Testimony before the Senate Banking and Insurance Committee

Tuesday, October 23, 2007

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Pennsylvania Insurance Department
Commonwealth of Pennsylvania

Good morning, Chairman White, Chairman Stack and committee members. For the record, my name is Joel Ario and I am the Acting Insurance Commissioner. Thank you for the opportunity to appear today, to provide an overview of the Pennsylvania health insurance marketplace and an update on the status of the Insurance Department's process for reviewing the Highmark and IBC proposed consolidation.

Let me begin with a short explanation of the legal limitations on my ability to comment and respond to questions regarding Highmark and IBC's application or any issue related to the application. Under Article XIV of "The Insurance Company Law of 1921," as the Acting Insurance Commissioner, I am required to make a determination on the application. In order to assure that the Insurance Department's administrative procedures comport with due process and to avoid any appearance of bias, I must limit my comments concerning the application to an explanation of the review process and a general description of the documents and comments received by the Department. The documents and comments received by the Department are part of the public record and are available on the Department's Web site (www.ins.state.pa.us). At this time and throughout the administrative review and adjudicatory process, it would be inappropriate for me to comment on the Department's or my own opinion of the substance or merit of the Highmark and IBC application or any of the comments or documents relating to it.

With that legal issue out of the way, I will start with some general comments on the health insurance marketplace and then turn to the 11 specific questions that Chairman White asked me to address in his October 17th letter.

Health care spending and insurance affordability

The proper starting point for any discussion of the health insurance marketplace is the increasing unaffordability of coverage. Simply put, Pennsylvania families and businesses cannot

keep up with health care inflation, which is rising much faster than either general inflation or wages. Between the years 2000 and 2006, health care insurance premiums rose 75.6%, while inflation went up 17% and median wages increased 13.3%. Run away health care inflation is putting enormous pressure on businesses struggling to provide health insurance to their employees and the situation is even tougher for those seeking individual coverage, especially if they have any health problems.

Insurance companies are frequently cited as the major cause of health care inflation, and as I'll discuss, health insurers clearly have a role to play in controlling health care costs. But the truth is that our cost problems go well beyond the insurance industry, which provides health insurance to less than half of all Pennsylvanians. If we look at the large employers who self insure or the government's provision of Medicare and Medicaid benefits, we see the same pattern: no one has a handle on health care spending and costs are rising for everyone.

In this context, cost control must be front and center in any health care reform agenda, as it has been for Governor Rendell and this General Assembly. Take hospital costs as an example. According to an examination of hospital charges in Pennsylvania for year 2005: $3.5 billion dollars was spent on additional days of hospital care due to potentially avoidable health care acquired infections; $1.7 billion was spent on hospitalizations that could have been avoided with better care for chronic disease patients; and $965 million was spent on additional days of hospital care due to readmissions for complications and infections, and for certain medical errors.

In each of these cases, a closer look at the facts shows that there is an interplay between unnecessary costs and health quality.

- Health care acquired infections add $150,000 to the average hospital charge. The average hospital case without a health care acquired infection costs $31,389, with

an acquired infection, the average case costs $185,260. Not only is the monetary cost far too great, but in 2005, there were 2,500 deaths due to hospital acquired infections.

- Improper chronic disease management in Pennsylvania represents charges for potentially avoidable hospitalization for diabetes, heart disease, asthma and lung disease. In addition to the high monetary costs, 63,366 Pennsylvanians may have been unnecessarily hospitalized in 2005.
- Cost for hospital medical errors and readmissions for complications and infections are not only monetary. In 2005, 20,693 Pennsylvanians were harmed by these errors and complications.

I congratulate the General Assembly for passing Act 52, which has begun to address health care-acquired infections and their impact on the cost of health care. Under Act 52, the cost of routine cultures and screenings will be reimbursable, subject to copays, coinsurance and deductibles, by insurers. Our Department is working to assure that insurers comply with this legislation, and we look forward to observing the impact on the cost of health care, and more importantly, on the health of our citizens, as health care-acquired infections are corralled and snuffed out. Our state also took a major step forward with the creation of the Chronic Care Commission and its ambitious plan to improve care and reduce costs for the treatment of chronic conditions.

Another key cost control issue is efficient use of the full range of qualified providers. On this issue, the General Assembly passed a series of bills that permit physician assistants (Acts 46 and 47), certified nurse practitioners (Act 48), clinical nurse specialists (Act 49), nurse-midwives (Act 50), and dental hygienists and independent hygiene practitioners (Act 51), to practice their

professions in Pennsylvania within the full scope of their education, training, and certification. There are reimbursement requirements in our insurance laws, and the Insurance Department is working to assure that insurers are properly reimbursing services rendered by these practitioners. We, like you, anticipate seeing the health benefits to our citizens that will occur with increased access to these many primary care providers.

Better access to the full range of providers is also connected to another cost saving measure: reducing use of emergency rooms. Pennsylvanians use emergency rooms 11% more than average Americans, and our use of this expensive form of care is growing twice as fast as the national average. It is projected that there will be 5.3 million emergency room visits in Pennsylvania for year 2007. This problem needs to be addressed to bring down the rising cost of health care.

More challenges remain, of course, including the cost of treating the uninsured in Pennsylvania. That cost is $1.4 billion dollars a year. According to an Insurance and Health Department study, the uninsured include 767,000 adult Pennsylvanians who are mostly employed and working for private companies. Pennsylvania taxpayers, private businesses and their employees who pay for health insurance and individuals who buy their own health insurance all pay for the care of the uninsured.

