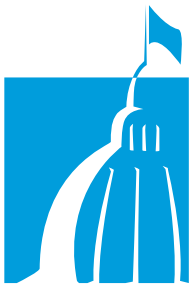

STATE COVERAGE INITIATIVES

The Pennsylvania Community Health Reinvestment Agreement:

Establishing Non-Profit Insurers' Community Benefit Obligations

by Carol Pryor and Catherine Dunham
The Access Project

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About the Authors

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Executive Summary

In February of 2005, Pennsylvania reached an agreement with the state's four non-profit Blue Cross and Blue Shield (Blue) Plans called the "Agreement on Community Health Reinvestment." The Agreement committed the Plans to annually contributing 1.6 percent of their annual health care premiums plus 1 percent of their Medicare and Medicaid premiums, less certain state taxes, to support community health programs. Under this formula, it was estimated that the Plans would contribute approximately $950 million over the six years of the Agreement. Sixty percent of the funds were allocated to provide health insurance to low-income people through state approved programs, such as Pennsylvania's adultBasic program for low-income adults. The rest was to go toward other publicly sanctioned health coverage programs or community benefit initiatives.

Nationally, many Blue Plans experienced financial problems in the late 1980s and early 1990s. Then in the late 1990s, many of the Plans began to see financial improvements, including large increases in retained earnings, which led some of them to consider conversion to for-profit status. The conversions raised questions about who should receive the assets of the non-profit corporations. In some cases the assets were transferred to charitable foundations, while in others they went directly to the state to support health-related programs and other efforts. This trend came to a temporary halt in the early 2000s, when a number of conversion requests were denied or voluntarily withdrawn. However, in many states, the issues raised by the conversion efforts led advocates and others to question whether the non-profit Plans were allocating funds to charitable activities commensurate with their resources and charitable mission. The increased scrutiny coincided with soaring Plan surpluses and rising health care premiums, as well as increasing numbers of uninsured residents and reduced federal support for public coverage programs.

Perhaps the earliest discussion in Pennsylvania of the Blue Plans' charitable obligations came in 1996, when two of Pennsylvania's then five Blue Plans consolidated to become Highmark Inc. In approving the change in control of the subsidiaries of the two Plans, the state's Insurance Commissioner required that the new entity direct 1.25 percent of its direct written premiums to social mission programs. In 2000, media stories began to question whether the state's Blue Plans were accumulating excessive surpluses. In 2001, class action suits were filed against all four of the Plans by small employers who claimed the Plans had excessive surpluses that should be used to lower health care premiums. The suits were followed by additional media coverage of the Plans' surpluses.

In 2002, the Pennsylvania Insurance Department (PID) held a public informational hearing to gather information about the surplus levels of the Blue Plans and, in January of 2004, it requested applications from the Plans justifying their surpluses.

The Plans claimed that the state did not have the authority to regulate maximum surpluses, but only to set minimum levels to guard against financial failures. However, they "voluntarily" agreed to submit applications. In the applications, all of the Plans claimed their surpluses were not excessive and were necessary to ensure financial solvency. Some claimed that they were not charities and did not have charitable obligations. The applications spurred a round of responses and counter-responses about whether the surpluses were excessive and what tools should be used to determine appropriate maximums. Advocacy groups claimed the surpluses were far above what was needed to protect against financial failure and said that excess surpluses should be used to fund the adultBasic program, whose waiting list had grown to over 100,000. In October of 2004, the state legislature became involved, calling for a study of the options available for regulation, oversight, and disposition of health insurers' surpluses. The Lewin Group was retained to perform that study.

It was against this backdrop that the Governor announced the signing of the "Agreement on Community Health Reinvestment." The Agreement had been negotiated confidentially by state officials, the PID, and representatives of the Blue Plans, and neither the legislature nor the public had input into the final Agreement. While the Plans agreed to contribute a set amount toward community benefit activities over the next six years, the Agreement did not make any specific

assertions about their statutory obligations to engage in community benefit activities.

Two days after the signing, the state Insurance Commissioner released a Determination finding that none of the Plans had excessive surpluses, although she prohibited three of the Plans from including a risk and contingency factor in their filed rates because of the size of their surpluses. The Commissioner denied any connection between the finding and the Community Health Reinvestment Agreement, although many advocates assumed that the Plans signed the Agreement in exchange for a finding that their surpluses were not excessive.

In the months that followed, the PID approved numerous rate hikes requested by the Plans in the individual and small group market, some of which had been on hold pending the Determination on the surpluses. The legislature, which had initially expressed concern about whether the Agreement exceeded the executive's authority to allocate funds, agreed in July to appropriate funds from the Agreement to support the adultBasic program. In June, The Lewin Group issued its report, in which it concurred with the PID's finding that the Plans did not have excessive surpluses and stated that the money allocated through the Agreement was at least as generous as the charitable contributions of Blue Plans in other states. Following the 2004 infusion of money from the Agreement into the adultBasic program, the number of enrollees has increased and the number on the waiting list has fallen sharply.

The Pennsylvania Community Health Reinvestment Agreement set some important precedents. It gained significant funding for state health programs through a voluntary agreement and without a Plan conversion. In addition, while the Pennsylvania Insurance Commissioner did not find that the Plans had excessive surpluses, she did assert her authority to establish the levels at which surpluses were likely excessive. Discussions elsewhere about Blue Plans' surpluses have led to investigations and proposed legislation, but as yet no other states have obtained funds except when a Plan converted to for-profit status. Key components in reaching the Agreement were advocacy efforts that brought public attention to the issue of the Blue Plans' surpluses and charitable obligations, and strong political leadership. Other states may want to consider this Agreement as they look for ways to fund health care for the uninsured in their own communities.

Introduction

On February 7, 2005, the Pennsylvania Deputy Insurance Commissioner and the heads of the four Blue Cross and Blue Shield (Blue) Plans in Pennsylvania[1] signed an "Agreement on Community Health Reinvestment."[2] The Agreement committed the Plans to annually contributing 1.6 percent of their health care premiums plus 1 percent of their Medicare and Medicaid premiums, less certain state taxes, or approximately $950 million over the six years of the Agreement, to support community health programs. It specified that 60 percent of the funds would go to support the state's adultBasic program, a health insurance program for low-income uninsured adults, while the remaining 40 percent would go toward other publicly sanctioned health coverage programs or community benefit initiatives.

Governor Edward Rendell's announcement of the Agreement took many by surprise. However, the Agreement was the culmination of many years of discussion and advocacy regarding the charitable obligations of the non-profit Blue Cross and Blue Shield plans in the state and the appropriate use of their increasing surpluses and reserves.

