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October 8, 2004

Mr. David M. O'Brien
Executive Vice President Government Services
Highmark Blue Cross Blue Shield
120 Fifth Avenue, Suite 3124
Pittsburgh, PA 15222

Re: Supplement to Milliman Report on Highmark Surplus Target Range

Dear Mr. O'Brien:

In our report entitled "Need for Statutory Surplus and Development of Optimal Surplus Target Range" and dated May 21, 2004, we summarized the results of the actuarial assessment Milliman undertook for the company. This report was included with documents filed by Highmark with the Pennsylvania Insurance Department (PID).

Subsequent to the filing of this material by Highmark, the public was afforded an opportunity to review and comment on it. The period of public comment was recently closed.

The attached material is intended to provide a brief response to some of the comments. It is a supplement to our original report of May 21, 2004, and should be considered only in combination with the full original report, which we hereby incorporate by reference. As with that original report, the material contained in this supplement will not necessarily apply to any other situation or set of circumstances (including any other Blue Plan in Pennsylvania or elsewhere), and may not be appropriate for other than its stated purpose. We understand that Highmark may wish to share this supplement with the PID, for its review. We hereby grant permission, so long as it is provided to the PID in its entirety.

We welcome any questions you may have.

Sincerely,

Ronald G. Harris, F.S.A.
Consulting Actuary

RGH/go/jpj
Enclosure

Supplement to Milliman Report

HIGHMARK INC.

Need for Statutory Surplus
and
Development of Optimal Surplus Target Range

October 8, 2004

Richard A. Kipp, M.A.A.A.

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SUPPLEMENT TO MILLIMAN REPORT

The material which follows is a supplement to the Milliman report entitled "Need for Statutory Surplus and Development of Optimal Surplus Target Range," dated May 21, 2004. It is intended to respond briefly to certain issues raised by various commentators regarding Highmark's filing dated April 15, 2004. Many of these comments appear to reflect a basic misunderstanding of the issues involved. The responses in this supplement should be considered within the context of our full original report, which we hereby incorporate by reference.

Financial Measurements for Highmark as an Enterprise[1]

Some commentators fail to recognize that the Highmark filing with the Pennsylvania Insurance Department addresses the company as an overall enterprise. That filing includes all of the corporate entities involved as part of the overall enterprise. Likewise, the actuarial analysis and assessment conducted by Milliman for Highmark addresses the entire enterprise. As a result, many of the comments and inferences made by such commentators are incorrect.

For example, one of the commentators[2] compared the reported surplus for Highmark Inc. with the incurred claims for Highmark Inc., and concluded that the surplus level was excessive. Similar comparisons were made by the same commentator, using revenues for Highmark Inc.; and a similar conclusion was stated.

This is inappropriate because the values used produce "apples and oranges" comparisons. The surplus reported by Highmark Inc. is the overall total surplus for the enterprise, including all subsidiaries and affiliates. The incurred claims and revenues reported by Highmark Inc., however, exclude amounts for all subsidiaries and affiliates. Such treatment of surplus vs.

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[1] The term "Highmark," as used in Milliman's original report and this supplement, refers to Highmark Inc. and its subsidiaries and affiliates, as an overall enterprise, unless specifically indicated otherwise. Highmark Inc., by contrast, refers to the non-profit parent company. For historical periods, this includes all predecessor companies, including Blue Cross of Western Pennsylvania and Pennsylvania Blue Shield.

[2] See comments submitted by Berger & Montague, P.C.

incurred claims or revenue is prescribed by statutory accounting principles. The appropriate comparison is between the surplus reported by Highmark Inc. (which is the total for the combined enterprise) and incurred claims or revenues for the combined enterprise, which is the approach that was used in preparing Highmark's filing and the related actuarial analysis undertaken by Milliman.

Correcting this inconsistency dramatically changes the comparisons prepared by the commentator, as can been seen below for one such measure of alleged excess.

2003 (Amounts in Billions)		
	Commentator, for Highmark Inc.	Corrected, for Highmark Combined Enterprise Insured Business
Claims & Expenses		
Claims Incurred	$3.5	$7.0
Operating Expenses	-	0.8
Total	$3.5	$7.8
Surplus	$2.2	$2.2
4-Month Threshold	$1.2	$2.6
Excess (alleged)	$1.0	N/A

We also note here that the common historical measures of surplus were relative to total expenses (claims and operating expenses) or to total premium revenue, rather than to claims alone. The table above corrects for this inconsistency as well.

