particularly those that proceeded into troubled financial status? The impact of rating agency actions (watchlist, downgrade, multiple successive downgrade, etc.) should be considered, especially for institutions where inadequate capital contributed significantly to failure. The experience of insolvencies and rehabilitations just prior to their decline should be examined, especially on those in which a key cause of difficulties was capital levels.

   b. <u>In setting surplus *targets* (not minimums, but "appropriate" levels to support operations—extending into, possibly, maximum levels), what other factors need to be considered?</u> These factors include:

      i. What are the risk characteristics of the business that are not captured in the RBC formula? The RBC formula is generic and not designed to capture the specific risk profile of every insurer. Often, large cases and influential constituencies can create higher risk levels. The geographic limitations of many Blues, including IBC and others, creates larger risk levels that must be recognized.

ii. What type of scenarios may reasonably occur that could significantly draw on surplus? These scenarios certainly go well beyond the underwriting cycle definitions that Mr. Kirsch's narrowly drawn report proposes. The unforeseen problems which can create adverse scenarios may occur singly or in combination and include, besides Mr. Kirsch's "adverse loss cycles" (p. 13, table):

- Costs of regulatory mandates (e.g., HIPAA)
- Costs of regulatory delays or reductions in premium increase requests
- Systems expense and displacement issues (operational, data quality, monitoring, etc.)
- Litigation expenses
- Invested asset deterioration
- Reinsurance collectability issues
- Catastrophic medical claim events (including general catastrophes and also volatility in lines such as stop loss)
- Financial problems experienced by subsidiaries and affiliates
- Competitor moves that create expensive market reactions

Even "adverse loss cycles," the only basis that Mr. Kirsch offers for surplus targets, should be viewed in their component parts:

- First, there is the risk of increased *utilization* of services (which can occur due to insured population shifts, demands for new services, epidemic, catastrophe, etc.).

- Second is the risk of increases in *cost* of services (e.g., skyrocketing costs of prescription drugs, costs of new procedures, etc.).

Furthermore, some of these issues may reasonably be expected to occur at the same time. The linkage of some of these costly problems seems obvious—one would *expect* multiple adverse occurrences. Anyone doubting that multiple problems can occur at the same time should consider the current situation of USAir (impacting Pennsylvania right now), which faces labor difficulties, high pension and wage costs, litigation costs and high energy prices – all at the same time. Or, in IBC's case, consider our earlier analysis of what's behind rising health insurance premiums. Look at the list of convergent contributors to the company's overall risk profile: rising medical and pharmaceutical costs, increased utilization of services; the aging of the population, government mandates, and so on.

iii. The degree of assurance that surplus should provide. The NAIC has set reasonable standards and these should be re-set only with extreme care

and very careful analysis. Is Mr. Kirsch proposing, for example, that a 75% "safety threshold" (see table, p. 13) is reasonable or sensible? If not, what exactly is he recommending with his model assumptions? ***Would a Blue or other insurer really want to tell a provider, a large group or an insured senior citizen—"give us your premium dollars now and we will assure that there is no worse than a 1 in 4 chance that we will fail to be there when you need us?"*** Does this seem like a real-world scenario? Would the NAIC consider it one? The BCBSA? Why would the PID?

iv. Surplus is not only about risk. There is also **vitality surplus** to be considered. Almost all insurers (as well as other corporations) must have the capital resources to react to changes in the marketplace. Blues are no different and in fact with the health insurance market so volatile, their need for surplus to remain viable is even greater than for most other insurers. To remain competitive, Blue plans—like all insurers—must have capital to spend on new product lines, system support for new ventures, network development, expanding fields (drug therapy, specialized rehabilitation, new surgical procedures, etc.) It is a given that health insurers will continue to face rapid change; if Blues are less financially able to respond, they are seriously disadvantaged.

v. What are our non-Blue competitors doing? The best practices of larger, well-managed companies need to be considered. It is clear that prior to 2001-2002, insurers were building surplus levels. This is notable given the disincentive to accumulate excess surplus where returns are low. In 2002-2003, insurance industry surplus declined primarily due to asset problems (lowered earnings rates, defaults), but now the rebuilding has started. Does a lower surplus requirement (through proposed caps and ranges) for Blues pass the reality test? Is the entire market wrong about surplus levels, while Mr. Kirsch's unsupported theories on reducing it are correct?

vi. Troubled financials, leading in some cases to rehabilitations and insolvencies, are traumatic events for members, the provider and the regulator-- as well as for the company itself. These situations are clearly to be avoided. An impact study of any changes to standards for such a serious matter is a necessity. How would this have prevented or created more trauma in the past? How many more health insurers would be affected by such a change? There is no evidence of the examination of any such considerations in Mr. Kirsch's report.

vii. Should any additional margin be considered in Pennsylvania? This is a state where there have been a relatively high number of insolvencies. Do caps and ranges that effectively reduce margins make sense in a state where it seems the opposite tact would be more logical?

Fortunately, the health insurance industry has considered many of these factors in setting surplus levels.

Regulators have considered risk models and various types of adverse scenarios in setting surplus levels that provide the bare minimum to survive and avoid regulatory intervention. They have also considered real world application of their models and formulas to ensure they provide a reasonable result. Nevertheless, no successful, well managed insurance company wishes to be at or near such a standard. In fact, rating agencies, the BCBSA, and prevailing best practices encourage—if not require—well-managed companies to maintain surplus levels that significantly exceed "minimum" standards.

IV. For the umpteenth time, IBC is not a charity

Numerous public comments referred to IBC's alleged status as a charity. This myth arises from the fact that IBC is a not-for-profit corporation.

But we are not a charity. Try sending us a tax-deductible contribution, and see what the IRS has to say about it.

No, IBC is **not** a charitable organization as that term is defined and understood under the laws of the United States and the Commonwealth of Pennsylvania. Rather, IBC is a "not-for-profit hospital plan corporation," which makes IBC a unique entity in this Commonwealth. IBC's enabling legislation defines a nonprofit hospital plan as "a plan whereby for prepayment, periodical or lump sum payment hospitalization or related health benefits ***may be provided to subscribers to such plan***." (40 Pa. C.S.A. § 6101).

Thus the plain language of the Hospital Plan Corporation Act authorized IBC to be organized solely for the benefit of its subscribers who pay insurance premiums.

Some of the comments state that IBC is a charity under the Institutions of Purely Public Charity Act (10 PS. § 371 et. seq.) ("the Charity Act") . This belief is misplaced. The Charity Act states that it does not apply to hospital plan corporations like IBC. (10 PS. § 385)

It is of note that neither the government of the United States nor the government of the Commonwealth of Pennsylvania treats IBC as a charitable organization. One of the hallmarks of any charitable organization is that such an organization does not pay taxes. IBC, however, pays federal income tax—ever since the mid-1980s when Congress recognized that Blue Plans were commercial enterprises. IBC also pays numerous taxes to both the Commonwealth and its political subdivisions. In 2003 IBC paid federal, state and local non-payroll taxes totaling more than $184 million.

While IBC acknowledges that it has an important Social Mission, one that it intends to maintain and grow, that Social Mission does not transform IBC into a charity.

V. Don't Believe All You Read: IBC Does Have A Social Mission

Reviewing the descriptions of IBC's Social Mission that were submitted to the Department by a number of special interests, one might envision greedy landlords chuckling while they evict hungry women and children from their homes in the cold of a winter's night. IBC's commitment to a Social Mission was criticized as insufficient, overstated and in need of rigorous government oversight.