This brief discusses the national and state developments surrounding the signing of the Agreement, the terms of the Agreement itself, and implications of the Pennsylvania experience for other states.

The National Context

The signing of the Community Health Reinvestment Agreement in Pennsylvania took place in a context of increased attention to the financial activities of Blue Plans nationally. In the late 1980s and early 1990s, many Blue Plans experienced financial problems, and incompetent and sometimes corrupt management was exposed in a number of states. For example, in Maryland at the end of the 1980s, the state's Blue Plan and its affiliate in the District of Columbia had major financial setbacks. Investigations revealed money-losing business strategies such as the creation of subsidiaries headquartered in Paris, Hong Kong, and Jamaica, combined with executive excesses such as trips to the Olympics, tours of resorts, and significant sums spent on golf balls and greens fees.[3] In New York, Empire Blue Cross experienced a financial collapse in 1989. By statute the plan was required to have minimum reserves of 12.5 percent of premium revenue to ensure that claims could be paid even in the face of unexpected adverse events. However, the Plan's reserves fell to less than one percent of premium revenue, leaving it essentially bankrupt and, between 1992 and 1996, it lost almost half of its enrollees. Excessive compensation and board and management perquisites were also revealed, as were fraudulent accounting practices.[4]

In the late 1990s, however, many Blue Plans began to see financial improvements, including large increases in their retained earnings.[5] As finances improved, many Blue Plans began to consider conversion to for-profit status. The California Blue Plans led the way, but conversions were subsequently pursued in other states, such as Virginia, New York, Wisconsin, and Washington. The conversions raised new questions: What was the true value of the companies and what should be done with their assets? In many communities, advocates claimed that the companies were being sold at less than their true worth and that their assets, accumulated while they were non-profit organizations, should be returned to the community. In some places, such as California, the assets were ultimately transferred to charitable foundations created to receive them. In others, such as New York and Wisconsin, the assets went directly to the state for use in supporting health-related or other programs.[6]

This trend came to at least a temporary halt when state officials in Maryland and Kansas denied conversion requests, and Blue Plans in New Jersey and North Carolina voluntarily withdrew conversion petitions.[7] The Maryland Insurance Commissioner, who denied the conversion request in 2003, said that CareFirst (the company created by the merger of the Maryland Blue Plans and the Blue Plan serving the District of Columbia, northern Virginia, and part of Maryland) had disregarded its mission as a nonprofit company and focused on growth

and market dominance rather than providing insurance at minimum cost to those in need. The Maryland legislature then required the company to take steps to address public health care needs as part of its non-profit mission. In Washington, D.C., activists who had opposed the conversion raised questions about whether the company was allocating funds to charitable activities commensurate with its resources and charitable mission. They called on policymakers to establish specific community benefit targets for use of the surplus.[8]

Other states have also taken an increasing interest in Blue Plans' surpluses and charitable activities in recent years. In North Carolina, two bills were introduced in the legislature in 2005 regarding its Blue Plan's surpluses, although neither passed. One set limits on the size of the company's reserves and allocated the excess to buy coverage for the uninsured; the other let regulators consider a plan's profits when deciding whether to approve premium increases.[9] In Tennessee, where the Blue Plan's reserves topped one billion dollars, critics, including health care providers, charged that the company was "less interested in providing affordable health insurance than in feathering its nest." Several bills were introduced in the legislature in 2003 to limit the reserves, including one at the urging of HCA, Inc., the Nashville-based hospital company; none of the bills passed.[10]

A variety of economic and political developments probably contributed to this increased scrutiny of Blue Plans' activities. The Plans' surpluses soared at the same time that the economy weakened and health care costs rose dramatically. State officials, faced with increasing numbers of uninsured and reduced federal support for public coverage programs, may have looked to the Blue Plans' surpluses as a potential resource for responding to health coverage needs in their states.

In addition, in recent years increasing attention has been paid to non-profit hospitals' billing and collections practices toward uninsured patients. The media has reported extensively on hospitals that overcharge the uninsured and use aggressive debt collection practices to extract payment. Advocates in many communities publicized the lack of transparent and equitable charity care policies at their local hospitals, and legislation was introduced in many states to set requirements for charity care. Congress has also investigated how nonprofit hospitals price services for the uninsured and then attempt to gain payment. As a result of these activities, many policymakers came to accept that non-profit hospitals had an obligation to provide charitable care in exchange for their tax exemptions.[11] Many may also have recognized that the arguments for holding non-profit hospitals accountable for their charitable mission applied to non-profit insurers as well.

Events in Pennsylvania Preceding the Signing of the Community Health Reinvestment Agreement

Perhaps the earliest discussion in Pennsylvania of the Blue Plans' charitable obligations came in 1996, when two of Pennsylvania's then five Blue Plans consolidated to become Highmark Inc. In approving the change in control of the subsidiaries of the two Plans, the state's Insurance Commissioner required that the new entity direct 1.25 percent of its direct written premiums to social mission programs, such as "outreach programs addressing problems of youth violence, teen pregnancy, and other community health needs; programs to provide affordable health insurance to low-income families, adults and children; and programs to provide affordable health care insurance to senior citizens."[12] The requirement that Blue Plans contribute to charitable activities was based on their enabling legislation in 1938, in which they were established as non-profit corporations engaged in the business of maintaining and operating non-profit hospital plans and professional health services. These types of entities were deemed by the statute to be "charitable and benevolent institutions" exempt from taxation by the state and its political subdivisions.[13]

In 2000, media stories began to appear that questioned whether the Blue Plans were accumulating excessive surpluses rather than using the funds to comply with their charitable obligations. An article in the Philadel-

phia Inquirer noted that Independence Blue Cross (IBC), one of the Pennsylvania Blue Plans, had used its surplus to fund losing ventures in new markets at the expense of providers (who had seen their reimbursement rates decline) and subscribers (who had seen their health premiums rapidly rise). Another noted that IBC had shifted a great deal of revenue from the parent non-profit company to for-profit subsidiaries, and reported that the amount of money the company devoted to charitable activities had declined from $43 million in 1996 to $15.6 million in 1999.[14]

In 2001 and 2002, class action suits were filed against all four of the state's Blue Plans by small businesses and their employees concerned about the high cost of the premiums for employer-sponsored group health plans.[15] The suits claimed that the insurers had accumulated reserves and surpluses far in excess of both insurance industry standards and what was needed to guarantee their financial solvency,[16] and that the Plans had amassed the money for purposes inconsistent with their obligations under Pennsylvania's Non-Profit Law. The plaintiffs contended that money that was being used to fund mergers, acquisitions, and potential conversions to for-profit status should instead be allocated to subsidize coverage for the state's uninsured residents, expand coverage, or be returned to policy holders in the form of lower premiums. The suits were followed by additional media coverage in 2002 of the Blue Plans' surpluses. Critics faulted state insurance regulators for allowing the accumulation of the surpluses while regularly approving rate hikes requested by the Plans. The companies countered by claiming that the reserves gave members confidence in their ability to pay claims in the event of an economic downturn.[17]