Health Insurer Role in Cost Control

As noted above, the Insurance Department has a role to play in making sure that insurers do their part to implement the new Pennsylvania laws on hospital infections, chronic care management, scope of practice, and other cost control strategies. But health insurers can and must do far more than implement these new laws. Indeed, the best insurers are using their leverage to promote a broad variety of cost control measures, and those that are lagging in this

area are being forced by market pressures to address cost control, at least for their larger accounts. The fact is that health insurers must offer cost control tools in order to compete in the large group market today. These tools include chronic care and disease management strategies that identify and help manage the most expensive cases, provider accountability strategies that ensure use of evidence-based medicine, wellness strategies that promote healthy lifestyles, and transparency strategies that demonstrate the insurer's accountability for cost and quality results.

I have heard all of this firsthand in my discussions with the CEOs and top managers of the nine largest health insurers in Pennsylvania. All of them spoke to the importance of cost control and offered impressive examples of what their companies had done and had planned for the future. However, I also noted that the focus was on large accounts, where the investment of time and resources was most cost effective. When I asked about similar support for smaller businesses, common themes were that it is tougher when the employer does not have its own human resources department to help implement items like health questionnaires, and that small employers may get a telephone call or Web address rather than a site visit. In other words, cost control is yet another area where small businesses lack the leverage to get needed services in the absence of some incentives beyond market forces. This is why Governor Rendell has proposed that rate reviews incorporate an assessment of insurer accountability for cost control.

Small Group and Individual Market Reform

The same theme –small businesses and individuals need government's help in securing benefits that large businesses can get through market leverage – applies to small group and individual market insurance reforms. I have been traveling the state to listen to small businesses speak about their health insurance problems, and the experience has reinforced for me some of the reasons why virtually every very large business (500+ employees) offers health insurance

while less than half of very small businesses (less than 10 employees) do.

The stories start with the same point that any sized business would make: health care costs are rising too fast and they are eating away at company bottom lines. But then these small business owners go on to share stories about how vulnerable they feel to premium increases based on relatively small changes in their workforce – one employee who has a major illness or a couple new older employees. These are not the concerns of large employers who can spread the costs of one or two sick employees across a large population of healthy employees. The small employers I spoke with understand that they could benefit from the current system if they could choose their employees with an eye toward health care cost, but they might run afoul of other laws and, more importantly, they do not want to go this route anymore than large employers want to save money by identifying their most costly employees and segregating them in a separate risk pool.

The best policy response to this situation is for Pennsylvania to join the 48 other states that have enacted rating reforms for the small group market (2-50 employees). Governor Rendell has offered such a proposal, with a ban on medical underwriting, 2:1 rate bands, and limitations on rating factors. Passage of this plan would improve the marketplace, but even a cursory scan of what other states have done indicates that there are a variety of policy options available, and the Governor has said he is open to alternative ideas on this as well as other health reform issues.

I have worked on small group and individual market reform for much of my 14 years in insurance regulation, and have spent a fair amount of time this fall exploring the issue here in Pennsylvania. That review has convinced me that the current Pennsylvania market is not a stable one for small groups and individuals. The traditional community rating approach used by the Blue Cross/Blue Shield (BCBS) plans is under assault as the tools for medical underwriting grow

ever sharper. Absent some new regulatory framework, market forces will continue to push all insurers to engage in more risk segmentation, to the point where the groups and individuals remaining in community rated pools will mostly be those that do not have other options.

I have heard a wide range of proposed solutions, including a "two tier" approach to rate regulation that would vary the rules based on market share. That would be a highly unusual approach, but it is worth considering since there are other aspects of the Pennsylvania market that are atypical as well.

With that background, let me turn to Chairman White's 11 questions.

Question 1: An overview of the non-medical assistance related market shares held by all health insurers in Pennsylvania, and how it generally compares with other states. This should include individual, small large and individual third party administrators.

Attachment 1 summarizes the Department's 2006 data on premium volume for the 11 largest health insurer groups, which account for approximately 88% of Pennsylvania's $33 billion health insurance marketplace. As indicated in the chart, the premium volume does not include third party administrator revenues, but does include medical assistance premium and other non-commercial premium since we have no reliable way to break out premium for different markets. I might note here that in my prior service in Oregon, I helped pass a law that required insurers to report more specific data, including total premium, average premiums, loss ratios and other data by market segment. I would be happy to work with this committee on similar reporting in Pennsylvania, perhaps as part of small group reform.

Attachment 1 shows that the Pennsylvania market can be divided into four tiers. The top tier is composed of Highmark and IBC, each with more than a quarter of the health insurance market and a combined premium volume of 53%. Both groups include a mix of non-profit and for profit companies.

The second tier is composed of four groups, each with 5-6% of the premium volume and a combined quarter of the market. These four companies include Aetna and Coventry, two national for-profit companies; Capital Blue Cross in central Pennsylvania; and the University of Pittsburgh Medical Center in western Pennsylvania.

The third tier is composed of five groups, each with 2-3% of the premium volume. This tier includes United Healthcare, the nation's largest for-profit insurer, Blue Cross of Northeastern Pennsylvania; Geisinger Health Plan in north central Pennsylvania; and two groups specializing in medical assistance (HealthPartners in Philadelphia; and Unison Health Plan in western Pennsylvania). It is worth noting that the overall size of the Pennsylvania market means that even these third tier insurers earned more than $700 million in premium in 2006.

The fourth and final tier consists of more than 700 companies that make up the remaining 12% of the health insurance marketplace in Pennsylvania. Each of these companies has a market share of less than 1%. These companies include a mix of national companies like Cigna, local companies like Teachers Protective, and specialized companies like Magellen.