We were even accused of counting the taxes we pay toward our total Social mission investment.

That, as the Department already knows, is not true—though it is typical of the claims which some made about our Social Mission. But let's talk about taxes for a minute, because there **is** a relationship between the taxes we pay and the Social Mission we carry out.

Several respondents referred to the establishment of Blue Cross companies as non-profits and the expectation that, in return for a tax-exempt status, they would carry out a robust Social Mission. They are correct. But they neglected to mention what has happened during the six decades since the Blues were established.

For starters, the Blues are no longer tax-exempt—recall the action by Congress, which recognized the Blue Plans as commercial enterprises. Today, IBC's only tax exemptions apply to the state premium and sales taxes on our indemnity business – and that represents less than 10 percent of our business.

So what was our 2003 tax exemption worth? About $12 million.

And what did IBC invest in its Social Mission that year? About $25.5 million.

> **That's right. The same company that paid $184 million in federal, state and local non-payroll taxes during 2003 also spent twice its tax exemption on Social Mission initiatives.**

Clearly, this is a fairly unique situation in the Commonwealth. Perhaps the Department could make a call over to the Revenue Department and get a list of the 10 largest taxpayers in Pennsylvania. Then let's call them and see how many have a Social Mission.

So why does IBC still pursue a Social Mission? Because we believe it's the right thing to do. And because we have been able to manage the company well enough to afford it. That, of course, could change—especially if the Department were to decide that we needed to change the way we manage the company's affairs.

So, no – IBC does not count the taxes we pay toward our total Social Mission investment. But we would appreciate some honest recognition for carrying out that mission *in spite of the taxes we pay.*

And finally, a number of respondents proposed that the Department impose a required level of Social Mission spending on the Blue Plans. This was, at least, a proposal with a precedent, established when the Department imposed such a requirement on Highmark as part of the merger between Blue Cross of Western Pennsylvania and Pennsylvania Blue Shield. But the seriousness with which we should take such an idea evaporated when we read one proposal that set the level at 3.75% of total premium collected. (Was it just coincidence that Mr. Stein chose the numbers 3-7-5 and failed to offer any rationale for their selection? His support of Mr. Kirsch's report, which criticized the Blues' lack of supporting documentation for its 375% RBC minimum, left us wondering.)

Well, Mr. Stein's proposal would have a truly interesting impact on insurance premiums in Southeastern Pennsylvania. Consider: 3.75% of our total premium in 2003 amounts to more than $321 million – **more than 150% of our net income for the year!** It will be IBC's pleasure to forward our rate-payers' angry letters to Mr. Stein's office.

VI. Conclusion

Is IBC's surplus excessive?

In January, the Insurance Department announced its intention to embark on a process to determine whether any of Pennsylvania's Blue Plans were holding excess surplus, and to identify a process for disposing of any that was deemed excessive.

The first half of this stated intention was fairly straightforward. In fact, Independence Blue Cross had been operating under the belief that the Department, which regularly receives reports on the size of our surplus and the RBC calculations that measured for its solvency, was comfortable with the size of our surplus. Nevertheless, we supplied the information necessary for the Department to again reach the conclusion that our surplus—while adequate to provide financial security to our members—was in no way excessive.

But the process—like the three-year-old debate that preceded it—has been anything but a straightforward regulatory exercise. It has become a metaphor for what happens when political opportunists and special interests play cavalierly with matters of serious public policy.

Independence Blue Cross asks that the Department refocus this process on the question at hand. Is IBC's surplus excessive?

- The Department did not think so in its January notice. With our 2003 Risk Based Capital of 391%, IBC's surplus fell at the low end of the Department's suggested range of 350—650% RBC.

- The Pennsylvania Medical Society does not think so. In its submission to the Department on September 24, the PMS suggested that the Blues be limited to 53 to 62 days of claims and expenses. Wrote the PMS in its September 24, 2004 submission to the PID: "Using this standard, Independence's surplus funding level (approximately 41 days) would be appropriate."

- Representative Phyllis Mundy must not think so. In her proposed legislation designated as HB 202, she calls for the Blues to be capped at 3 months of claims, over and above the Commonwealth's 200% RBC minimum. Again, IBC has less than 6 weeks.

- Even the class action lawyers who want control of our surplus proposed a cap of 3 months of claims—a level that far exceeds IBC's 2003 level of 41 days.

The truth is, no one has offered one coherent, supportable argument for capping the Blues' surpluses at a level lower than IBC's current level of 41 days of claims. We suggest there is a clear reason for that:

Our surplus is not excessive.

So why have special interests filed so many pages of submissions, accusing IBC of hoarding surplus, misrepresenting its financial picture and abandoning its Social Mission? Why the all-out assault on a Blue Plan that day in and day out is, far and away, the health insurer of choice for residents of Southeastern Pennsylvania?

Now you're getting warm. The reason for the vitriol is not all that surprising. Let's review the recommendations:

- Force IBC to significantly reduce its surplus, leaving the company thinly capitalized and incapable of promising its members and customers financial security.

- Require IBC to behave like a charity. (No word from the government about how they'll replace that $184 million in tax revenue.)

- Require IBC to devote a significant percentage of its revenue—from for-profit subsidiaries as well as not-for-profit ones—to insuring the uninsured.

- Reduce IBC's surplus and use the money to fund government programs. (If not that, just don't give it back to the people who pay the premiums.)

These recommendations, if implemented, would unfairly and unwisely change the competitive landscape of the health insurance market in Pennsylvania. This is about taking four successful health insurance companies and changing the conditions of their business so dramatically that they no longer pose a threat to their non-Blue competitors. And anyone who has paid attention to this debate over the past three years is well aware of the organizations determined to do just that.

This is about pushing IBC into box. And make no mistake, that box is a coffin.

Why should it surprise anyone that the President of the federation representing IBC's non-Blue competitors wants the surpluses of the Blues to be held to new and tougher standards? Why should it be surprising that he wants the Department to impose a level of Social Mission giving on the Blues? Why should it be surprising that he warns the Department not to let the Blues give any surplus back to their members—lest it "weaken competition." (After all, he represents those who might be weakened.)

Yes, we are asked to take seriously the recommendations of such a clearly self-interested party as the Insurance Federation—the same group that advocates that IBC be forced to use Community Rating to set premiums for its small employer groups, while IBC's competitors—the Federation's members—can offer better rates through Demographic Rating and Medical Underwriting.

Oh, the high-mindedness of it all.

We trust that the Department will see through this smoke, which seeks to distract regulators from the question at hand. After all, it certainly would be ironic for the Department to handicap the business wherewithal of a company that:

- Devotes more of the premium dollar than its non-Blue competitors to members' health care, and

- Devotes MUCH more of the company's revenue than its commercial competitors to health care for the uninsured.

That sounds like the kind of company a state would be proud to have around.

It is the hope of Independence Blue Cross that the professional regulators who are charged with ensuring the solvency of Pennsylvania's health insurance companies can focus squarely on the triggering question posed in the January notice.

Is IBC's surplus excessive?

No. And anyone who understands health insurance economics—as the regulators in the Pennsylvania Insurance Department clearly do—knows it is not excessive.

Hopefully, once that question is put to rest, once and for all, all of us can focus on the real issues that are driving our health care system toward economic implosion.