In September 2002, the Pennsylvania Insurance Department (PID) held a public informational hearing to gather information about the reserve and surplus levels of the Blue Plans, which by the end of that year totaled approximately $3.5 billion.[18] Representatives of employer groups testified that the surplus was excessive, especially in light of steep increases in premium rates for small employers. They called for the PID to formally determine acceptable limits to Blue Plans' surpluses and ensure that excess funds be used to bring down premium rates for employer groups.[19] In December of the following year, the PID denied about two dozen rate hikes requested by the Blue Plans, saying it needed more information to determine whether the Plans should be using some of their surpluses and reserves to mitigate premium increases.[20] Then, on January 16, 2004, the state Insurance Commissioner requested applications from the Blue Plans justifying their surpluses and reserves. The notification to the Plans said, "...to assure that the Blues Plans are maintaining properly stated reserve levels and appropriate but not excessive surplus to properly fulfill corporate obligations and social missions, the Department has determined that each Blues Plan must submit an application for approval of its reserve and surplus." The notification also requested that the Plans identify the "funds dedicated, allocated or expended for charitable purposes" in the previous two years, as well as planned charitable allocations for the next three years.[21]

The Blue Plans submitted their applications in April of 2004, but asserted that much of the information was proprietary and confidential – in February and March three of the Plans had filed suit to prevent the PID from releasing the information to the public. Ultimately, in July, the court ruled that the historical parts of the applications could be made public, while the forward-looking parts, such as business plans, had to be kept confidential. The PID then posted the applications (with confidential information redacted) and, in August, solicited public comments. The applications, responses, and counter-responses involved conflicting arguments about whether the current reserves were excessive, whether the PID had the authority to set maximum reserve levels, what tools should be used to determine appropriate levels of reserves, and whether the Blue Plans had charitable obligations.[22]

While each Blue Plan submitted its own

application, they had some common elements. All of the Plans claimed that their surpluses were not excessive, but were needed to meet "needs and ongoing business objectives." The Plans said that the surpluses were needed to protect against possible financial insolvency, and noted that recent insolvencies of Pennsylvania insurers had left thousands of insured people with unpaid claims. They also said that, as nonprofit organizations, they did not have access to capital markets to raise funds, and thus had to rely solely on their surpluses to fund "enhancements in our services, new product offerings, and infrastructure improvements." All maintained that the PID had no authority to establish a maximum level of surplus, but only to set minimum levels to prevent against financial failures. All of the Plans questioned the PID's use of a Risk-Based Capital (RBC) ratio to set appropriate ranges for surpluses. (An RBC ratio is a tool used to determine the minimum level of capital required to protect a carrier from insolvency.) Some of the Plans also suggested it would be unfair to set a single standard for all of the Plans, as their differing sizes and situations required different levels of surplus to guarantee their financial stability.

While the Plans generally acknowledged that they had a social mission, some denied they were charities. In its response to public comments, Independence Blue Cross said, "For the umpteenth time, IBC is not a charity.... Rather, IBC is a not-for-profit hospital plan corporation.... to be organized solely for the benefit of its subscribers who pay insurance premiums." [23] Blue Cross of Northeastern Pennsylvania claimed as initiatives in fulfillment of its social mission the use of its surplus to fund activities such as an "appreciation credit" that reduced rate increases for its insured and self-funded businesses; investments in information technology; and subsidies in its non-group individual markets. Without the use of its surplus, the Plan said all of these activities would have resulted in higher rates for subscribers. It also listed more familiar charitable giving, such as the endowment of a foundation it formed in 2001 to fund innovative programs that would improve the overall health and wellness of the communities it served, as well as donations to community programs, such as an education program to provide nutrition, safety, and hygiene information to first- and second-grade students. [24]

Numerous groups and individuals responded to the solicitation of public comments on the applications, including legislators, industry representatives, and trade groups. A coalition of thirteen organizations representing advocacy groups, trade unions, and groups serving low-income people submitted comments that disputed many of the Blue Plans' assertions. These organizations pointed to a crisis of lack of insurance in the state, with a rising percentage of uninsured residents caused in part by rising health premiums, and growing numbers of people on the waiting list for the state's adultBasic health coverage program for low-income uninsured. (By June of 2004, the waiting list had grown to over 100,000 applicants.)

The coalition alleged that the Plans' current surpluses and reserves were far in excess of what was needed to maintain financial solvency in the event of reasonably projected risks, and that resources the Plans had dedicated to charitable activities were grossly insufficient in terms of their statutory obligation as charitable and benevolent institutions. Finally, the advocates said that using the excess funds solely to reduce premiums for employer-based groups was inadequate because many working people did not have access to insurance through their employment. They called on the PID to require the Blue Plans to use part of their reserves to support government programs that provide health insurance coverage to low-income residents, such as adultBasic and the state's Children's Health Insurance Program (CHIP). [25]

The coalition of groups also retained a consultant, Larry Kirsch, to independently review the Blue Plans' applications. Kirsch challenged the assertions in the Plans' applications, maintaining that the $3.9 billion combined surplus in the applications was a serious underestimate of actual surpluses because the Plans had reported on the parent companies' surpluses only, and had not included surpluses in their independently owned subsidiaries. If subsidiaries were included, he estimated that actual surpluses

Blue Plan	Number of Enrollees	Direct Written Premiums	Total Adjusted Surplus
Highmark Inc.	3,800,000	$7,718,743,276.00	$2,194,249,672.00
Independence Blue Cross	3,500,000	$7,972,861,893.00	$840,916,664.00
Capital BlueCross	1,000,000	$1,762,752,061.00	$515,476,773.00
Blue Cross of Northeastern Pennsylvania	600,000	$597,691,466.00	$404,694,781.00
TOTAL	8,900,000	$18,052,048,696.00	$3,955,337,890.00

Source: Pennsylvania Insurance Department, cited in the Department's Determination on the Blue Plans' surpluses. Figures are from Plan Annual Statements in 2003.

would be approximately $6.2 billion.[26] Kirsch criticized the Plans' estimates of the funds required to protect against unexpected claims as much higher than actually necessary. He also said he was unable to recommend a specific upper bound figure for the surplus because of a lack of access to essential data such as the Plans' business and financial plans and the risk assessment models they used to generate proposed maximum surplus levels. He thus called for the PID to hold formal "contested-case" hearings in which the necessary data would be shared and Plan assumptions independently tested.[27]

Given the lack of public data, Kirsch ultimately recommended that, at a minimum, the PID require that the Plans meet the community benefit standard established in the 1996 order with Highmark Inc. and contribute 1.25 percent of direct written premiums to charitable activities. In addition, he said the state should define and clarify what types of activities could appropriately be claimed as charitable. The Plans then submitted responses to the comments, disputing many of the claims.