The same form of correction can be made to the other inconsistent comparisons provided by this commentator. Doing so produces a similar impact on the alleged excess in surplus.

Reporting of Cost-Plus and Other Self-Funded Business

Several commentators did not appear to recognize the change in statutory accounting requirements and reporting by Highmark beginning in 2001 for cost-plus and other self-funded business. This same required change in statutory accounting and reporting affected most, if not all, Blue Plans around the country. Prior to that time, such business was treated in a generally similar manner to insured business. Under statutory accounting codification, which served to standardize statutory reporting in certain prescribed ways, the paid claims, operating expenses, unpaid claims liability, and revenue for cost-plus and other self-funded business is required to be treated very differently. The Pennsylvania Insurance Department accounting staff is familiar with the details of this, both before and after codification.

A consequence of this required change in accounting is that Highmark's reported premium revenue, claims expense, operating expense, unpaid claims liability, and other line items decreased significantly in 2001 vs. 2000. Certain commentators appear to believe that this result reflects some type of inappropriate behavior on the part of Highmark, whereas it actually is simply the consequence of the mandated changes in statutory accounting and reporting.

This change in the treatment of cost-plus and other self-funded business affects how one understands and must consider specific analyses of surplus targets for a particular company, or more general benchmarks reflecting conventional wisdom as to reasonable target surplus levels. Rough, generic, benchmark "rules of thumb" that may have been used in the past, such as surplus equal to three or four months of claims and expenses, reflected a Blue Plan's total business activity – both insured lines of business plus cost-plus and other self-funded business. Individual company surplus studies likewise reflected the statutory reporting practices of the particular company at the time.

For example, one of the commentators[3] argues that Milliman had previously developed results or discussed historical industry norms that are inconsistent with its recent analysis for Highmark.

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[3] Ibid.

First, every company is unique; therefore, a company-specific analysis cannot be transported responsibly to another entity without a thorough analysis and evaluation. Second, the matters being addressed in each situation were specific to that situation and different in nature. Third, both sets of analysis and commentary cited by the commentator applied to measures of claims and expenses or premium revenue which specifically included cost-plus and other self-funded business (for our Highmark analysis, consistent with current statutory reporting, such business is excluded). The corresponding surplus measures – whether number of months of claims and expenses or percent of premium revenue – are substantially higher as a matter of simple arithmetic when the target dollar amount of surplus is expressed relative to insured business only, as opposed to total business which includes cost-plus and other self-funded business.

This simple fact can be readily shown for Highmark by referring to the chart from the section above. The historical threshold cited by the commentator of four months of claims should have included operating expenses to reflect the historical benchmarks used, and should have reflected total business (including cost-plus and other self-funded business), consistent with Blue Plan statutory reporting practices at the time. It must also include subsidiary business, so that the total combined enterprise is reflected. The table below shows how the results would change if this deficiency were corrected by including operating expenses and self-funded business, and by recognizing the combined experience for the entire enterprise.

2003 (Amounts in Billions)			
	Commentator, for Highmark Inc.	Corrected, for Highmark Combined Enterprise Insured Business	Corrected, for Highmark Total Business Including Self-Funded
Claims & Expenses			
Claims Incurred	$3.5	$7.0	$10.8
Operating Expenses	-	0.8	1.4
Total	$3.5	$7.8	$12.2
Surplus	$2.2	$2.2	$2.2
4-Month Threshold	$1.2	$2.6	$4.1
Excess (alleged)	$1.0	N/A	N/A

The impact of properly reflecting the correct values dramatically alters the results, from an alleged excess of $1.0 billion to a substantial shortfall.

As with the example described in the section above, a similar correction to recognize total premium revenue (including premium equivalents to adjust for cost-plus and other self-funded business), not just statutory reported revenue for Highmark Inc. alone, is needed in the other comparisons provided by this commentator. Doing so produces a dramatic reversal of results, similar to that in the chart above.

Need for Surplus

A number of the commentators do not seem to appreciate the full scope or extent of the Plan's surplus needs. The surplus for a Plan like Highmark is the capital (excess of assets over liabilities) available to ensure the protection and security of Highmark's subscribers, as well as the future viability of the company. Ensuring future viability recognizes (i) the possibility of adverse financial results and of unexpected events occurring, (ii) the periodic need to provide for extraordinary health care development costs or investments in support of the company's operations, and (iii) the capacity necessary to enable reasonable growth.