Attachment 2 compares Pennsylvania market shares to those of six neighboring states, using the top writer, the top two writers, and the top ten writers. The chart, which is based on annual statements filed with the Insurance Department and the NAIC, shows Pennsylvania to be similar to surrounding states, but a critical caveat here is that NAIC reporting is not by group basis, but on a company basis. When we compare Pennsylvania on a group basis with neighboring states on a company basis, Pennsylvania does show a high concentration for the top writers. Group basis reporting for Pennsylvania's neighboring states is not readily available and we cannot provide that comparison.

Question 2: An overview of the market shares held by BCBS plans both statewide and the regions in which they serve. This should include holdings of their for-profit subsidiaries

and affiliates.

Attachment 3 provides more detail on the 2006 market shares held by the four BCBS groups in Pennsylvania, including a breakdown of each non-profit and for profit company in the group and the market share of each company. The chart shows that the four groups had a combined market share of 60% in 2006, and that all four groups include for profit subsidiaries, many with substantial market share. The chart does not provide regional breakdowns because the Department does not have readily available data in that form, though we know that the vast majority of this business is regionally based in accord with trade association rules. We will be seeking much more data about local markets as part of our review of the proposed Highmark/IBC consolidation.

From the BCBS Web sites we have the following information on service areas. Blue Cross of Northeast PA services Bradford, Carbon, Clinton, Lackawanna, Luzerne, Lycoming, Monroe, Pike, Sullivan, Susquehanna, Tioga, Wayne and Wyoming counties. Capital Blue Cross services Adams, Berks, Centre, Columbia, Cumberland, Dauphin, Franklin, Fulton, Juniata, Lancaster, Lebanon, Lehigh, Mifflin, Montour, Northampton, Northumberland, Perry, Schuylkill, Snyder, Union and York counties. IBC services Bucks, Chester, Delaware Montgomery and Philadelphia counties. Highmark provides services statewide.

Question 3: Provide a historical overview of how the health insurance marketplace has changed over the last 30 years in Pennsylvania. Whose market presence has grown? Who has left the market?

Attachments 4-7 provide some historical information on the market shares of leading groups in 2001, 1996, 1986, and 1976. Attachment 8 augments the charts with some narrative information on when companies started, as well as key mergers and acquisitions. Some

observations about that history:

- Although the configuration of BCBS plans has changed over the last 30 years, most notably with the formation of Highmark in 1996, the combined market share of insurers operating under the BCBS label has remained relatively constant in the 60% range since 1976, except for a dip below 50% in the 1980s. The four BCBS plans have maintained roughly the same 60% market share since 1976.
- In each of the four designated historical years (1976, 1986, 1996, and 2001), there have been two to four significant national insurers in the top ten and the combined market share of those national companies has generally been in the 13-15% range, with a high of 17% in 1986 and a low of 10% in 1996.
- Market shares stayed relatively constant from 2001 to 2006 with the BCBS plans losing about 2% and the national companies gaining about 1%. The three national companies in the top ten in 2006 are all very well capitalized, though they all say that their continued commitment to the Pennsylvania market depends on our having a competitive playing field.
- The current top ten also includes two Pennsylvania provider based groups that were formed relatively recently: Geisinger began operations as an insurer in 1985 with a 2.4% market share in 2006, and UMPC began operations as an insurer in 1996 with a 5.6% market share in 2006.

Question 4: Describe the rate review process used by the Insurance Department. How often are rate filings disapproved and why or why not?

Act 159 of 1996 governs Accident & Health insurance product rates and forms. (40 P.S. §§3801 et seq.). Act 159 amended a significant number of provisions which provided the

Department broad rate regulation, while exempting certain commercial insurer groups from rate filing. The portion of the group insurance market subject to regulation is the business written by health maintenance organizations (HMOs) and health plan corporations. Health plan corporations are BCBS entities, at the parent level. Their for profit subsidiaries and affiliates are not subject to rate regulation.

The HMOs and health plan corporations file base rates or rating formulas under a regulatory review standard commonly referred to as "file and use". Proposed changes to those rates or rating formulas must be filed. If an insurer wants to deviate from the approved base rate or rating formula by more than 10%, then it must file for approval (an exception to this is that insurers have the ability to deviate from the approved base rate or rating formula up to 15% without filing for individual group policies). These rate increases are subject to prior approval. The Department has 45 days to review and approve rate increases. By statute, if the Department takes no action the rate increases are deemed approved 45 days after filing, and 30 days after filing a resubmission for a rate increase. For the individual market, all individual rates must be filed and are subject to prior approval. Again by statute the rate filings are deemed approved 45 days after filing and 30 days after resubmission. There is a statutory provision which allows the Commissioner to exempt from filing individual rates that "cannot practicably be filed before they are used."

The Department is seeking prior approval authority over all health filings in the individual and small group market. This prior approval will allow the Department to ensure that rates are actuarially sound and that insurers are acting to control costs as discussed above. It also will give us better information on the full marketplace.

During Fiscal Year 2007 (July 1, 2006 to June 30, 2007) the Department received a total

of 885 rate, rule and rate formula filings for review. Many of the filings upon first-time Department review did not meet the actuarial standard of "not excessive, inadequate or unfairly discriminatory" and were disapproved. Upon receiving a disapproval, the filing companies typically amend their requests in accordance with the Department's actuarial requirements and resubmit their changes for reconsideration. Nearly 40 % of rate filings are disapproved, generally due to the lack of actuarial supporting justification.

Question 5: Present a summary of the conditions, if any, placed on the 1996 merger of Blue Cross of Western Pennsylvania and Pennsylvania Blue Shield.