Hospital Reimbursement Trends

Total facility costs have risen 77% in the past five years --- **from just over $2 billion to $3.7 billion for 2003**

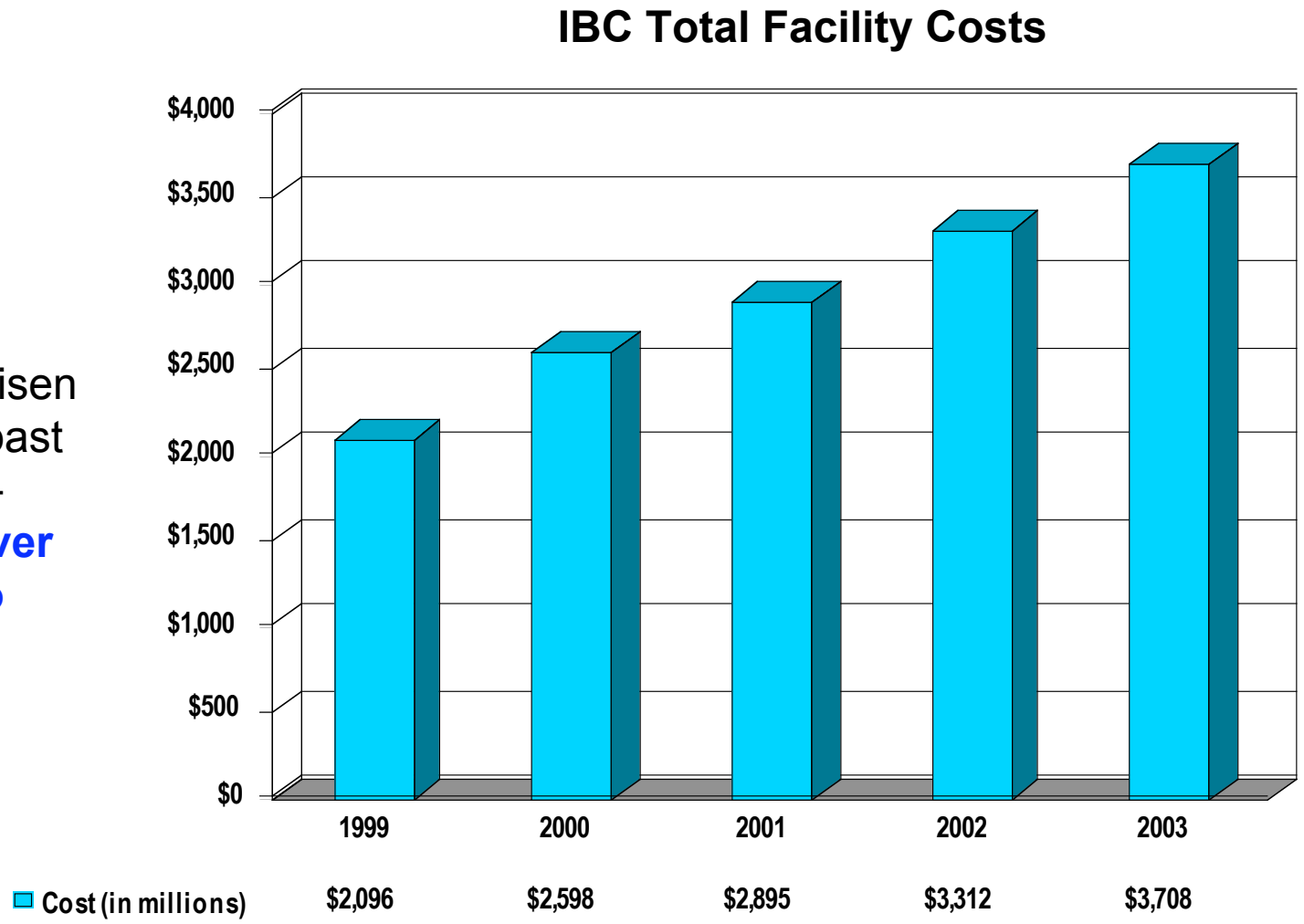


Chart #1

Payments to Physicians

Total physician payments are up 110%

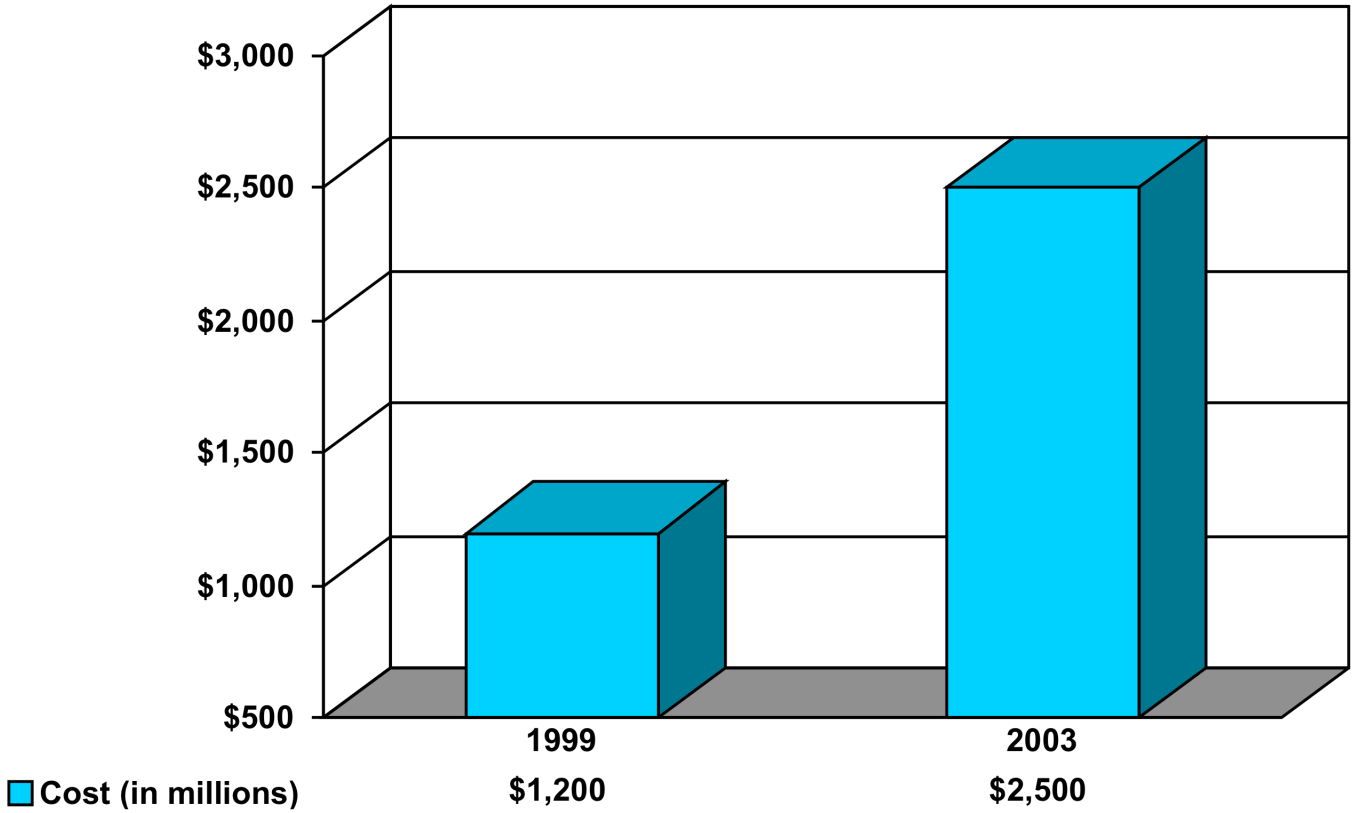
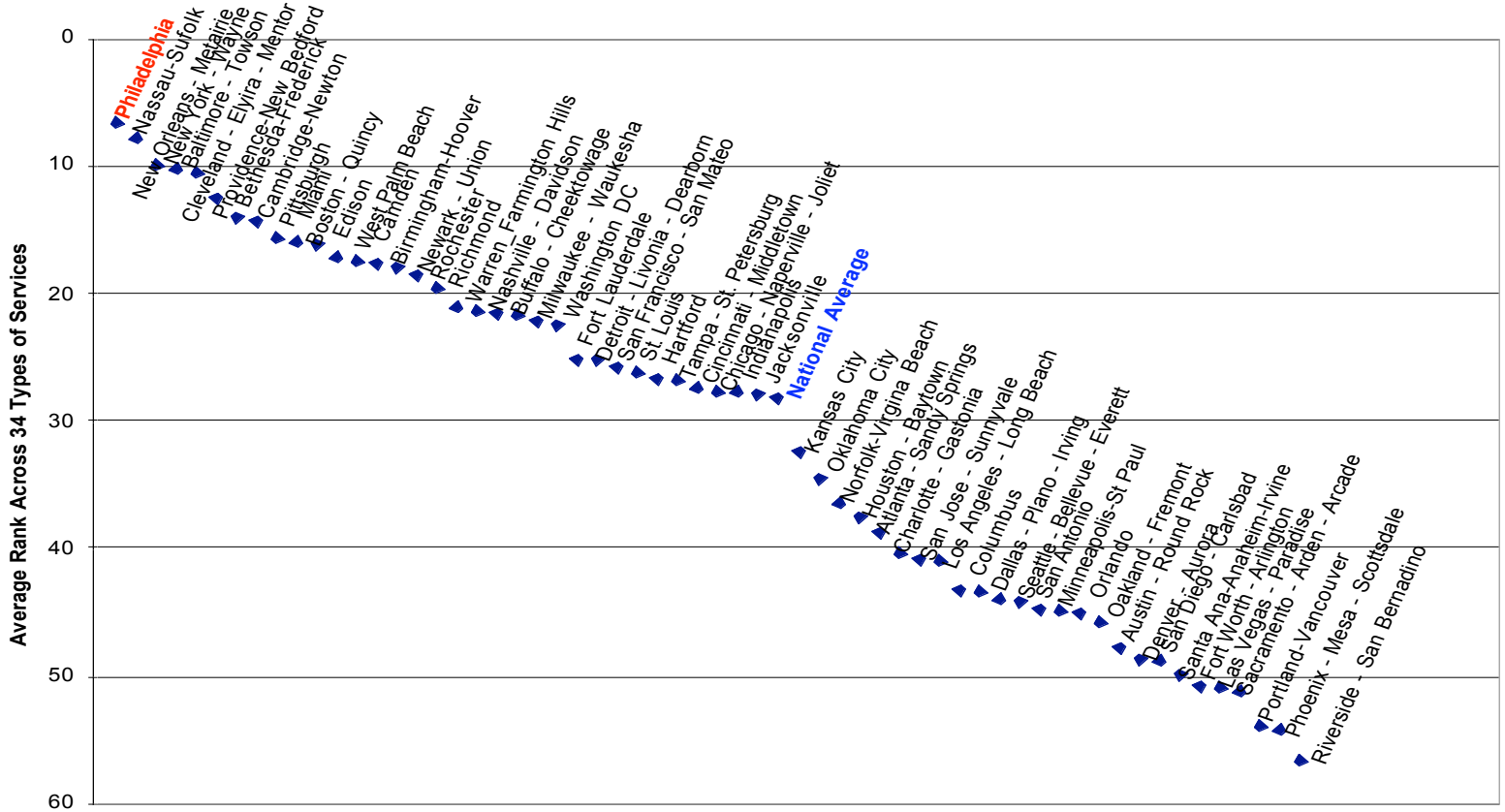


Chart #2

Combined Utilization By MSA

Across 34 Types of Health Care Services, Philadelphia has the Highest Average Rate in the Country



Note: Includes Inpatient services, Outpatient services and Physician visits

Chart #3

Source: Milliman U.S.A. Inc. 2004 - 2002 Data / Health Cost Guidelines Commercial Area Factors