In October of 2004, the state legislature became involved. The House of Representatives tasked the Legislative Budget and Finance Committee to "examine options and alternatives available to the Commonwealth with respect to the regulation, oversight, and disposition of reserves and surpluses of health insurers." The Committee retained The Lewin Group to perform this study.[28]

It was against this backdrop, with a decision pending by the Insurance Commissioner on the appropriateness of the Blue Plans reserves and surpluses and The Lewin Group report for the legislature not yet completed, that Governor Rendell announced the signing of the "Agreement on Community Health Reinvestment" on February 7, 2005. The arrangement was negotiated confidentially among a limited number of parties, mainly state officials in the Governor's Office of Health Care Reform, the Governor's Office, the PID, and representatives of the four Blue Plans; neither legislators nor the public had input into its terms.

Legal and Regulatory Background

The extent of the state's authority to regulate the Blue Plans' surpluses and reserves and mandate their use for charitable purposes rested on two key legal issues. One was whether the Blue Plans had a legal obligation to contribute to charitable activities. The second was whether the PID had the authority to determine whether the Blue Plans' surpluses and reserves were excessive in light of this charitable obligation.

As previously noted, the state claimed that the Blue Plans had a charitable obligation based on the 1938 legislation that established them as non-profit corporations engaged in the business of maintaining and operating non-profit hospital and professional health services plans. These types of entities were deemed by statute to be "charitable and benevolent institutions" exempt from taxation by the state and its political subdivisions and, according to the Insurance Commissioner, commonly recognized as "insurers of last resort."[29] The legislative history behind the

original statute, subsequent case law, and later legislation provided additional support for this claim. Until the recent discussions of the Blue Plans' charitable obligations, however, state regulation focused almost entirely on their responsibilities as insurers of last resort.[30] The Blue Plans thus claimed as their main community benefits their underwriting losses in the non-group market and losses in services provided to the state for its CHIP and adultBasic programs.[31]

The second issue concerned the state's authority to regulate the Blue Plans reserves and surpluses and determine when these funds were excessive.[32] The state had clear authority to approve or disapprove insurers' requests for rate changes under the Accident and Health Filing Reform Act.[33] However, that statute provides only general rate-specific criteria for making these decisions, saying that health insurance rates could not be "excessive, inadequate, or unfairly discriminatory." Some criticized the statutorily mandated procedures for regulating premium rates as overly friendly to the insurance industry because of a "file-and-use" provision that allowed rate changes to go into effect automatically after 45 days if not officially disapproved, and because public input is difficult and admitted only at the Insurance Commissioner's discretion.[34]

Regulation of the insurers' reserves and surpluses, however, represented a slightly different issue. Historically, most states have regulated insurers' reserves to ensure that the companies had sufficient capital to survive unexpected adverse events. Pennsylvania was no exception; according to PID staff, prior to 2005 the PID was mainly concerned with ensuring that the Blue Plans had adequate minimum reserves.[35] In 2001, the state adopted RBC legislation based on a model act created by the National Association of Insurance Commissioners. The act established lower bounds for insurers' reserves and surpluses; when reserves and surpluses fell below these levels, the state could intervene to protect against insurer insolvency. The only specific language in state statute that applied to maximum surplus and reserve levels said that the rates charged subscribers, the rates paid to hospitals and providers, and the reserves to be maintained were at all times subject to prior approval by the PID. In requesting applications for approval of the Blue Plans' surplus and reserves, the PID claimed that the statute gave them the authority to regulate and limit the reserves, and said that the term "reserves" applied to all aspects of the Blue Plans' reserves and surpluses.[37] In their April 2004 filings justifying their surpluses and reserves the Blue Plans, while "voluntarily" complying with the PID's request, objected to any attempt by the Department to limit their reserves.[38]

Agreement on Community Health Reinvestment

The Community Health Reinvestment Agreement between the state and the four Pennsylvania Blue Plans signed on February 7, 2005 specified how much money the insurers would contribute to community benefit activities over the ensuing six years (2005-2010) and how the money would be allocated.[39] Each Plan agreed to contribute 1.6 percent annually of its direct written premium revenues from the commercial accounts of the parent plan plus any subsidiaries, plus 1 percent of its Medicare and Medicaid premiums, minus the amount of any state premium tax and income tax owed. It was estimated that this formula would result in an aggregate contribution over the life of the Agreement of approximately $950 million.[40]

The Agreement defined allowable community benefit activities as any of the following:

- contributions to health coverage programs for low-income and/or uninsured persons, such as adultBasic and CHIP;
- other programs or means of subsidizing or providing health care coverage to those unable to pay for such coverage or services, such as rate subsidies for individual market products or operating subsidies for public programs;
- other community health care-related expenditures, distributions, or uses approved by the PID.

Timeline

1996 November	PID approves the change in control of the subsidiaries of the two Pennsylvania Blue Plans that consolidated to form Highmark Inc., but Insurance Commissioner requires that the new entity direct 1.25% of direct written premiums to social mission programs.
2000 September	Articles begin appearing in the press that question whether the Blue Plans are accumulating excessive surpluses and failing to comply with their charitable obligations.
2001 May & June	Class action suits are filed against all four Pennsylvania Blue Plans claiming that their reserves are excessive and are not being used in a way that is consistent with their charitable obligations.
2002 February & March	The media renews coverage of the Blue Plans' surpluses. The articles fault the Insurance Commissioner for allowing the accumulation of surpluses while regularly approving rate hikes.
September	PID holds public informational hearing to gather information about the reserve and surplus levels of the Blue Plans.
2003 December	PID denies about two dozen rate hikes requested by the Blue Plans, saying it needs to determine if more of their surpluses should be used to mitigate the increases.
2004 January	Insurance Commissioner requests applications from the Blue Plans justifying their surpluses and reserves.
February & March	Suits are filed by three Blue Plans to prevent the PID from releasing the applications to the public, claiming the information is proprietary.
April	Blue Plans submit their applications, claiming their reserves are not excessive.
July	Court rules on Blue Plans suit, finding that historical information in the applications can be released, but forward-looking parts must be kept confidential.
August	PID solicits public comments on the applications.
September	Coalition of 13 organizations submits comments alleging that the surpluses are excessive and that funds should be used to support the state's adultBasic program.
	Larry Kirsch, consulting to the coalition, submits report challenging Blue Plans' reporting of their surpluses and claiming that the surpluses are far in excess of what is required to guarantee financial solvency.
October	Independence Blue Cross releases response to public comments. Larry Kirsch releases supplemental report challenging assertions made in response.
	State legislature asks Budget and Finance Committee to "examine options and alternatives... with respect to the regulation, oversight, and disposition of reserves and surpluses of health insurers." Committee retains The Lewin Group to perform the study.
2005 February	Governor Edward Rendell announces the signing of the Agreement on Community Health Reinvestment. The Plans agree to contribute close to $1 billion over six years to community benefit activities.
	Two days later, the Insurance Commissioner releases Determination on the Blue Plans' applications, finding that none of the Plans have excessive surpluses.
March	Blue Plans begin filing requests for rate hikes.
June	PID approves several of the rate hikes, though with slightly lower increases than requested, and continues to review other requests.
	The Lewin Group publishes its report, finding that the Blue Plans' surpluses are not excessive and that the funds committed under the Agreement are "at least as generous" as the amounts contributed by Blue Plans in other states.
July	Legislature creates a restricted account for funds from the Agreement and appropriates them for support of the adultBasic program.
September	State begins to receive payments from the Community Health Reinvestment Agreement.
2006 June	adultBasic has over 50,700 enrollees, more than at any previous point. Waiting list for the program is reduced from 127,000 prior to receipt of funding from the Agreement to 48,680.