Attachment 9 summarizes 25 conditions placed on the 1996 merger. Key ones include prohibiting Highmark from entering into exclusive contracts with hospitals and prohibiting most favored nation clauses in hospital contracts (restricted by section (a)(1) the Accident and Health Filing Reform Act and the Unfair Insurance Practices Act). Also key is the dedication of 1.25% of direct written premium to social and other health endeavors, and requiring Highmark to participate in CHIP and provide open enrollment during the entire calendar year.

Question 6: Define what ability the Insurance Department has to control competition among the BCBS plans.

The Insurance Department is empowered by the "Insurance Holding Companies Act" to review the competitive impact of corporate transactions in the insurance marketplace. As this Committee is aware, Pennsylvania's four BCBS Plans are not currently subject to the Insurance Holding Companies Act, although their insurance company subsidiaries are. The Insurance Department does not regulate the service areas within Pennsylvania in which the BCBS Plans do business. The service areas are matters of agreement between the four BCBS Plans and their national association, the BCBS Association.

Question 7: Explain whether the Insurance Department considers the revenue generated from the BCBS for-profit subsidiaries and affiliates when considering rate filing requests.

The Department does not generally consider information on other companies or other products when reviewing rate filing requests. Each product or line must stand on its own merit when reviewing rate-filing requests.

When considering rate filing requests from BCBS plans, as a policy matter, the Department may consider company affiliates and other products. Department staff would be cognizant of the revenues generated by the BCBS subsidiaries and affiliates. Whether and to what extent this information would be considered in a particular rate filing would depend on the circumstances of the filing and the information provided in that filing. The financials of the BCBS subsidiaries and affiliates would be one of the many different types of information that Department has and may consider in it review process.

Question 8: Provide a timeframe on the expected completion of the review of the for-profit subsidiary filings by Highmark and IBC.

The Department anticipates that, at the earliest, its review of the Highmark-IBC consolidation application will be completed and a decision rendered in the summer or fall of 2008. However, the completion of the Department's review depends on numerous factors outside the Department's control. Some of those factors include the Department's ability to obtain ongoing information from the applicants, the Department's ability to obtain experts and the number and type of comments the Department receives during the public comment period and at the public hearings the Department plans to hold.

In order to promote transparency and facilitate public comment, the Department determined that it would publish all public parts of the Form A filing, all substantive public

comments, all public responses by the applicants to comments, and all public expert reports on the Department's internet site. This process is consistent with the Department's past reviews of major Form A filings.

Prior to initiating the review of the Highmark-IBC consolidation application, the Department established a written process and timeline. The steps in this procedure include publishing notice of the filing in the Pennsylvania Bulletin and establishing a public comment period. As part of the process, all public comments received by the Department will be sent to the applicants for written response. The Department plans to hold several public informational hearings in various parts of the Commonwealth, including at least Philadelphia, Pittsburgh and Harrisburg. The public informational hearings will be presided over by the Commissioner. The Department, in conjunction with the Commissioner, will then analyze the filing, the entire public file, all public comments, and any other documents and expert reports, before reaching a decision. The Department will publish the decision on its Web site. The Department's decision may be subject to appeal to Commonwealth Court under 42 Pa. C.S. §763.

The applicable standard of review of the application is set forth in 40 P.S. §991.1402(f)(2). The Department must approve the transaction unless it makes an affirmative finding that any one of seven standards is violated. The seven standards are:

> (1) After the change of control, the domestic insurer would not be able to satisfy the requirements for the issuance of a license to write the line or lines of insurance for which it is presently licensed.
>
> (2) The effect of the merger or other acquisition of control would substantially lessen competition in insurance in the Commonwealth or tend to create a monopoly. This standard incorporates the standards set forth in Section 1403(d)(2). Under 1403(d)(2), a

transaction is prima facie anti-competitive if it triggers one of two numerical tests which examine market share and market concentration. Even if a transaction is not prima facie anti-competitive, the Department has the opportunity to establish a violation through other substantial evidence, including: market share, volatility of rankings of market leaders, number of competitors, concentration, trend of concentration in the industry and ease of entry and exit into the market. If a transaction is prima facie anti-competitive, a party is able to establish the absence of anti-competitive impact through the same type of evidence. Finally, an otherwise anti-competitive transaction must nevertheless be approved if: (a) the acquisition will yield substantial economies of scale or resource utilization that cannot feasibly be achieved in any other way and the public benefit of the economies of scale/resource utilization outweighs the public benefit that would arise from not lessening competition; or (b) the acquisition will substantially increase the availability of insurance and the public benefit of the increase outweighs the public benefit of not lessening competition.

(3) The financial condition of any acquiring party might jeopardize the financial stability of the insurer or prejudice the interest of its policyholders.

(4) The plans or proposals which the acquiring party has to liquidate the insurer, sell its assets or consolidate or merge it with any person, or to make any other material change in its business or corporate structure or management, are unfair and unreasonable to policyholders of the insurer and not in the public interest.

(5) The competence, experience and integrity of those persons who would control the operation of the insurer are such that it would not be in the interest of

policyholders of the insurer and of the public to permit the merger or other acquisition of control.

(6) The acquisition is likely to be hazardous or prejudicial to the insurance buying public.

(7) The merger or other acquisition of control is not in compliance with the laws of this Commonwealth, including provisions of the "Insurance Company Mutual-to-Stock Conversion Act."