Pennsylvania's Hospital Utilization Close to Highest in the Country

Inpatient Days/1000-States with Population >3M

At just over 838 days per 1000 members, Pennsylvania ranks third highest in in-patient utilization in the entire country (major markets)

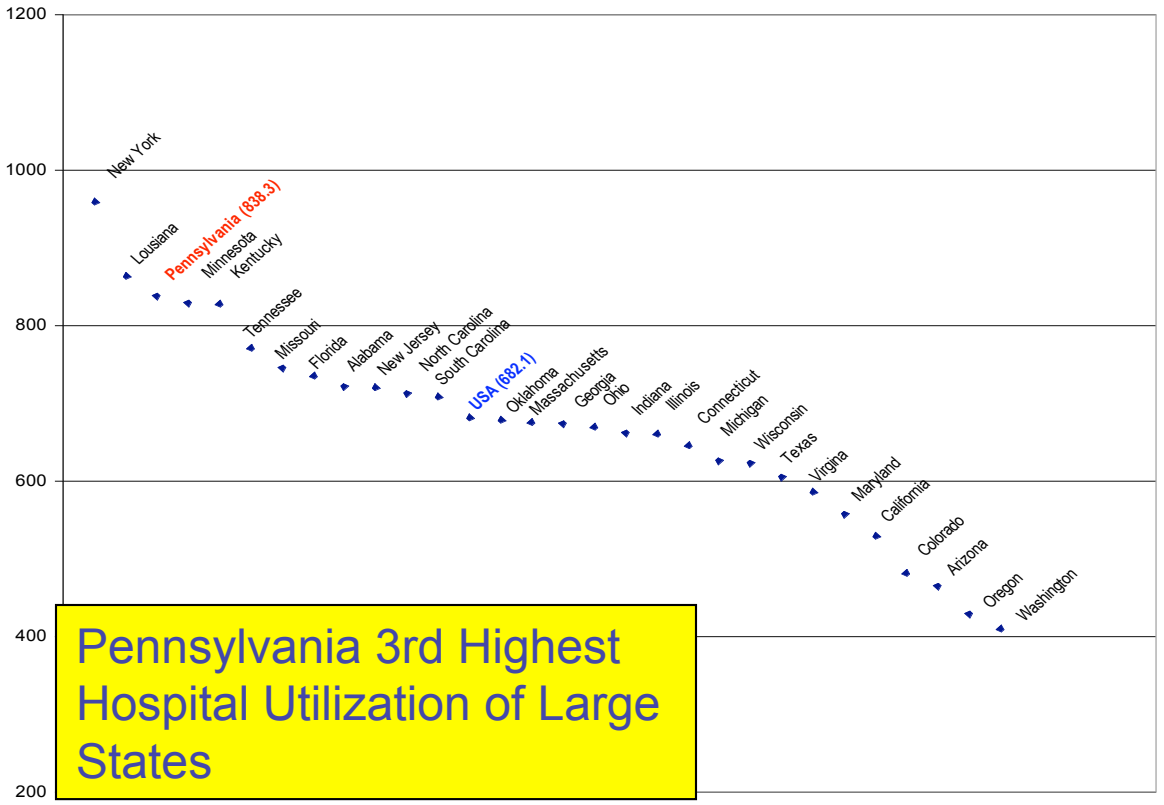


Chart #4

Reviewed and Updated: 03/24/04

Source: AHA Hospital Statistics 2004 -2002 Data

Extraordinarily High Hospital Bed Capacity

Hospital Capacity

Beds / 1000 population

Philadelphia's exceptionally high utilization is also fueled, in part, by…

- Extraordinarily high hospital bed capacity ---- 46% higher than the US average
- Bed capacity 24% higher than PA average