It was agreed that 60 percent of the contributions each year would be used to cover what was called the Commonwealth Directed Low Income Health Insurance Portion – that is, subsidies to state-approved programs for low-income persons, such as but not limited to adultBasic.

The Agreement included a number of protections for the Plans. It specified that each Plan's year-to-year annual community health reinvestment contribution could not exceed the previous year's contribution by more than 7.5 percent. (Conversely, in the event that the overall contribution decreased by more than 5 percent, the percent allocated to state low-income health insurance programs would be adjusted so that it did not decrease by more than 5 percent of the amount they received the previous year.) The Agreement also specified certain events that would allow the Plans to seek a modification or cause termination of the Agreement. Plans could apply to the Insurance Commissioner for relief if their RBC ratios dropped by more than 100 points within a 12-month period or fell below the Blue Cross Blue Shield Association's early warning level.[41] It also terminated all obligations under the Agreement if the state enacted legislation that required the Blue Plans to make state tax payments or assessments greater than the contributions required under the Agreement. In addition, while the Plans were required to provide information to the PID annually that would allow it to verify the calculation, expenditure, distribution or use of the annual community health reinvestment contributions, the PID was required to keep confidential any information that the Plans considered proprietary.

Finally, the wording of the Agreement avoided making any specific assertions about the Blue Plans' statutory obligations as charitable institutions to engage in community benefit activities. It noted that the Plans had "traditionally and voluntarily" engaged in such activities in the past to benefit the communities in their service areas, and stated that "the Department and the Blue Plans wish to formalize their understanding relating to the existence, nature, and scope of the Blue Plans' Community Activities on a prospective basis." It also said that the Agreement was intended to be "a complete and total resolution of the issue of the Blue Plans' Community Activities (sometimes referred to…as 'social mission,' 'charitable and/or benevolent endeavors,' or 'community activities')" raised in the PID's original request for the Blue Plans to submit applications for approval of their surpluses. The Agreement did not reference or make any statements about the amount of the Plans' surpluses and reserves and whether these amounts should be considered excessive.

Events Following the Signing of the Agreement

Two days after the signing of the Agreement on Community Health Reinvestment, the Insurance Commissioner released a Determination on the applications of the four Blue Plans regarding their surpluses and reserves.[42] The Commissioner claimed statutory authority under the Health Plan Corporations Act[43] to assess the surpluses, and said the Determination "analyzes the adequacy and efficiency of the surplus levels of each of the Blue Plans." She noted, however, that the public comments on the application had led to recognition that Blue Plans' charitable activities should be better defined, and said that this was "addressed in a separate Agreement on Community Health Reinvestment."

With respect to the appropriateness of determining maximum surplus levels, the finding noted:

> One can reasonably argue that each additional dollar of available surplus reduces a Plan's probability of ruin and increases the likelihood that the Plan will be able to meet its obligations. This is essentially a central argument posited by each Blue Plan as to why none of their surplus is "excess."
>
> While this argument is correct on a certain level, it fails to provide any guidance for determining an outcome based on recognized principles of economic efficiency. That is, this argument fails to acknowledge the diminishing nature of the marginal reduction in probability of ruin or default from successive dollars of surplus. It also fails to balance this marginal reduction in risk against the benefits of using these same surplus funds in an alternative fashion. Clearly,

the Blue Plans are not subject to all of the capital market efficiency constraints that promote the efficient allocation and use of capital by publicly traded firms.[44]

The Determination then went on to define what it termed efficient, sufficient, and inefficient levels of surplus.

- An economically efficient level of surplus was one at which Plans did not face solvency issues from routine fluctuations in factors such as underwriting cycles. Plans in this range were not restricted.
- A sufficient level of surplus was one at which any probable drain from unexpected severity or incidence of claims would not reduce it below a safe operating level. Plans in this range would not be allowed to include a five percent risk and contingency factor in their filed premium rates.
- An inefficient level of surplus was one that exceeded what would be considered efficient. Plans in this range would be required to file a report justifying their surpluses or outlining how they would divest themselves of the excess, with such divestiture to occur in a manner and within a period of time deemed reasonable by the Commissioner.

The Determination noted that the acceptable ranges might vary based on a Plan's particular circumstances and thus defined appropriate RBC ratios for each individual Plan. The Determination then found that Highmark Inc., Capital BlueCross, and Blue Cross of Northeastern Pennsylvania had surpluses in the sufficient range, so they would not be permitted to include a risk and contingency factor in their filed rates, while Independence Blue Cross' surplus was in the efficient range. None of the Plans was found to have an inefficient – that is, likely excessive – level of surplus.

In response to critics who claimed that the Plans had underestimated surpluses in their applications by excluding their subsidiaries, the Determination said the PID had treated each individual Plan and its subsidiaries as if they were one corporation, and had consolidated their surpluses when performing its analysis.