The Departments activities to date are as follows. On April 27, 2007, Highmark. and IBC filed applications seeking approval of the acquisition of control of their Pennsylvania domiciled insurance company subsidiaries by the new corporation formed by the consolidation of Highmark and IBC. The filings and related materials were made available on the Department's Web site (www.ins.state.pa.us) on April 30, 2007. The applications and supplemental documents were also made available for public inspection at the Department's regional offices. In the Pennsylvania Bulletin on Saturday, May 12, 2007, the Department published notice of receipt of the applications and invited all interested parties to submit written comment on the applications to the Department for a period to expire no earlier than July 11, 2007. On July 7, 2007, the Department published notice in the Pennsylvania Bulletin announcing the extension of the public comment period for an indefinite period of time to afford all persons ample opportunity to submit written comments. On August 7, 2007, the Department sent a letter to Highmark and IBC with a list of 71 questions and comments. This letter requested additional materials and clarifications from the companies. On October 22, 2007, the Department received responses to nine of the 71 questions and comments contained in its August 7, 2007 letter to the applicants. One of the nine responses was 2,800 pages in length.

Posted on the Department's Web site are the Highmark and IBC applications with attachments, the Department's request to Highmark and IBC for additional materials/clarifications, all comments received by the Department, the Highmark and IBC responses to those comments, and all correspondence between the Department and Highmark and IBC. The Department's Web site has a cumulative public index which as of October 5, 2007 had 263 posted documents, of which 75 were public comments. The Web site is being constantly updated as new comments and documents are received.

Public input is a necessary and integral part of our evaluation of these applications and we encourage the public to participate in the process. The Department's goal is to make the review process as transparent as possible.

Question 9: Detail what effect, if any, the Insurance Department's ability to have holding company oversight will have on the merger review process. What information or authority will you have that you do not currently have?

Current law exempts BCBS plans from the provisions of the "Insurance Holding Companies Act." This exemption creates a regulatory gap since other carriers are covered under the law, and their policyholders are afforded the protection of the Act. Both the GAA Amendments Act and the "Insurance Holding Companies Act" direct the Department to protect the interests of policyholders in reviewing corporate transactions. (15 P.S. §21205(b); 40 P.S. §991.1402(f)). In addition, the "Insurance Holding Companies Act" directs the Department to protect the integrity of the insurance market by reviewing corporate transactions for anti-competitive effect. (40 P.S. 991.1402(f)(iii)). If this gap in the Department's regulatory authority is allowed to persist, the Department will remain unable to fully protect the interests of the BCBS Plans' policyholders in ruling on corporate transactions or to review any pending transaction involving the parent BCBS Plans for anti-competitive effect.

Under the proposed amendments to the "Holding Companies Act," Pennsylvania's four BCBS Plans will be subject to the same level of oversight as other Pennsylvania domiciled insurance companies.

Question 10: A general overview of how other states have handled the review of BCBS plans consolidations and mergers as well as for-profit conversions.

Attachment 10 summarizes recent history on BCBS transactions in other states, under two broad categories: conversions and merger/consolidations. In the last fifteen years, the health insurance industry has seen a definite trend towards consolidation. During the 1990's and early 2000's, two for-profit BCBS Plans, WellPoint and Anthem, acquired ten BCBS Plans and themselves merged in 2004. Health Care Services Corporation, a non-profit mutual insurance company, acquired BCBS Plans in three western states, the last in 2005. However, the trend towards consolidation has come under increasingly intense public scrutiny in the last several years. The last three major attempts at conversion and acquisition of non-profit BCBS Plans by for-profit companies were disapproved by insurance regulators in Washington in 2004 and Kansas and Maryland in 2002. Conversion applications were withdrawn in New Jersey and North Carolina in 2001. Health Care Services Corporation withdrew its application to affiliate with the non-profit Regence BCBS in Oregon, Washington, Utah and Idaho in 2001.

The proceedings in Washington, Kansas, and Maryland are good examples of the amount of scrutiny these transactions face. In these three proceedings, the impact on competition and the public benefits were thoroughly examined. As is planned in Pennsylvania, these states conducted professional review processes that involved retention of technical experts in investment banking and economics. Each state solicited extensive public comment and held

public hearings. The review process in Pennsylvania will be every bit as comprehensive and thorough.

Question 11: An explanation of whether BCBS Plans are able to convert to for-profit under current law in Pennsylvania.

Legal counsel has preliminarily opined that BCBS Plans cannot convert to for-profit corporations under current law. BCBS Plans lack statutory authority to convert to the for-profit form under either the "Health Plan Corporations Act" or the "Non Profit Law."

Under the "Health Plan Corporations Act," BCBS Plans are specifically defined as non-profit corporations. (40 Pa. C.S. §6101; 40 Pa. C.S. §6302). The Act's provisions that BCBS Plans are tax-exempt charitable and benevolent institutions are consistent with their non-profit status. (40 Pa. C.S. §§ 6103(b), 6307(b)). However, unlike mutual insurance companies, there is no provision in this Act that grants BCBS Plans specific authority to convert to for-profit corporations. (40 P.S. §§911-A to 929-A).

The "Non Profit Law" establishes a general rule that allows nonprofit corporations to convert to the for-profit form. However, corporations that are "subject to the supervision" of the Insurance Department are excluded from the general rule. (15 P.S. §5961(b)). BCBS Plans are subject to the supervision of the Insurance Department, with respect to their formation, their operations and financial condition, and their dissolution or liquidation. This law recognizes that Title 40 grants certain types of insurance corporations the authority to convert to for-profit form and specifically preserves that authority from repeal. (15 Pa. C.S. §5961(b)(2)).

Conclusion

Thank you again for this opportunity to testify and I would be happy to answer any of your questions.