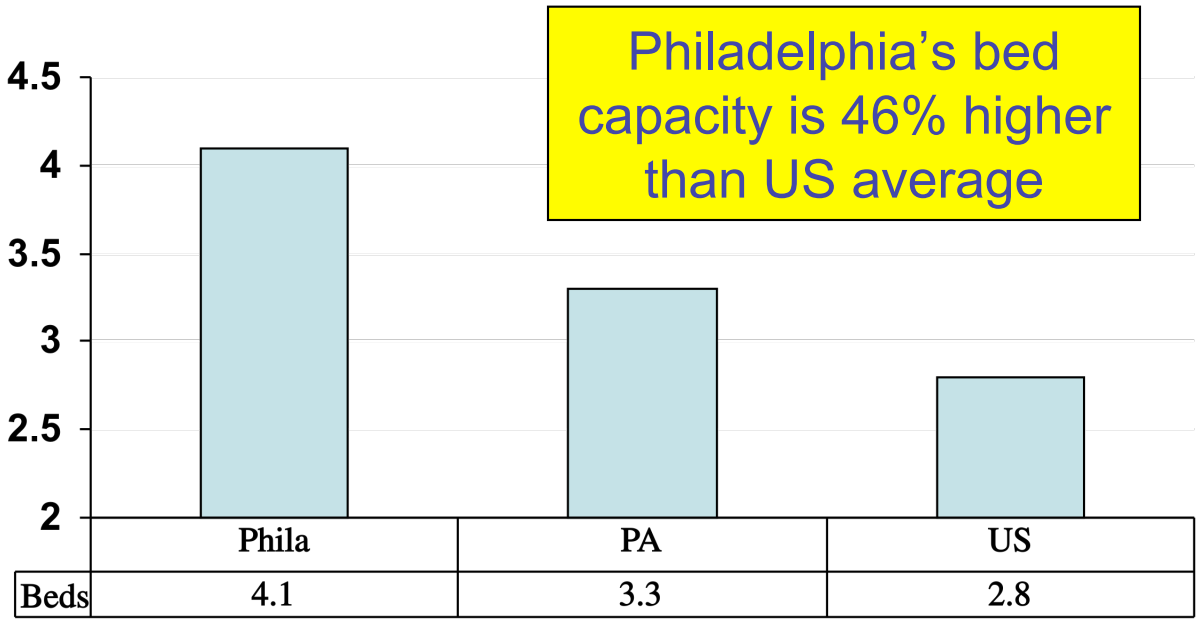


Chart #5

Source: Data are for FY 2001 as reported in InterStudy, 2003 (Philadelphia) and FY 2002 as reported in AHA, 2004 (PA and US)

Reviewed and Updated: 03/24/04

Physician Utilization Rates

High inpatient utilization rates also create very high rates of physician visits to hospitals

Physician Inpatient Visits per 1000 Commercial Members

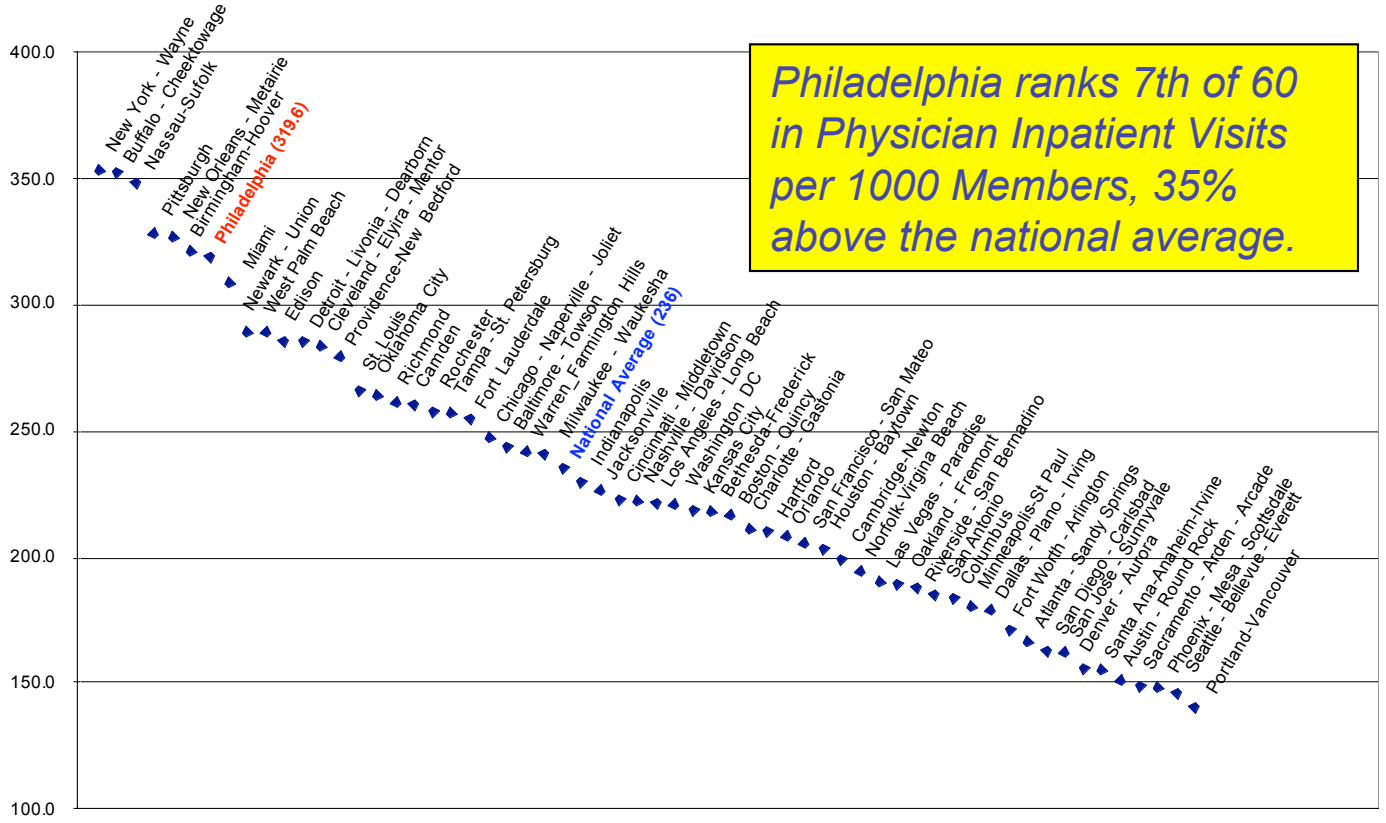


Chart #6

Source: Milliman U.S.A., Inc. 2004 - 2002 Data/ Health Cost Guidelines Commercial Area Factors - Includes visits to a hospital or Skilled Nursing Facility by a physician

