

How Much Is Too Much: Have Nonprofit Blue Cross Blue Shield Plans Amassed Excessive Amounts of Surplus?

EXECUTIVE SUMMARY

In the last decade, nonprofit Blue Cross and Blue Shield (BCBS) plans have set aside billions of dollars in surplus, even as they raised rates for many customers. Surplus is the excess of a company's assets over liabilities – essentially a health plan's retained profits—which plans hold to protect the company and its policyholders and providers from financial losses. Nonprofit BCBS plans, including community-owned charitable plans and subscriber-owned mutual plans, held more than \$32 billion in surplus at the end of 2008.

Those surplus funds are built primarily with consumers' premium dollars, and insurers typically include a targeted contribution to surplus in rate increases. Surplus can be used to moderate premium increases, yet we found that some financially strong BCBS plans with large surpluses have continued to seek double-digit rate increases.

In our sampling of ten diverse nonprofit BCBS plans, we found that 7 out of 10 of the plans held more than three times the amount of surplus that regulators consider to be the minimum amount needed for solvency protection. For example, as of the end of 2009, BCBS of Arizona has surplus more than seven times the regulatory minimum. Health Care Service Corporation, a mutual insurer doing business as BCBS of Texas, Illinois, New Mexico and Oklahoma, has five times the regulatory minimum. Meanwhile, over the past three years both insurers continued to raise their rates.

In this report, Consumers Union provides background information, analysis and policy recommendations on many of the key issues concerning health insurer surplus.

CU's recommendations include:

- States should rigorously reexamine the purpose of surplus and establish minimum and maximum ranges of surplus based on current solvency risks and other appropriate factors, including affordability for consumers.
- Other non-solvency purposes for surplus, such as business "growth and development" should be transparently presented and weighed against the necessity to keep premiums affordable.

- States should analyze surplus as part of their review process for rate increases. When a company has more surplus than is necessary for solvency protection, regulators should consider disapproving additional contributions to surplus, which are included in premiums increases. In some cases, it may be appropriate to reject rate increases when previously accumulated surpluses are sufficient to absorb potential underwriting losses.
- If surplus is found to be excessive, insurers should hold the excess in a rate stabilization reserve designed to offset rate increases, refund excess amounts to policyholders, or for nonprofit plans, spend the money for charitable purposes such as community health programs or affordable-coverage initiatives.

Introduction

American consumers and businesses have experienced rising costs of their health care for decades – often up to twice the rate of inflation for all other products. Before, during, and after the long legislative battle to pass major reforms of the health insurance system, polls consistently showed that consumers and businesses are more concerned about rising costs than any other of the numerous issues related to health care.

The newly enacted Patient Protection and Affordable Care Act (PPACA) does not contain direct cost controls on the price of health care goods and services. Instead, to slow cost growth, the Act relies on a variety of discrete changes intended to improve competition and transparency and to make our health care delivery system more cost-effective. With respect to rising premiums, the Act continues to leave review of rate increases to the states, which have traditionally had this responsibility. The new law does require the federal Department of Health and Human Services, in conjunction with the states, to establish a process for annual review of “unreasonable” rate increases and provides grants to states to improve their rate review. But the authority to approve or deny insurers’ rate increases remains with the states, if they choose to exercise it.

Currently, a majority of states have given their regulators the responsibility to review and approve or deny some rates before increases go into effect; other states allow insurers to increase rates without pre-approval but give regulators authority to retroactively review increases. A handful of states merely require insurers to file rates “for information only.”

Because the PPACA requires all Americans to have health insurance by 2014, it is imperative that states strive to maintain affordable premiums. This will require states to carefully scrutinize insurers’ proposed rate increases to ensure they are absolutely necessary for maintaining the solvency of the system. States must exercise or expand their authority to refuse to allow rates to rise beyond that.

Surplus is the difference between a health insurance company's assets and liabilities. The key function of surplus is to protect the plan against unexpected losses.

In this context, one issue that is becoming increasingly important as states use or improve their rate review is how much surplus an insurer should hold for solvency protection. Surplus is the difference between a health insurance company's assets and liabilities. In other words, surplus is primarily retained profits that are built with consumers' premium dollars and held by insurers.¹ The primary reason that insurers hold surplus is to protect the company against unexpected financial losses. Surplus may also be referred to as "net worth" or "capital and surplus."²

State regulations require all health insurers to hold a minimum amount of surplus to protect the solvency of the company and its ability to pay its members' medical claims in the event of financial losses. But while states require a minimum amount of surplus, most state laws do not set an upper limit on how much surplus an insurer can accumulate and hold. And in most states, regulators do not have an explicit mandate to consider an insurer's surplus level when deciding whether to approve or deny rate increases.