The analysis conducted by Milliman reflected the major risk and contingency categories faced by Highmark. They were:

Major Risk and Contingency Categories	
(1)	Rating adequacy and fluctuation
(2)	Unpaid claim liabilities and other estimates
(3)	Interest rates and portfolio asset values
(4)	Overhead expense recovery risk
(5)	Other business risks, including self-funded business
(6)	Catastrophic events, including litigation
(7)	Provision for development and growth

These categories generally follow the types of risk categories recognized in the RBC formula for managed care companies, but they further reflect development and growth associated with ongoing viability (beyond solvency alone).[4]

Several commentators failed to recognize that maintaining adequate risk capital to help ensure ongoing viability is necessary for a health insurer such as Highmark in order that all of the risks faced by the company can be met without the company becoming impaired. Without adequate risk-taking capital of its own, a health insurer is faced with a small number of potential alternatives. They may include:

- permanent capital infusion from an external source (not generally available to a not-for-profit insurer, other than possibly as part of a merger or acquisition).

- temporary capital infusion from an external source, such as a surplus note (which may or may not be available or affordable, and which usually has significant strings attached, typically involving loss of some or all of the control of the Board of Directors).

- transfer of risk to another entity with adequate risk capital (which may or may not exist or be feasible), and the loss of control that might accompany such a shift.

- compensation for inadequate surplus by immediately charging extraordinarily high premium rates for the company's products (difficult, if not impossible, in a competitive and closely regulated market), to eliminate as much as possible the risk of future losses.

- compensation for inadequate surplus by immediately taking inordinately deep cost cutting actions, to mitigate as much as possible the risk of future losses.

For Highmark most of these potential alternatives are not feasible, and none of them is likely to come without serious ramifications. Specifically, extraordinarily high premium rates or

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[4] For more detailed explanations of these factors see pages 33-38 of the original Milliman report.

inordinately deep cost cutting actions cannot be made in a vacuum; they would have severely adverse effects such as significant enrollment losses due to uncompetitive pricing or poor customer service. Instead, capital must continue to be accumulated over time, along with the investment earnings generated from the invested assets such capital provides.

One commentator that was critical of Highmark's surplus level seemed to ignore all forward looking reasons to maintain surplus, such as the need for surplus to fund health care development costs or operational capacity (infrastructure) investments. These might be improvements or innovations such as new product development; periodic revamping of delivery system networks, reimbursement structures, or management of utilization; or development or acquisition of new communications, information, or processing systems. Such investments must be made regularly, and the corresponding costs incurred, if the company is to be successful in the health insurance business. Often such capital expenditures do not produce hard assets that can be admitted on the company's statutory balance sheet. This means that such expenditures generally must be absorbed immediately out of surplus. Further, the precise details of such needs and their timing are not always known years in advance, despite the fact that surplus funds to support them must be generated systematically over an extended period of time.

One commentator questioned the appropriateness of accumulating surplus for growth and expansion. Growth and expansion is an important goal for most successful business entities operating in a competitive market. It requires the presence of market opportunity, plus the resources necessary to pursue growth from such opportunities. Growth can be achieved directly through day-to-day competition in existing markets, through entry into relatively new markets, or through long-term affiliation in existing or new market areas. Examples at this particular time include new consumer oriented product demands and opportunities, and expansion of insured products to the senior market under Medicare reform.

Developing and absorbing growth requires capital to fund developmental costs, to cover any initial losses resulting from the uncertainties involved, to absorb any losses resulting from setbacks or inexperience in the new market, and to withstand the short-term surplus strain (i.e., growth in enrollment or volume of business in force, without corresponding immediate growth in

surplus). Obviously, a prerequisite for financially sound growth for a not-for-profit health insurer is strong surplus.

Limitations of Formulaic Benchmark Calculations

The risk based capital (RBC) formulas and thresholds for managed care organizations (MCOs) have been adopted by many states as part of a flagging mechanism for identifying a health plan or insurer facing the prospect of financial insolvency. As was stated in a Milliman and Robertson Research Report on the subject, the methodology underlying the RBC mechanism reflected various elements of some of the research and development work by experts in the field. The threshold levels themselves were adopted through a process of negotiation and compromise, recognizing the fact that many HMOs were severely undercapitalized at the time and would have been put out of business under stringent surplus requirement standards.