The Insurance Commissioner claimed that the release of the Determination on the Blue Plans' surplus levels so soon after the signing of the Agreement on Community Health Investment was a coincidence. However, many advocates assumed that the Blue Plans had signed the Agreement on Community Health Reinvestment in exchange for a determination that their surpluses were not excessive. Beth McConnell, director of the Pennsylvania Public Interest Group said, "The fact that the Insurance Department ruled in a way that the Blues must be thrilled with leads us to be more suspicious of the arrangement between the governor, the Blues, and the Insurance Department. Christmas has come either very late or very, very early."[45]

In March, the Blue Plans began filing requests for rate hikes, which the PID had not been approving pending the determination on their surpluses. Blue Cross of Northeastern Pennsylvania filed a request with the PID for a 20 percent rate increase in its Access Care II plan for small businesses. According to its spokesperson, as reported in the Scranton Times-Tribune, "This is almost two years of pent-up historic demand, plus future projections of care costs." The article went on to say that the fact that none of the Blue Plans had had rate adjustments since 2003 might lead to "high increases later in th[e] year in Blue Cross Plans."[46] Between April and June, Blue Cross of Northeastern Pennsylvania and Highmark Inc. filed rate requests for seven plans that provided health coverage for small businesses or individuals, with some of the requests in the double digits.[47] On June 9, the PID approved several of the rate requests, although some with slightly lower increases than requested, while continuing to review other rate requests for non-group coverage.[48]

On June 13, The Lewin Group published its report, Considerations for Regulating Surplus Accumulation and Community Benefit Activities of Pennsylvania's Blue Cross and Blue Shield Plans, which had been requested by the Pennsylvania legislature.[49] The report concluded that the Insurance Commissioner had set "reasonable bounds" on the Blue Plans' accumulation of surplus and said that the upper

limits would slow premium growth somewhat. The report also found that the Pennsylvania Blue Plans were spending amounts on community benefits that were "at least as generous as, if not more generous than, the amounts allocated by their counterparts elsewhere," and that the funds committed by the Plans under the Community Health Reinvestment Agreement were consistent with both Blue Plans' giving in other states and the value of their tax exemption. It did not recommend further regulation of the Blue Plans' community benefit activities, although it did suggest that the PID establish more specific criteria for acceptable community benefit activities for the portion of the Plans' community health investment that was not dedicated to supporting the adultBasic program.[50]

According to a state official closely involved in negotiating the Agreement, some state legislators expressed concern after the Agreement was announced, claiming that it exceeded the executive's authority to allocate funds.[51] The Governor's office then spent six months negotiating with the legislature over its implementation. Finally, in the state budget enacted in July 2005, the legislature created a restricted account for the Commonwealth Directed Low Income Health Insurance Portion of the Agreement and appropriated the funds in the account to the Insurance Department to support the adultBasic program.[52]

While advocates were disappointed in the Insurance Commissioner's ruling on the Blue Plans' surpluses, most interviewed for this report saw the increased funding for the adultBasic program as a significant advance. The state began receiving payments from the Agreement in September 2005. According to the PID, since that time the number of adultBasic enrollees has increased from 35,000 to over 50,700. The waiting list has been reduced from 127,000, prior to the infusion of new funds, to 48,860.[53]

Since the Pennsylvania Agreement was signed, scrutiny of Blue Plans' surpluses has continued in other states. In Washington, the insurance commissioner recently noted a "disconnect" between "premiums [that] continue to rise at the same time the [health insurance] companies are continuing to boast some of the largest surpluses in their history."[54] A state legislator also introduced a bill to limit the Blue Plans' reserves to two months of paid claims, with activists considering putting the question on the ballot as a citizens' initiative.[55] Earlier this year in Minnesota, Attorney General Mike Hatch released the results of a compliance review of the state's Blue Plan, which said that the company was stockpiling excess revenues rather than reducing premiums for its subscribers. Hatch disputed the insurer's reported reserves of $640 million, saying it had wrongly excluded $416 million of company assets. He estimated the actual surplus exceeded $1 billion. He also cited the company's excessive increases in administrative costs and overly generous executive compensation and benefits. The review recommended that at least $400 million of Blue Cross' excess net worth be returned to its policyholders, that the state agency in charge of regulating the company be more diligent in its oversight, and that the insurer's board be made more accountable to subscribers and the public.[56] Lawmakers in New Jersey have also questioned whether Horizon Blue Cross Blue Shield should be forced to share some of the $1.25 billion it holds in reserves. Three legislators introduced a bill that would give the state's insurance commissioner the authority to examine the Plan's reserves and transfer any portion deemed excessive to a state fund dedicated to covering the uninsured.[57]

Finally, following the long struggle in Washington, D.C. over CareFirst's surpluses and charitable obligations, Council member Jim Graham introduced a measure requiring the Mayor to periodically examine the adequacy of surpluses of insurers covered by the Hospital and Medical Services Corporations Regulatory Act and, if he determined the surplus was "unreasonably high," order the corporation to submit a plan for distribution of the excess in a fair and equitable manner.[58] Graham is now considering revising the measure to model it closely on the Community Health Reinvestment Agreement in Pennsylvania.

Discussion

The Lewin Group report noted that while several states have requirements regarding hospitals' and managed care plans' charitable contributions, few have gone beyond regulating access to coverage to adopt formal community benefit standards for nonprofit insurers. The report cited Maryland as having the most specific requirements, which mandate that a plan spend amounts equal to the value of its premium tax exemption in activities to benefit the public interest.[59] It also said that while most states regulate minimum insurance surplus and reserve levels to ensure financial solvency, only four have chosen to regulate maximum levels of surplus accumulation. However, one of these states repealed the regulations in 2005 (Minnesota) and one did not enforce them (New Hampshire). In the other two states (Michigan and Hawaii), the Blue Plans' surpluses have never reached the mandated maximum.[60]

The Community Health Reinvestment Agreement in Pennsylvania set some important precedents. While it did not assert a statutory obligation for the Blue Plans' charitable contributions, it did set specific levels of contribution and specific requirements for how the money would be allocated for the life of the Agreement. In addition, while the Insurance Commissioner did not find that any of the Blue Plans had excessive surpluses, she did assert the PID's legal authority to establish surplus operating ranges, including those above which surpluses are likely excessive.

In other states where Blue Plan assets have been used to support community benefit programs, access to these funds has resulted from Plan conversions to for-profit status and the transfer of assets either to charitable foundations or directly to the state. Discussions of the Blue Plans' surpluses and charitable obligations elsewhere have led to investigations and the introduction of legislation, but most of the proposed measures have not been enacted. The Community Health Reinvestment Agreement in Pennsylvania is notable because it did not result from either a Plan conversion or from legislation, but from a voluntary, negotiated agreement between the state and the insurers.

The discussions and developments that preceded the signing of the Agreement depended on certain elements that may not apply in all states. For example, not all states statutorily deem their Blue Plans "charitable and benevolent" and, in Pennsylvania, this legal definition was important in discussions of whether the Plans had charitable obligations. However, the successful outcome in Pennsylvania depended as much on the political forces in play as on the state's existing statutes and regulations and, as previously noted, the final Agreement did not state that the Plans were legally required to make community benefit contributions.