Physician Utilization Rates

High facility outpatient utilization rates also create high rates of related physician surgery

Physician Outpatient Surgery Office Visits
per 1000 Commercial Members

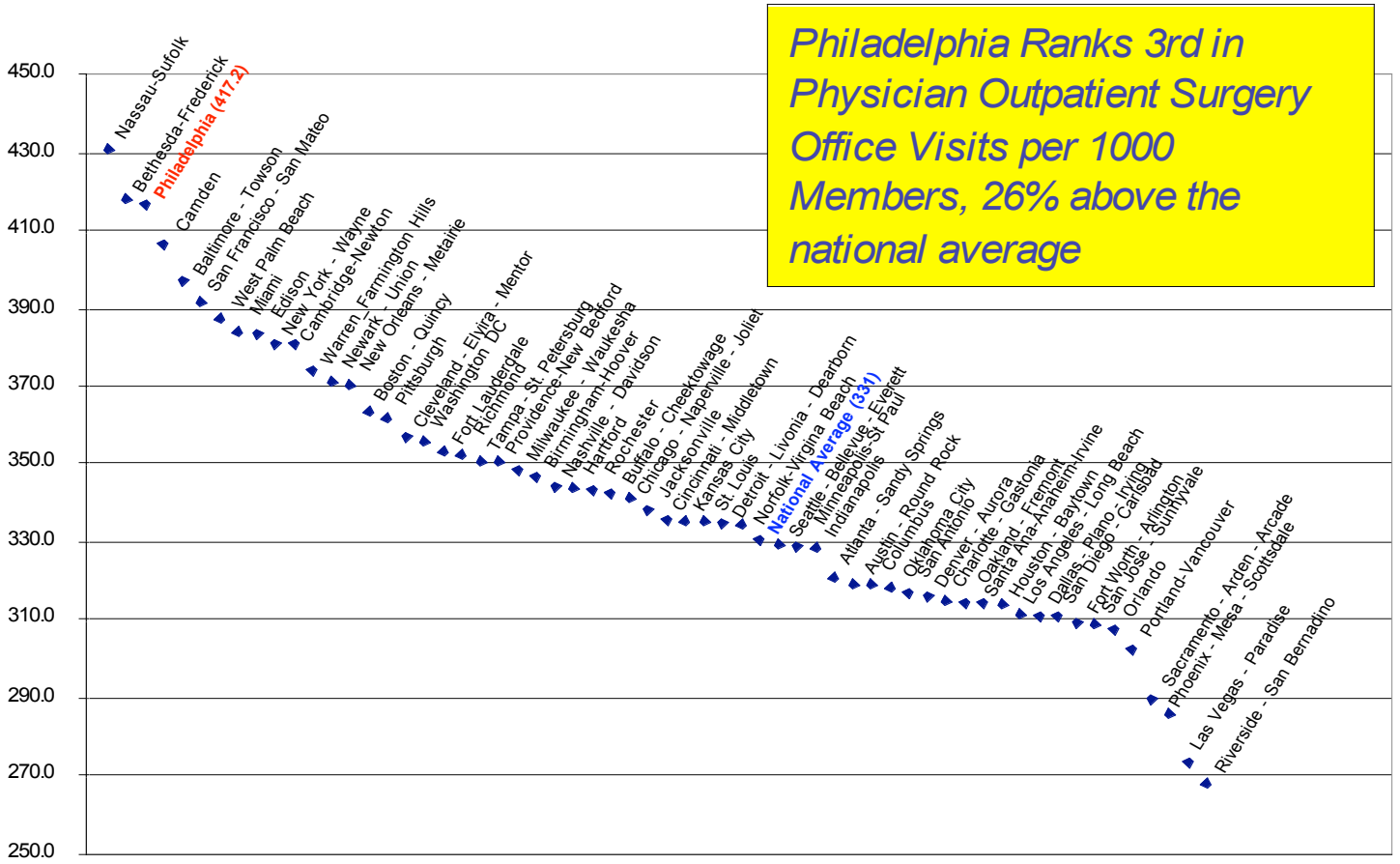
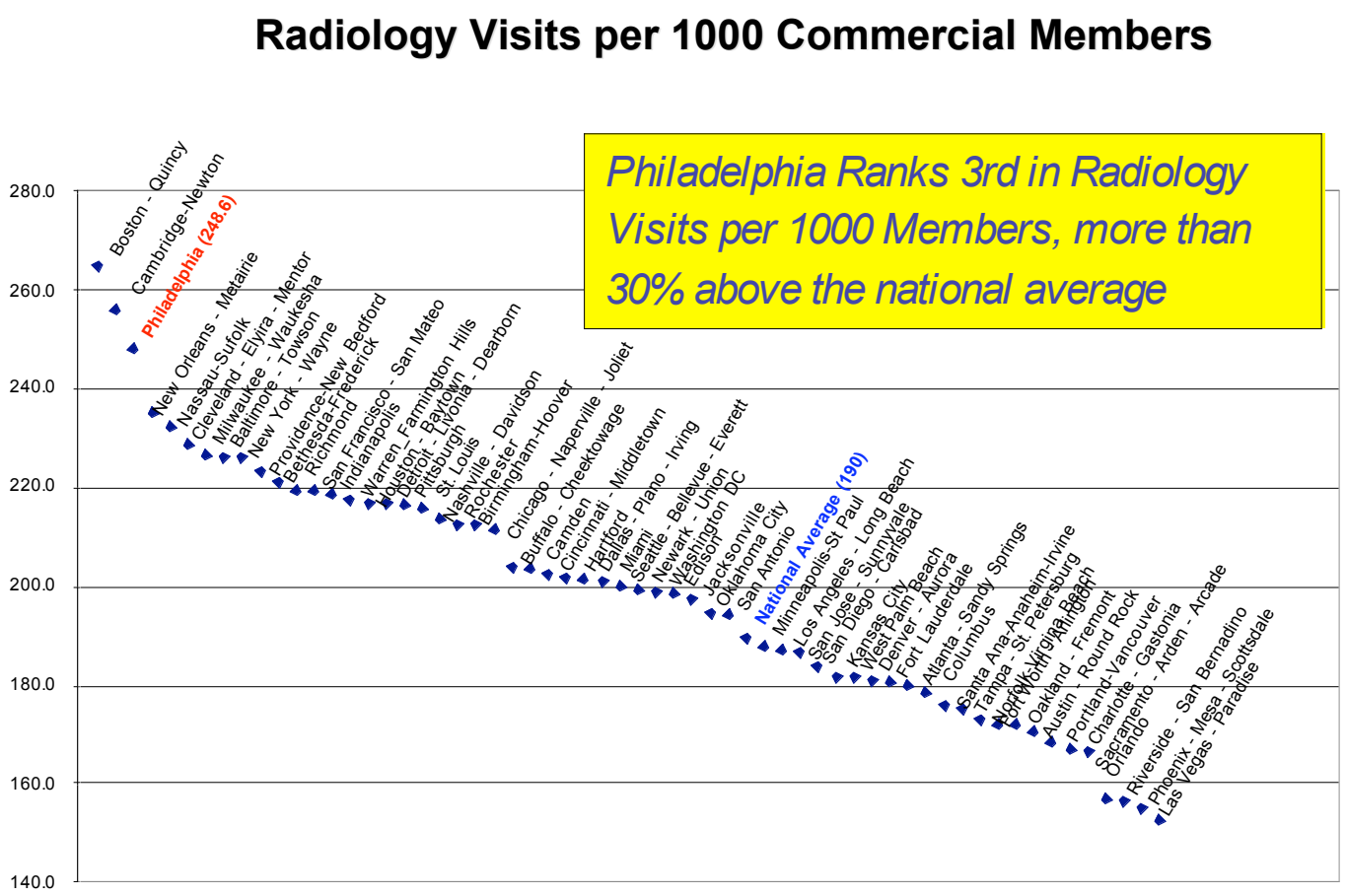