One commentator cites a percentage of "[the BCBSA] Capital Benchmark" in a note which concludes that all of the Pennsylvania Blue Plans have excess surplus. Prior to adopting RBC as the mechanism for establishing minimum surplus thresholds, the Blue Cross and Blue Shield Association had maintained a Capital Benchmark formula for identifying Blue Plans not meeting minimum surplus requirements. It is worth noting that if one were to examine the dollar surplus level produced by a 200% threshold under the former Capital Benchmark formula, it would produce a much higher figure in actual dollars than 200% of ACL under the current RBC formulas.

The Association adopted a threshold for loss of the use of the Blue brand – in effect a business catastrophe for a member Blue Plan – at the same point as the Company Action Level under RBC, which is 200% of the Authorized Control Level (ACL). The Association currently applies 375% of ACL as its early warning monitoring level – signifying that the particular Blue Plan has moved into a range approaching financial jeopardy, and necessitating external oversight and scrutiny Both of these surplus levels are minimums, points at which intervention by an outside overseer is triggered. They are not desirable or optimal levels of surplus for a healthy, viable company.

The RBC mechanism is generic and relatively crude, by its very nature. It is intended to be applied across the entire health plan industry – for-profit and non-profit companies, large and small entities, local and national operations, independent insurers and provider-owned or affiliated health plans, independent free-standing entities and individual companies operating under a multi-insurer holding company. As a result, it cannot begin to recognize all of the risk capital needs of any particular company. Further, since it is focused solely on the threat of insolvency, it does not even attempt to address other capital needs (e.g., for development and growth) for a company to remain viable. It is useful, however, for its intended purpose – to flag health plans for regulatory intervention (by a state or by the Blue Cross and Blue Shield Association) due to the apparent prospect of pending insolvency.

A meaningful target surplus range for a particular company, by contrast, must consider that company's own history, experience, structure, risk characteristics, and operating environment. It was precisely elements such as this that Highmark asked Milliman to analyze and evaluate in constructing a recommended target surplus range for the company as a whole, and that Highmark proposed in its filing dated April 15, 2004.

A number of commentators suggested making comparisons between surplus for the Pennsylvania Blue Plans and non-Blue health insurers operating in the state, most of which are for-profit companies. A simple, direct comparison is not meaningful for this purpose, for a number of reasons. For example, a for-profit insurer has access to external equity capital markets, which a non-profit does not have. Further, it may well operate under a holding company structure which enables the maintenance of minimal statutory capital levels in the insurance company but broader access to other capital through the holding company.

Continuing Uncertainty

One of the commentators noted that losses by many health insurers in recent years have not presented to the same degree as in the past, so the commentator concluded that less surplus is needed by Highmark.

Underwriting gain/(loss) levels for Blue Plans overall have exhibited somewhat different patterns during the past several years, as was documented in our report. There are a number of possible explanations for changes in the pattern of underwriting results over time, and it is important to attempt to identify and understand them. For example, underwriting loss cycles observed for the health insurance industry were somewhat lower during the 1990s than previously. This occurred during a time marked by unprecedented moderation in health cost trends, resulting at least in part from low inflation coupled with aggressive carrier contracting with providers and significant expansion of managed care activities. In addition, many health plans had negotiated global fee schedules, and even provider risk-taking arrangements that provided some protection to the insurer against losses by transferring risk to providers. Many of these moderating factors have since diminished or disappeared, creating higher trends and considerably more uncertainty and volatility for health insurers.

A number of specific features of the health insurance business environment have changed over the course of the past 20-25 years, but the fundamental nature of the uncertainties that exist and the characteristics of the products that give rise to cyclical results still remain. Within the past 3-4 years, a number of specific changes have occurred that warrant consideration and ongoing attention with regard to the Highmark enterprise's need for surplus. Principal among them are:

- Reduction in managed care constraints, affecting utilization levels and trends, without incorporation of other forms of compensating controls by providers.

- Intensity of provider price and contracting pressures, due at least in part to government program cost-shifting and provider consolidations.

- Resulting high and volatile medical cost per member trends.

- Underlying market instability, produced by recent but continuing high medical cost trends.

- Legislative and regulatory mandates and compliance requirements, necessitating ongoing operational investments.

- Escalating technology support and information demands.

- Growing market pressure for new group and individual products, with stronger financial incentives for members.

- Ongoing reform of Medicare, with the opportunities and uncertainties created for health plans.