One key component in reaching an agreement was the presence of strong and sustained efforts by advocates to bring the issue of the Blue Plans' reserves to public attention. The groups included organizations representing the unemployed, children and youth, retirees, unionized workers, and small employers. Over a period of years, they raised public awareness about the surpluses and put pressure on state officials to take action. Such advocacy was probably necessary, given the high degree of political influence held by the opposing forces.

At the same time, events in Pennsylvania highlighted the difficulty of evaluating the appropriateness of insurers' surpluses through a public process. The Plans maintained that the information necessary to make such an evaluation was proprietary, and they were willing to go to court to defend this position. While they did not achieve a complete legal victory, most of the specific financial information they submitted to the state to justify their surpluses was never made public, which made it harder for advocacy groups to challenge their assertions that the surpluses were not excessive. In addition, arguments over the appropriate methods for deciding whether reserves were excessive were highly technical and difficult for the public at large to understand.

In the face of these difficulties, achieving an agreement required strong leadership, which in Pennsylvania came from the Governor's office. State officials hammered out the agreement with the Blue Plans "behind closed doors," without input from either the legislature or the public. Without strong executive action, it is unlikely that an agreement would have been reached. Howev-

er, the history of negative publicity surrounding the Plans and the state's pending decision on the appropriateness of the Plans' surpluses may have provided state officials with the leverage necessary to push the issue to a resolution.

Attention to the financial activities of non-profit insurers is likely to continue. States are faced with growing numbers of uninsured residents as health insurance premiums rise and comprehensive health insurance becomes increasingly unaffordable. Many states have begun to scrutinize both non-profit hospitals and health insurers to determine if their practices conform to their charitable missions. The Community Health Reinvestment Agreement in Pennsylvania represents one state's initiative to establish the community benefit obligations of non-profit insurers. Other states may want to seriously consider this type of Agreement as they look for ways to ease the health coverage crises in their own communities.

Endnotes

1 The four plans that signed the Agreement were Capital BlueCross, Highmark Inc., Independence Blue Cross, and Hospital Service Association of Northeastern Pennsylvania d/b/a Blue Cross of Northeastern Pennsylvania.

2 Agreement on Community Health Reinvestment by and among the Insurance Department of the Commonwealth of Pennsylvania and Capital BlueCross, Highmark Inc., Independence Blue Cross, and Blue Cross of Northeastern Pennsylvania, February 2, 2005. The Agreement is available at http://www.ins.state.pa.us/ins/cwp/view.asp?A=11&Q=543490.

3 Robinson, J., "For-Profit Non-Conversion and Regulatory Firestorm at CareFirst BlueCross BlueShield," Health Affairs, Volume 23, No. 4, July/August 2004.

4 Robinson, J., "The Curious Conversion of Empire Blue Cross," Health Affairs, Volume 22, No. 4, July/August 2003.

5 The Lewin Group, Considerations for Regulating Surplus Accumulation and Community Benefit Activities of Pennsylvania's Blue Cross and Blue Shield Plans, June 13, 2005, p. 3.

6 Robinson, J., "For-Profit Non-Conversion and Regulatory Firestorm at CareFirst BlueCross BlueShield," op.cit.

7 Ibid.

8 DC Appleseed Center, CareFirst: Meeting Its Charitable Obligation to Citizens of the National Capital Area, December 6, 2004.

9 House Bill 1441 and House Bill 1412, General Assembly of North Carolina, Session 2005.

10 Pack, T. "Not-for-profit BlueCross has $1B in bank, insurer says it's making good use of reserves; critics appalled at its size," Tennessean, August 14, 2005.

11 Seifert, R. and C. Pryor, Unintended Consequences: An Update on Consumer Medical Debt, The Commonwealth Fund, http://www.cmwf.org/usr_doc/pryor_medicaldebt_749.html.

12 Decision and Order rendered by the Insurance Commissioner of Pennsylvania, November 27, 1996.

13 40 Pa. C.S.A. §§6101-6127, 6301-6335. For specific language on these entities' charitable nature, see in particular 40 Pa. C.S.A. §6103(b), §6307(b). Cited in Determination Before the Insurance Department of the Commonwealth of Pennsylvania re Applications of Capital BlueCross, Highmark Inc., Hospital Service Association of Northeastern Pennsylvania d/b/a Blue Cross of Northeastern Pennsylvania and Independence Blue Cross for Approval of Reserves and Surplus, Misc. Docket No. MS05-02-006, February 9, 2005.

14 Stark, K. "Local Revenues Fuel Blue Cross Ventures; Health Workers Ask if They and Patients Financed Costly Expansion; Blue Cross Says Growth Did Not Affect Rates," Philadelphia Inquirer, September 17, 2000. Stark, K. "Blue Cross No Longer Has Charitable Priority," Philadelphia Inquirer, September 18, 2000.

15 Herman v. Highmark Inc. and Herman v. Capital BlueCross, June 29, 2001. Ciamaichelo and Rob Stevens, Inc. v. Independence Blue Cross, May 1, 2001. Petty v. Blue Cross of Northeastern PA, April 23, 2002.

16 Determining whether a company's reserves are too high remains complicated and controversial. Two benchmarks are regularly cited for required minimum surpluses; one was established by the Blue Cross Blue Shield Association for its member organizations, and the other by the National Association of Insurance Commissioners. However, there is not a consensus about how to determine when surpluses are excessive. The issue is further complicated by two different approaches to examining the balance sheet – Generally Accepted Accounting Principles (GAAP), which views the organization as a going concern, and Statutory-basis accounting (STAT), which views assets and liabilities as if the firm were under threat of insolvency or liquidation. Hence, the difference between assets and liabilities in GAAP is greater than STAT. In Ciamaichelo and Rob Stevens, Inc. v. Independence Blue Cross, the plaintiffs cited a report by the Pennsylvania Medical Society that Blue Cross of Northeastern Pennsylvania, with a surplus of $392 million, would be able to pay 330 days' worth of claims, six times longer than any other private health insurance company in the state.

17 Ditzen, L. S. "Cash-rich insurers sit on billions in surplus," Philadelphia Inquirer, February 24, 2002. "Blues clues: Insurers' surplus signals health-care woes," Philadelphia Inquirer, February 27, 2002. Stein, J. "Message to Blues: Your cheatin' heart will tell on you," Philadelphia Inquirer, March 25, 2002.