Chart #7

Source: Milliman U.S.A., Inc. 2004 - 2002 Data/ Health Cost Guidelines Commercial Area Factors - Includes surgery by a physician in a physician's office

Outpatient Imaging Utilization

Extensive use of outpatient services drives high physician radiology services



Source: Milliman U.S.A., Inc. 2004 - 2002 Data/ Health Cost Guidelines Commercial Area Factors - Includes the technical component of Radiology services performed by a hospital outpatient department or free-standing facility

Outpatient Cardiovascular Utilization

Contributing to high outpatient use is the very high rate of cardiovascular related visits

These visits are primarily for diagnostic testing such as EKGs and stress tests

Hospital Outpatient Visits / 1000 Commercial Members

Philadelphia ranks 3rd of 60 in Outpatient Cardiovascular visits per 1000 Members, more than 30% over the national average

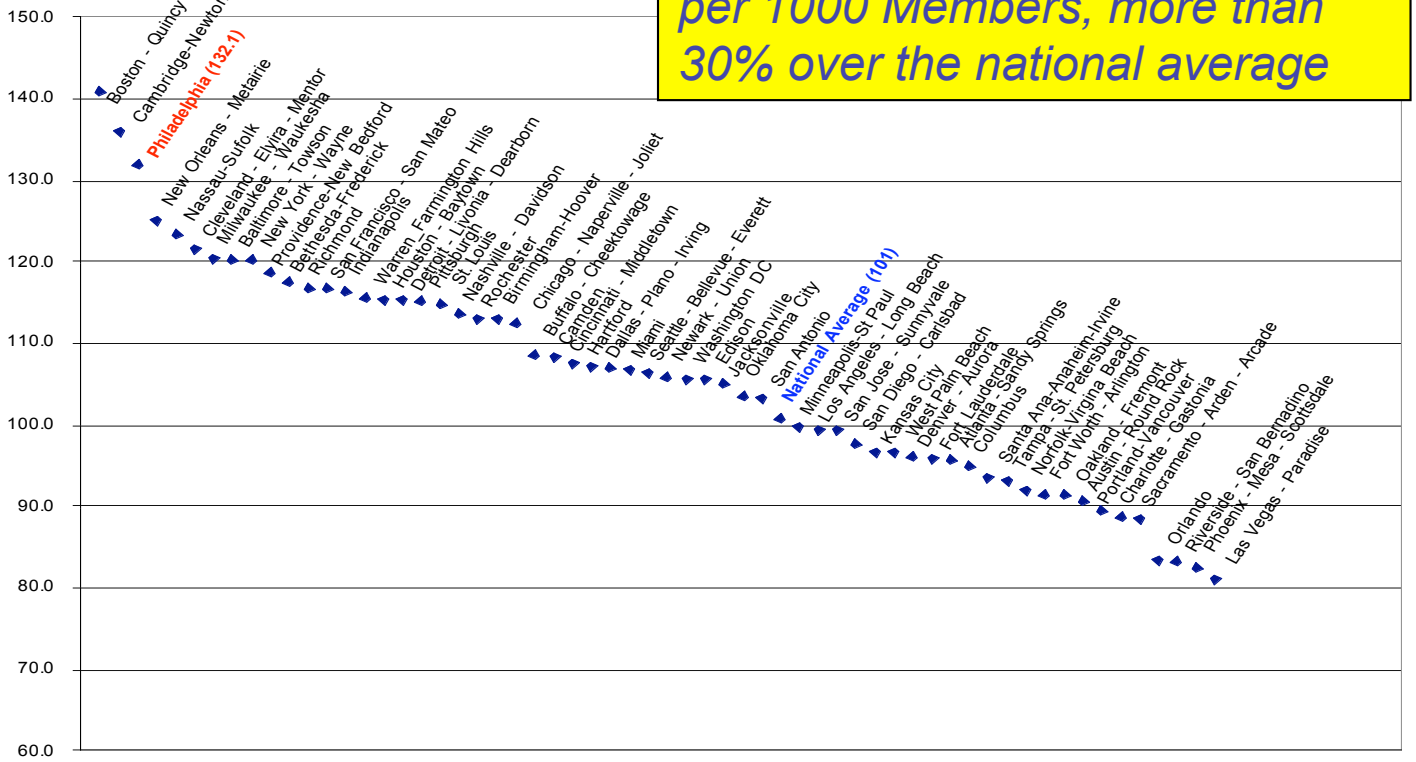


Chart #9

Source: Milliman U.S.A., Inc. 2004 - 2002 Data/ Health Cost Guidelines Commercial Area Factors -Includes cardiology services such as EKG tests & cardiac stress tests performed in a hospital outpatient department or free-standing facility