PENNSYLVANIA Insurance Department
2006 Accident and Health Market Share
All $ Amounts Rounded to Thousands

Rank	Company Name	Direct Premiums Written (1)	Market Share
1	Highmark Group Total	$8,808,905	26.79%
2	Independence Blue Cross Group Total	8,710,407	26.49%
3	Aetna Group Total	1,917,440	5.83%
4	University of Pittsburgh Medical Center Group Total	1,831,186	5.57%
5	Health America (Coventry) Group Total	1,808,147	5.50%
6	Capital Blue Cross Group Total	1,735,225	5.28%
7	United Healthcare Group Total	950,082	2.89%
8	Health Partners Group Total	875,655	2.66%
9	Geisinger Group Total	788,805	2.40%
10	Unison Group Total	764,301	2.32%
11	Blue Cross of Northeastern Pa. Group Total	700,654	2.13%
	Totals for the top eleven groups	**$28,890,807**	**87.85%**
	Totals for all other groups	**$3,994,886**	**12.15%**
	Grand Totals	**$32,885,693**	**100.00%**

(1) - Includes: Individual Health, Group Health, Medicare, Medicaid, Vision and Dental; Excludes: TPA premiums

Source: Annual Statements filed with the Pennsylvania Insurance Dept. and the NAIC

Attachment 1

State by State Market Share A&H - 2006

State	Top Writer	Top 2 Writers	Top 10 Writers
Delaware	18.94%	31.46%	67.52%
Maryland	16.47%	29.42%	73.39%
New Jersey	25.81%	40.21%	76.81%
New York	12.03%	23.14%	69.83%
Ohio	22.31%	32.77%	64.57%
West Virginia	31.95%	41.29%	76.20%
Pennsylvania	14.17%	25.89%	63.53%
Pennsylvania (group basis) (1)	26.79%	53.28%	85.72%

(1) - For states other than Pennsylvania the "group basis" was not readily available

Source: Annual Statements filed with the Pennsylvania Insurance Dept. and the NAIC

Attachment 2

Pennsylvania Insurance Department
2006 BC/BS Market Share

Companies by Group	Domicile	Direct Premiums Written	Market Share
Highmark Group Totals (9 Companies)		**8,808,638**	**26.79%**
Highmark Inc	PA	4,658,925	14.17%
Keystone Health Plan W Inc	**PA**	**2,409,786**	**7.33%**
Gateway Health Plan Inc	**PA**	**1,178,161**	**3.58%**
United Concordia Life & Hlth Ins Co	**PA**	**304,120**	**0.92%**
Highmark Senior Resources Inc	**PA**	**110,271**	**0.34%**
Highmark Cas Ins Co	**PA**	**63,436**	**0.19%**
HM Life Ins Co	**PA**	**50,382**	**0.15%**
United Concordia Dental Plan PA Inc	**PA**	**33,557**	**0.10%**
Healthguard Of Lancaster Inc	**PA**	**267**	**0.00%**
IBC Group Totals (7 Companies)		**8,710,407**	**26.49%**
Keystone Health Plan E Inc	**PA**	**3,855,905**	**11.73%**
QCC Ins Co	**PA**	**2,873,953**	**8.74%**
Vista Health Plan Inc	**PA**	**1,475,136**	**4.49%**
Independence Blue Cross	PA	300,103	0.91%
Amerihealth Hmo Inc	**PA**	**108,864**	**0.33%**
Inter Cty Hospitalization Plan Inc	PA	63,639	0.19%
Inter County Health Plan Inc	PA	32,807	0.10%
Capital Blue Cross Group Totals (4 Companies)		**1,735,225**	**5.28%**
Capital Advantage Ins Co	**PA**	**980,536**	**2.98%**
Keystone Health Plan Central Inc	**PA**	**447,316**	**1.36%**
Capital Blue Cross	PA	286,412	0.87%
Avalon Ins Co	**PA**	**20,961**	**0.06%**
Blue Cross of NE PA Group Totals (3 Companies)		**700,654**	**2.13%**
Hospital Service Assn of NE PA	PA	370,065	1.13%
Hmo Of NE PA	PA	330,183	1.00%
Significa Ins Grp Inc	**PA**	**406**	**0.00%**
23 Companies in the Report		**19,955,191**	**60.68%**

For profits are in BOLD

Source: Annual Statements filed with the Pennsylvania Insurance Dept. and the NAIC

Attachment 3

PENNSYLVANIA Insurance Department
2001 Accident and Health Market Share
All $ Amounts Rounded to Thousands

Rank	Company Name	Direct Premiums Written (1)	Market Share
1	Highmark Group Total	$6,242,981	28.51%
2	Independence Blue Cross Group Total	5,642,958	25.77%
3	Aetna Group Total	2,091,117	9.55%
4	Capital Blue Cross Group Total	1,407,763	6.43%
5	Health America (Coventry) Group Total	805,251	3.68%
6	University of Pittsburgh Medical Center Group Total	703,612	3.21%
7	Geisinger Group Total	605,069	2.76%
8	Blue Cross of Northeastern Pa. Group Total	496,229	2.27%
	Totals for the top eight groups	**$17,994,980**	**82.19%**
	Totals for all other groups	**$3,901,897**	**17.81%**
	Grand Totals	**$21,896,877**	**100.00%**

(1) - Includes: Individual Health, Group Health, Medicare, Medicaid, Vision and Dental; Excludes: TPA premiums

Source: Annual Statements filed with the Pennsylvania Insurance Dept. and the NAIC

Attachment 4

PENNSYLVANIA Insurance Department
1996 Accident and Health Market Share
All $ Amounts Rounded to Thousands