- Growing catastrophic risks, from litigation and terrorism.

The first four of these environmental factors are all contributors to, or consequences of, high and volatile medical cost trends. Historically, uncertainty as to trends, and periodic intervals of high trend levels, have contributed directly to downward business cycles. In addition, trends create "surplus strain" – not unlike enrollment growth – where the absolute dollar level of required surplus grows significantly simply because the dollar volume of business has grown.

The remaining five environmental factors contribute to either significant investment needs or the risk of catastrophic loss. The pressure on capital investments for infrastructure and new products is likely to be ongoing; responses to market opportunities and pressures is essential; and the prospects for catastrophic events are heightened, in our judgment.

It is impossible to predict the form or timing of future business cycles. For over thirty (30) years, Blue Plans experienced a repeating pattern of business cycles overall which, for the Plans in aggregate, was characterized by six-year periods containing three years of gains followed by three years of losses. Whether that traditional six-year underwriting cycle will reappear at the industry-wide level, in either its previous form or some modified version, is uncertain. Nevertheless, the forces and factors at work serve to create cyclical financial results for a health

insurer. As a result, multi-year cycles in financial results at the company level are virtually inevitable.

Health insurers can take steps to minimize the impact of the adverse part of the cycles facing them, but cyclical results are heavily driven by the basic nature of health insurance and its guarantees, and by external competitive forces. Note that trend escalation and volatility, which has historically led to adverse cycles, continues. Such volatility in trends is a reminder of the considerable uncertainties in the health insurance business, and historically has been a direct contributor to cyclical underwriting results.

Highmark is subject to the same types of cyclical forces that drive the results for the industry overall. It is subject to uncertainty in trends, as well as to periodic cycles in the trend levels themselves. With its geographic market, and resulting concentration of business, Highmark is sensitive to this sort of risk. Once losses have begun and have been measured, Highmark then faces inherent delays in effecting correction due to the basic nature of health insurance, including advance notice of rates and rate guarantees.

Highmark has experienced three distinct adverse cycles since 1980, the worst of which occurred in the recent past. This is shown in the chart below.

	Highmark Cumulative Operating Loss Cycles*			
	1980-82	**1986-88**	**1995-99**	**Average**
Combined Highmark Enterprise	(14.5)%	(13.3)%	(18.4)%	(15.4)%

* Gain/(loss) expressed as a percent of insured annual premium. Excludes the estimated amount of self-funded premium equivalents for all years. Operating gain/(loss) is the excess of premium over claims and expenses, prior to investment income or taxes. Cumulative percentages are the sum of annual loss percentages, over the loss cycle indicated.

While certain factors or conditions that caused previous industry loss cycles may have changed to some degree or even been lessened, others have taken their place (as discussed above).

It should be noted that investment income was significant in magnitude during each of the three historical operating loss cycles shown in the chart above. This provided a meaningful offset (an average of over 3% of premium for each year of the cycle) to the impact of these adverse cycles on Highmark's surplus. Recently, however, investment income levels have been substantially lower.

Solvency vs. Ongoing Viability

As indicated above, statutory surplus at a level of 200% of ACL is the threshold for mandatory corrective action plan notification by domestic insurers to the Pennsylvania Insurance Commissioner. The 200% of ACL level is also the threshold at which a Blue Plan loses the use of the Blue brand. Stated simply, 200% of ACL for Highmark's current mix of business equates to just over 8% of annual insured claims and administrative expenses for the enterprise, or funds that would permit the Plan to operate for about 4 weeks.

Loss of the Blue brand due to inadequate financial strength would, we believe, have severe consequences: if the brand were lost the remaining organization, and more importantly its Pennsylvania subscribers, would lose the breadth and strength of the Blues' system. Product recognition, favorable reimbursement rates out-of-area, and a level of service that is often sought out by employer groups would be forfeited. Certain other financial opportunities would also be lost as a result, such as the ability to offer benefits to certain large national accounts and the Federal Employees Health Benefits Program. Furthermore, removal of the brand due to financial weakness would open the door to the entry of a non-Pennsylvania replacement Blue Plan. Such an organization could potentially be a for-profit company with a very different mission than Highmark.

The BCBSA risk-based capital thresholds are directed at minimum levels – specifically, early warning monitoring (375% of ACL) and withdrawal of the brand (200% of ACL). Where states have adopted the RBC-based standard, the application is likewise directed at minimum solvency levels. The focus of oversight and regulatory bodies on adequate minimum surplus levels is

understandable and appropriate. These bodies bear responsibility for monitoring the continuing solvency of the health plans under their jurisdiction, and for taking actions before impending insolvency and closure.