Pharmacy Costs

IBC Pharmacy cost continues to increase

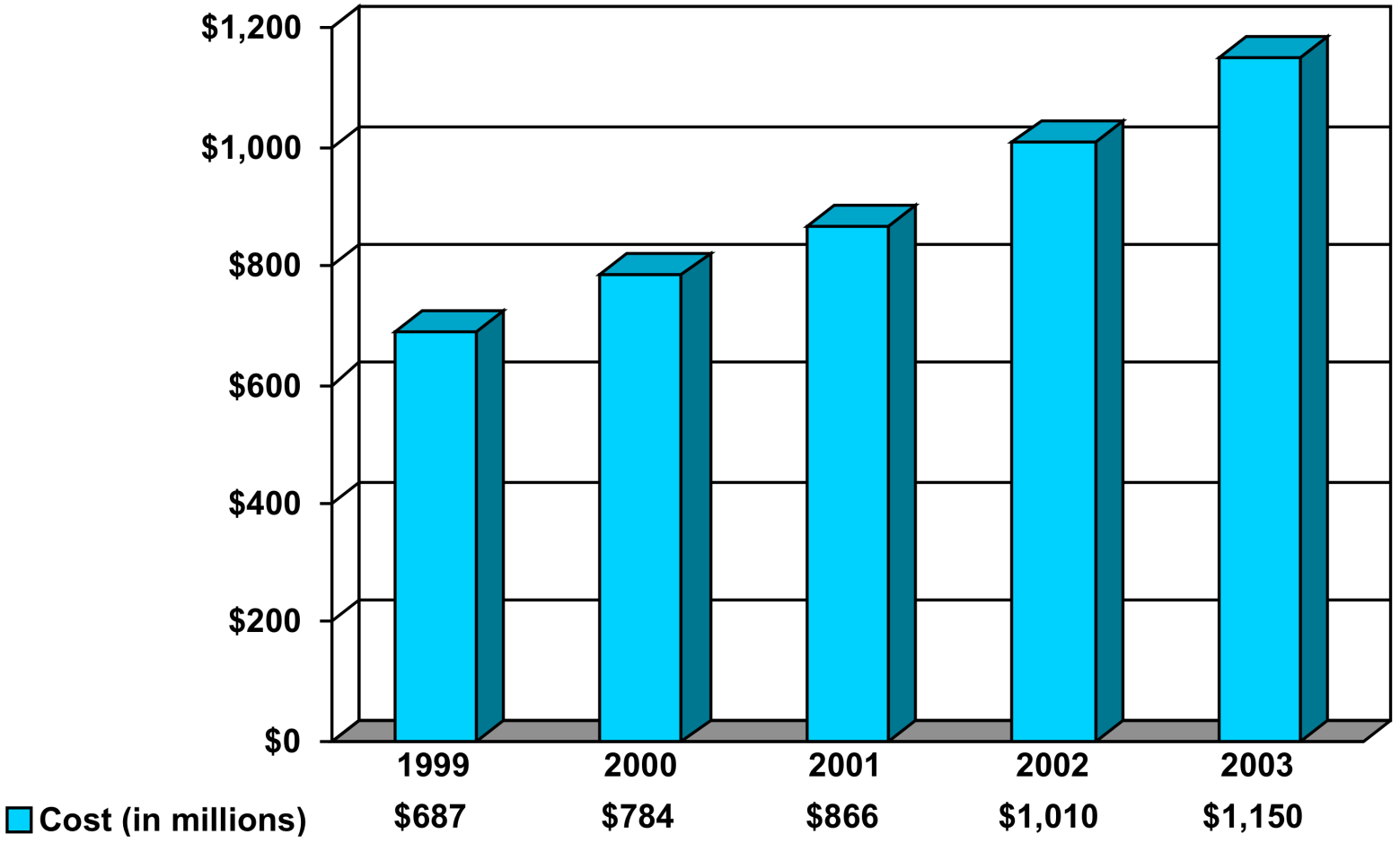
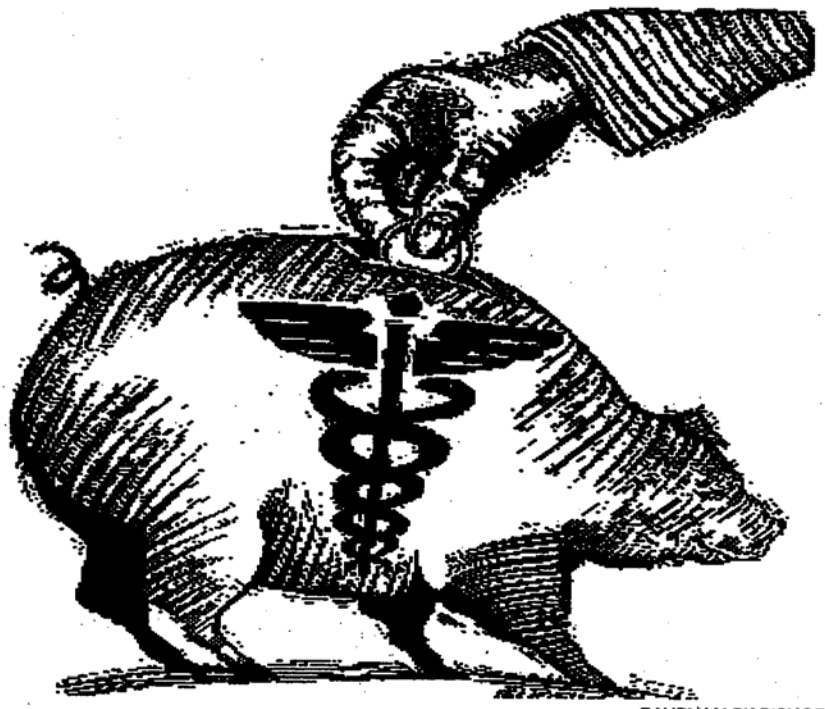


Chart #10

Bitter is not better in the dialogue on soaring health costs.

A futile hunt for villains

By G. Fred DiBona Jr.



RANDY MACK BISHOP

Remember Nero, the emperor who fiddled while Rome burned? Don't look now, but while some of the players in the great health-care debate are serenading us with the "Reserves Are Too High Blues," flames are shooting up all around us. And what's burning is America's health-care system.

Alarmist? Take a look at just a few facts:

• For the third consecutive year, health-care costs are increasing at a double-digit pace. By one estimate, health-care costs this year are running about 40 percent higher than they were in 1999.

• Insurance premiums in 2001 increased an average of 11 percent. This year, premiums are up an estimated 15 percent.

• During the most recent recession, an estimated 2 million Americans lost their health plans along with their jobs. The number of uninsured Americans now exceeds 40 million.

Were it not for America's war on terrorism, the number one issue on our national agenda might well be the cost of health care. But it's not. And in addition to the events of Sept. 11, there's a reason it's not.

This problem is just too complex. In this era of sound-bite solutions for everything from nuclear defense to education reform, America is avoiding the complexities of the health-care-cost issue like, well, a plague. That makes simplistic explanations seductive.

Take the recent fascination with reserves — the funds that insurers like Independence Blue Cross (IBC) set aside to pay members' claims in the event of an emergency. If you believe the squad of class-action lawyers who are busily selling their pitch to reporters and legislators, those reserves are the reason you're paying higher health-insurance premiums.

Absolutely no one who understands the insurance business would tell you IBC's reserves are excessive. And just to set the record straight, IBC is not maintaining its current level of reserves just to satisfy state regulators or the Blue Cross and Blue Shield Association's condition for keeping our license. We also maintain our reserves because fiscal stability requires it. This month, and every month during 2002, IBC expects to pay more than $500 million in claims in Southeastern Pennsylvania.

Having examined the facts, the Inquirer Editorial Board said IBC's level of reserves — which stood at $763 million at the end of 2001 — represented "fiscal prudence, not hoarding of revenues."

So if the culprit is not reserves, what is it? What is driving up health care costs? The cost of pharmaceutical drugs? Overutilization of medical testing and services? The aging of the population? New, high-priced technology? Unnecessary duplication of hospital services? The cost of malpractice insurance? Medical fraud? Cumbersome, overly complex insurance processes? Too much government-mandated care?

Yes. All of the above. And more.

As the Inquirer's Editorial Board wisely concluded, "no single region, no single insurer can wrestle the cost question to the ground." This problem is complex, incredibly complex, precisely because so many factors are causing it. So, you ask, how do we attack the problem if we cannot isolate a villain?

How about agreeing that the only villain is the one who denies playing a role in the problem? This community is desperate for meaningful public discussion on the soaring cost of health care — and an open-minded consideration of remedies. We don't need any more villains; we need ideas. We don't need any more anecdotes that raise emotions; we need proposals that inspire compromises. We don't need any more controversy; we need collaboration. We need doctors, lawyers, hospitals, insurers, patients and the media to make an unprecedented commitment to resuscitate a dying system, and to make it accessible to millions of additional people.

We know from experience how difficult that will be. But in this health-care crisis, our search for villains has gotten us nowhere.

Let's all stop pointing fingers. Let's start working — together — on solutions

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G. Fred DiBona Jr. is president and chief executive officer of Independence Blue Cross.