Rank	Company Name	Direct Premiums Written (1)	Market Share
1	Highmark Group Total	$6,699,355	22.91%
2	Independence Blue Cross Group Total	1,973,306	12.17%
3	Aetna Group Total	1,668,564	10.29%
4	Capital Blue Cross Group Total	1,132,702	6.99%
5	Blue Cross of Northeastern Pa. Group Total	660,834	4.08%
6	Health America (Coventry) Group Total	549,728	3.39%
7	Prudential Group Total	314,747	1.94%
8	Penn State Geisinger Group Total	251,839	1.55%
9	Qualmed Group Total	231,399	1.43%
	Totals for the top nine groups	**$13,482,474**	**83.18%**
	Totals for all other groups	**$2,725,564**	**16.82%**
	Grand Totals	**$16,208,038**	**100.00%**

* - Comprehensive market share reports were not produced in 1996. At that time health insurers filed various types of annual statements making it impossible to electronically compile data for the entire industry. Every effort was made to capture the same information manually that is now available electronically for more recent years.

(1) - Includes: Individual Health, Group Health, Medicare, Medicaid, Vision, Dental and TPA premiums

Source: Annual Statements filed with the Pennsylvania Insurance Dept. and the NAIC

PENNSYLVANIA Insurance Department
1986 Accident and Health Market Share
All $ Amounts Rounded to Thousands

Rank	Company Name	Direct Premiums Written (1)	Market Share
1	PA Blue Shield (Medical Service Assoc. of PA)	$1,407,595	22.49%
2	Blue Cross of Western PA	1,157,387	18.49%
3	Independence Blue Cross (BC of Greater Phila.)	769,260	12.29%
4	Capital Blue Cross	536,484	8.57%
5	Us Health Care System Of PA Inc	286,845	4.58%
6	Blue Cross of Northeastern Pa.	245,893	3.93%
7	Prudential Ins Co of America	163,613	2.61%
8	Inter County Group Total	82,656	1.32%
9	Maxicare / Health America (Coventry) Group Total	73,601	1.18%
10	Connecticut General Life Ins Co	72,310	1.16%
	Totals for the top ten groups	**$4,795,644**	**76.62%**
	Totals for all other groups	**$1,463,090**	**23.38%**
	Grand Totals	**$6,258,734**	**100.00%**

* - Comprehensive market share reports were not produced in 1986. At that time health insurers filed various types of annual statements making it impossible to electronically compile data for the entire industry. Every effort was made to capture the same information manually that is now available electronically for more recent years.

(1) - Includes: Individual Health, Group Health, Medicare, Medicaid, Vision, Dental and TPA premiums

Source: Annual Statements filed with the Pennsylvania Insurance Dept. and the NAIC

Attachment 6

PENNSYLVANIA Insurance Department
1976 Accident and Health Market Share
All $ Amounts Rounded to Thousands

Rank	Company Name	Direct Premiums Written (1)	Market Share
1	PA Blue Shield (Medical Service Assoc. of PA)	$407,642	16.65%
2	Blue Cross of Western PA	377,734	15.43%
3	Independence Blue Cross (BC of Greater Phila.)	345,994	14.13%
4	Capital Blue Cross	112,768	4.61%
5	Travelers Ins Co	109,362	4.47%
6	Prudential Ins Co of America	108,021	4.41%
7	Equitable Life Assurance Society of the US	91,127	3.72%
8	Hospital Service Assn of NE PA	76,615	3.13%
9	Hospital Service Assn Lehigh Valley	52,489	2.14%
10	Metropolitan Life Ins Co	50,242	2.05%
	Totals for the top ten groups	**$1,731,994**	**70.74%**
	Totals for all other groups	**$716,467**	**29.26%**
	Grand Totals	**$2,448,461**	**100.00%**

* - Comprehensive market share reports were not produced in 1976. At that time health insurers filed various types of annual statements making it impossible to electronically compile data for the entire industry. Every effort was made to capture the same information manually that is now available electronically for more recent years.

(1) - Includes: Individual Health, Group Health, Medicare, Medicaid, Vision, Dental and TPA premiums

Source: Annual Statements filed with the Pennsylvania Insurance Dept. and the NAIC

Attachment 7

HISTORY OF PENNSYLVANIA HEALTH COMPANIES

1. Inter-County Hospitalization Plan, Inc. - Began operation in 1937.

2. Capital Blue Cross, Blue Cross of the NE, IBC, Highmark and Hospital Service Plan of the Lehigh Valley (Its predecessor was Blue Cross of Western PA) - All began operations in 1938.

3. Highmark (Its predecessor was PA Blue Shield) - Began operation in 1940.

4. HealthAmerica, Inc. - Began operation 1/13/1975.

5. U.S. Healthcare System of Pa - Began operation in 1975 - Purchased by Aetna on 9/19/1996.

6. Geisinger Health Plan - Began operation 3/1/1985.

7. Hospital Service Plan of the Lehigh Valley - Merged into Capital Blue Cross on 11/21/1985.

8. Inter-County Hospital & Health Plans - Acquired by PA Blue Shield on 7/31/1989.

9. United Healthcare Ins. Co. - Licensed to do business in PA on 10/26/1994.

10. UPMC Health Plan, Inc. - Began operation 3/1/1996.

11. Highmark, Inc. - On 11/27/1996, PA Blue Shield and Blue Cross of Western PA consolidated.

12. Keystone Health Plan East - 50% owned by Highmark was sold to IBC on 5/6/1997. IBC then owned 100%.

13. Prudential Insurance Company - Sold its A&H business to Aetna on 8/6/1999.

14. Keystone Health Plan Central - 50% owned by Highmark was sold to Capital Blue Cross on 7/17/2003. Capital then owned 100%.