The proper focus of a financially healthy non-profit Blue Plan, however, is on achieving and maintaining an optimal ongoing surplus level. Such a level is intended to (i) ensure the continuing viability of the company, (ii) inspire warranted confidence by groups, subscribers and providers, (iii) enable the development of competitive yet adequate premium rates for customers, (rather than needing to be excessively high, because of inadequate surplus to back them), and (iv) provide funding for long-term development costs and investments. Such a focus by company management is prudent and appropriate.

An optimal ongoing operating range for a company's surplus level clearly will be higher than the minimum level used by regulators and oversight bodies as a benchmark for warning signals against insolvency and necessary intervention. Prudent company management will focus not only on an appropriate range for its ongoing and long-term needs, but also on the avoidance of approaching levels that may trigger special external scrutiny or intervention, or that may create subscriber, provider, or public concern. Such a range, therefore, must be (i) high enough to avoid having the company's surplus falling to a level where external scrutiny is initiated, and (ii) wide enough to absorb the rises and declines in relative surplus levels that occur during the normal course of business over an extended period of time.

A maximum level for surplus, by contrast, represents the point at which additional accumulation of funds does not contribute meaningfully to furthering the goal of ensuring the future viability of the company or protecting its members. By definition, exceeding such a level does not add to the well being of the company.

In our actuarial analysis, Milliman articulated a set of goals for developing an optimal surplus target range for Highmark. Specifically, they were:

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- ***Early Warning Monitoring Threshold Avoidance*** – Provide a high likelihood that the overall surplus level for Highmark, as an entire enterprise, will remain above the Blue Cross and Blue Shield Association (BCBSA) Early Warning Monitoring threshold level, even after a particularly adverse period of multi-year operating or underwriting losses, thereby enabling ongoing viability;

- ***Loss of Trademark Avoidance*** – Assure with virtual certainty that surplus will remain above the BCBSA Loss of Trademark (Blue brand) threshold level for the enterprise, even if a severely adverse period of multi-year underwriting losses were experienced, or if back-to-back loss cycles were to occur without adequate recovery between them, thereby avoiding failure; and

- ***Adequate Provision for Development and Growth*** – Provide capital to enable periodic investments in technology, product development, building or acquisition of complementary business capacity, and growth in business in force without jeopardizing the company's risk capital position.

Based on these goals, Highmark's target range of 650-950% of ACL was developed by Milliman, using a quantitatively-based pro forma projection approach which incorporated both historical experience operating loss measurements and alternatively simulated loss cycles based on an assessment of Highmark risks and contingencies.

Approach to Developing Highmark's Target Surplus Range

Milliman was retained by Highmark to undertake a comprehensive actuarial development of an appropriate and prudent target range for the surplus of the combined enterprise. The methodology, assumptions, and rationale are described in our report dated May 21, 2004.

The Milliman report begins with recognition and consideration of minimum surplus requirements which create a floor for analysis and development. The report then describes our development of alternative bases for establishing the amount of provision to be made against risk of loss and other contingencies. It presents historical operating loss results for the industry as a whole, for Highmark, and for a comparison set of Blue Plans. This data provides an empirically-derived basis for making provision against future multi-year adverse loss periods. Next, we address specific risks and contingencies facing Highmark, which are quantified and combined through Monte Carlo simulation. The result is an alternative approach to making provision for loss periods, based on risk assessment rather than actual historical operating results. Together, these two alternative approaches help to form a range of multi-year operating loss levels, against which Highmark's surplus needs to provide protection for the company. Finally, we apply the resulting loss levels using pro forma financial projections, in order to determine the amount of surplus needed by Highmark to operate under normal circumstances as a viable company.

One commentator proposes that a technical analysis be conducted, and generally describes his suggested approach. In fact, such an approach was incorporated directly as a key component of Milliman's actuarial analysis. We not only incorporated and tested comparable assumptions to those proposed by the commentator, we went substantially further in breadth and depth of modeling and analysis. We stand prepared to assist in the Pennsylvania Insurance Department's (PID's) review by holding actuary-to-actuary meetings, answering questions, explaining details, and enabling the PID's actuarial staff to test the sensitivity of the results we prepared.