18 The Lewin Group, op.cit., pp. 3-4.

19 Buck, E., testimony before the Pennsylvania Insurance Department on Behalf of the Builder Service, Inc. on Surplus and Reserve Levels of Hospital Plan and Professional Health Service Plan Corporations, September 4, 2002.

20 Sonderman, J. "Blues make pitch for privacy," The Scranton Times-Tribune, July 13, 2004.

21 Reserve and Surplus Levels of Hospital Plan and Professional Health Services Plan Corporations: Application; Notice 2004-01, Pennsylvania Bulletin, 34

Pa.B. 458, January 16, 2004.

22 Letter from Patricia Wong, Supervising Counsel, Capital BlueCross to Diane Koken, Pennsylvania Insurance Commissioner, August 31, 2004, available at http://www.ins.state.pa.us/ins/cwp/view.asp?A=11&Q=543490.

23 Independence Blue Cross, Response to Comments Regarding IBC Reserves/Surplus Application, October 4, 2004, available at http://www.ins.state.pa.us/ins/cwp/view.asp?A=11&Q=543490.

24 Letter to Pennsylvania Insurance Department from Blue Cross of Northeastern Pennsylvania ("BCNE-PA"), Description of Social Mission Activity, March 22, 2004, available at http://www.ins.state.pa.us/ins/cwp/view.asp?A=11&Q=543490.

25 Comments before the Pennsylvania Insurance Department in re Reserve and Surplus Levels of Hospital Plan and Professional Health Services Plan Corporations, Notice 2004-01, Philadelphia Unemployment Project et al., September 24, 2004.

26 It is important to note that subsequently, the PID Determination explained that the surpluses of the parent companies were already included in the surpluses of the subsidiaries. See page 26 within the Determination Before the Insurance Department of the Commonwealth of Pennsylvania re Applications of Capital BlueCross

27 Kirsch, L. IMR Health Economics, LLC, Report to the Pennsylvania Insurance Department Concerning the Applications of Blue Cross Plans for the Approval of Reserves and Surpluses, September 23, 2004. In response to the Blue Plans' responses to comments, Kirsch also submitted a supplementary report in October. Kirsch, L. Supplemental Report to the Pennsylvania Insurance Department Concerning the Applications of Blue Cross Plans for the Approval of Reserves and Surplus, October 29, 2004.

28 The Lewin Group, op.cit.

29 40 Pa. C.S.A. §§6101-6127, 6301-6335. Cited in Determination Before the Insurance Department of the Commonwealth of Pennsylvania re Applications of Capital BlueCross, et al, op.cit.

30 The Lewin Group, op.cit., p. 26.

31 Ibid., p. 28.

32 Reserves refer to funds held to cover known claims costs in the present as well as the estimated future costs of current subscribers. Surpluses refer to the difference between insurers' total assets and total liabilities or, in other words, their net worth.

33 40 PS §§3801-3815.

34 Buck, E. op.cit.

35 The Lewin Group, op.cit, p. 7.

36 Health RBC Act, 40 P.S. §§221.1-B-221.15-B.

37 40 Pa. C.S. Chapters 61 and 63. Also see footnote 17 within the Determination Before the Insurance Department of the Commonwealth of Pennsylvania re Applications of Capital BlueCross, et al, op.cit.

38 Sonderman, J. "Blue Cross defends reserves," The Scranton Times-Tribune, August 11, 2004.

39 The Pennsylvania Agreement shares its name with the Community Reinvestment Act, which places on banks "a continuing and affirmative obligation to help meet the credit needs of the local communities in which they are chartered." (12 U.S.C. §2901(a)(3) (2001)) To fulfill this obligation, banks may for example provide community development loans and loans to borrowers at different income levels. According to Pennsylvania state officials, the similarity of the names was coincidental; the Pennsylvania Agreement was based on the charitable obligations of the Blue Plans as non-profit insurers, while the banking regulation applies to all banks, for- and non-profit. However, there is no clear reason why the thinking behind the banking regulation might not apply to health insurers as well. It raises a question of whether all insurers, not just non-profits, should be obligated to provide some form of benefits to the communities in which they do business.

40 Some of these funds were not "new" funds, because the Agreement superseded Highmark's previous agreement with the state over community benefit contributions. Highmark projected outlays of $94 million for community benefits in 2004, double its formal obligation under the 1996 order, and $75 million in 2005. The Lewin Group, op.cit., p. 32.

41 The Blue Cross Blue Shield Association sets an "early warning" RBC ratio at 375 percent of the authorized control level (ACL) of capital for its members, in contrast to the National Association of Insurance Commissioners level of 200 percent for carriers generally.

42 Determination in re Applications of Capital BlueCross, Highmark Inc., Hospital Service Association of Northeastern Pennsylvania d/b/a Blue Cross of Northeastern Pennsylvania and Independence Blue Cross for Approval of Reserves and Surpluses, February 9, 2005, available at http://www.ins.state.pa.us/ins/cwp/view.asp?A=11&Q=543490.

43 40 Pa. C.S.A. §§6101-6127, 6301-6335.

44 Determination in re Blue Cross Plans Applications, op.cit., pp. 14-15.

45 Sonderman, J. "Insurers need not pay back reserves," The Scranton Times-Tribune, February 10, 2005.

46 Sonderman, J. "Blues seek approval of 20% hike for Access Care II," The Scranton Times-Tribune, March 16, 2005.

47 Sonderman, J. "State mulling Blue Cross rate-hike requests," The Scranton Times-Tribune, June 5, 2005.

48 Sonderman, J. "Blues awarded lower rate hike," The Scranton Times-Tribune, June 9, 2005.

49 The Lewin Group, op.cit.

50 Ibid, page viii.

51 Personal conversation with Rosemarie Greco, Pennsylvania Office of Health Care Reform, August 3, 2006.

52 Pennsylvania General Assembly, House Bill 815.

53 Figures from the Pennsylvania Insurance Department web site www.ins.state.pa.us, June 2006.

54 "Finding Their Own Way," State of the States, State Coverage Initiatives, January 2006, p. 40.

55 Galloway, A. "Health insurers' rising reserves draw scrutiny," Seattle Post-Intelligencer, January 19, 2006.

56 Attorney General Hatch Releases The Blue Cross and Blue Shield of Minnesota Compliance Review, Office Found Non-Profit Had Little Incentive to Freeze or Reduce Policy Holder Premiums, April 27, 2006, http://www.ag.state.mn.us/consumer/PR/PR_060407BCBSMComplianceReview.htm.

57 "Lawmakers: Horizon should share reserve," Daily Record, May 12, 2006.

58 Medical Insurance Empowerment Act of 2005.

59 Maryland Code, Insurance, §14-106, cited in The Lewin Group, op.cit., p. 33.

60 Ibid., p. ii.

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