CONDITIONS TO 1996 HIGHMARK ORDER – SUMMARY

Number	Description	In Effect
1.	Commissioner Jurisdiction and Applicable Law	Yes.
2.	Prior Written Notice of Fundamental and Other Corporate Changes	Yes.
3.	Prior Written Notice of Changes in Service Area	Yes.
4.	Dedication of 1.25% of Direct Written Premium to Social or Other Charitable Health Endeavors	No. Superseded by 2005 CHR Agreement.
5.	Continued Application to Participate in CHIP	No. Expired 4 years after consolidation effective. Required to participate under CHIP statute.
6.	Open Enrollment During Entire Calendar Year.	Yes.
7.	Exclusive Contracts with Hospitals Prohibited.	No. Expired 3 years after consolidation effective. Continuing requirement under PA law.
8.	Most Favored Nation Clauses in Hospital Contracts Prohibited.	No. Expired 3 years after consolidation effective. Continuing requirement under PA law.
9.	Filing of Annual and Quarterly Financial Statements including revenue and expenses of hospital plan and health services plan.	Yes.
10.	Reporting with Annual Statements and Rate Filings of number of policies issued and lives covered, by product line.	Yes.
11.	Prior Written Notice of Staff Reductions.	Yes.
12.	Prior Written Notice of Plans to Relocate or Consolidate Offices.	Yes.
13.	Reporting of Annual Compensation of Top Ten Highest Paid Executives With Annual Statement	Yes.
14.	Advisory Counsel of Health Care Professionals	No. Expired 2 years after consolidation effective.
15	Five Year Plan for Managing Paid Claims Held In Reserve.	No. Plan Filed Within 6 months of consolidation.
16.	Filing of RBC Results.	No. Required by statute since June, 2000.
17.	Statement of Cost Savings Achieved from Consolidation and Change in Control of Subsidiaries	No. Expired 3 years after consolidation effective.
18.	Timely Payment of NAIC database fees.	Yes.
19.	Reporting of improvements in customer service and claims administration as a result of consolidation and change in control.	No. Expired 3 years after consolidation effective.
20.	Reporting of Material Changes in accreditation status of Affiliates.	Yes.
21.	Application for Accreditation of Keystone Health Plan West.	No. Completed.
22.	All Necessary Steps by Highmark to Assure That Keystone Health Plan West Applies for Accreditation	No. See #21.
23.	Prohibition on Conversion Unless Specifically Authorized by Legislation.	No. Expired 2 years after consolidation effective.
24.	Effective Date of Consolidation.	No. Completed December, 1996.
25.	Commissioner may grant such relief from conditions as may be appropriate.	Yes.

RECENT BLUE PLAN CONVERSIONS AND MERGERS/CONSOLIDATIONS

Decision Date	Blue Plan	State	Entity Type	Decision
Conversions				
Pending	EmblemHealth (NonBlue)	NY	Non Profit	Pending
07/25/2004	Premera Blue Cross Blue Shield	WA and AL	Non Profit	Disapproved
03/05/2003	CareFirst, Inc. – Conversion and Acquisition by WellPoint	MD, DE, DC	NonProfit	Disapproved
10/08/2002	Empire Blue Cross and Blue Shield	New York	NonProfit	Approved
10/01/2002	Maryland Blue Cross Blue Shield	MD	NonProfit	Approved
02/11/2002	Blue Cross and Blue Shield of Kansas – conversion and acquisition by Anthem	KA	NonProfit	Disapproved
08/25/2001	Anthem Insurance Company	IN	Mutual	Approved
2001	Blue Cross Blue Shield North Carolina	NC	Non-Profit	Withdrawn.
2001	Horizon Blue Cross Blue Shield	NJ	Non-Profit	Withdrawn
2000	Blue Cross and Blue Shield of Maine – conversion and acquisition by Anthem	ME	Non-Profit	Approved
Merger/Consolidation				
2005	Merger of Wellpoint and WellChoice (formerly Empire)	NY	For Profit	Approved
2005	Merger of Blue Cross Blue Shield of Oklahoma into Health Care Service Corp.	OK	Mutual	Approved
2004	Merger of Anthem and Wellpoint	IN, CA	For Profit	Approved
2003	Merger of WellPoint and Cobalt Corp.	WI	For Profit	Approved
2002	Merger of Anthem and Trigon Corp.	VA	For Profit	Approved
2001	Merger of Blue Cross and Blue Shield of New Mexico into Health Care Service Corp.	NM	Mutual	Approved
2001	Affiliation of Regence Blue Cross Blue Shield with Health Care Service Corp.	OR, WA, UT, ID	Non-Profit	Withdrawn
03/20/2000	Affiliation of Blue Cross Blue Shield Delaware with CareFirst, Inc.	DE	Non Profit	Approved
1999	Anthem acquires Blue Cross and Blue Shield of New Hampshire	NY	Mutual	Approved

Decision Date	Blue Plan	State	Entity Type	Decision
Merger/Consolidation				
1999	Anthem acquires Blue Cross and Blue Shield of Colorado and Nevada	CO, NV	Mutual`	Approved
1998	Merger of Blue Cross and Blue Shield of Texas into Health Care Service Corp.	TX	Mutual	Approved
1997	Merger of Anthem and Blue Cross Blue Shield of Connecticut	CN	Mutual	Approved
1996	Merger of Blue Cross of Western Iowa and South Dakota into South Dakota Blue Cross Blue Shield	Iowa, South Dakota	Mutual	Approved
1995	Merger of Anthem and Community Mutual	OH	Mutual	Approved
1993	Merger of Anthem and Blue Cross and Blue Shield of Kentucky	KE	Mutual	Approved