With few constraints on how high surplus can go, many health insurers have amassed millions or even billions of dollars in surplus, far beyond the required minimums. Even as they have become financially strong and able to weather a potential underwriting loss with minimal danger of insolvency, many insurers have continued to seek double-digit rate increases on individual market or small business consumers, and have continued to build even larger surpluses with premium dollars. In the face of the ever increasing cost burden on consumers, the question arises: how much surplus is too much?

This issue is particularly salient with respect to nonprofit Blue Cross Blue Shield plans because many nonprofit plans are chartered as "charitable and benevolent" organizations with a mission to provide affordable health care. Other nonprofit BCBS plans are organized as mutual companies that are owned by their policyholders. As nonprofits, the "profits" of these companies must be used for the benefit of their members or the community-at-large. BCBS plans potentially could use portions of surplus to reduce the need for large rate increases, but evidence suggests that they do not use these large stores of capital to moderate premiums.

In a few examples, Consumers Union found:

- Blue Cross Blue Shield of Arizona raised rates for its individual market customers between 14.5% and 19.4% in 2007, 13.1% and 15% in 2008, and 8.8% and 18.4% in 2009. From 2007 to 2009, the company grew surplus from \$648.3 million to \$717.1 million, an amount more than seven times the regulatory minimum.
- Regence Blue Cross Blue Shield of Oregon raised rates on some individual policies an average 25.3% in April 2009 and 16% in April 2010. As

reported at the end of 2009, Regence has \$565.2 million in surplus, about 3.6 times the regulatory minimum.

- Blue Cross Blue Shield of North Carolina raised rates on some individuals and families 18.44% in 2008, 8.5% in 2009, and 12.24% in 2010, while growing surplus to \$1.4 billion in 2009, about 4.5 times the regulatory minimum.
- Health Care Service Corporation (HCSC), a mutual insurer doing business as Blue Cross Blue Shield of Texas, Illinois, New Mexico and Oklahoma, raised rates in Texas on some individual and family plans multiple times in a year from 2007 to 2010. Some Blue Cross Blue Shield of Texas rate increases exceeded 20%. In Illinois, the company raised rates 10.2% in 2007, 18% in 2008, and 8.4% in 2009 for some customers, and in New Mexico, some customers faced annual increases of more than 20% since 2007. At the time of these increases, HCSC's surplus grew from \$6.1 billion in 2007 to \$6.7 billion in 2009, up from \$4.3 billion just four years earlier in 2005. The company's surplus is five times the amount that regulators consider to be the minimum necessary for solvency protection.

This report provides background information, analysis, and policy recommendations on many of the key issues concerning health insurer surplus. While this brief focuses on nonprofit BCBS plans, many of the principles and recommendations discussed may apply to for-profits as well.

Topics covered in this brief include:

- Why surplus is an important issue for consumers.
- How states currently regulate health insurer surplus.
- Aside from solvency protection, other purposes that nonprofit insurers identify as creating a need to maintain a large surplus. How does this affect premiums?
- Calculations of target surplus levels: is the methodology out of date? Are there signs of excess surplus in the system?
- Forums for addressing surplus adequacy: the states, the National Association of Insurance Commissioners, and the federal role.
- Recommendations for action.

Why Is Surplus An Important Issue For Consumers?

One out of three Americans with private health coverage is insured by a nonprofit Blue Cross and Blue Shield (BCBS) plan.³ Those plans held more than \$32 billion in surplus funds on their balance sheets at the end of 2008, an

average of about \$897 million per plan.⁴ That represents a sharp increase over levels reported just a few years earlier.

The growing amount of surplus, particularly among nonprofit BCBS plans, has precipitated debate about how much surplus protection is adequate and cost-effective and how much surplus is “excessive.” This debate has already begun to bubble up in state legislative and regulatory proceedings. The topic promises to come under even greater scrutiny as the rate review and insurance access provisions of the federal health reform law are implemented and as insurance regulators continue to confront the double-digit rate hikes sought by some plans.

All health insurance companies need surplus to reduce the likelihood of plan insolvency and to ensure that unforeseen contingencies do not render a company unable to meet its obligations to its policyholders and providers. Apart from a clear interest in assuring insurers’ financial safety, consumers also have an interest in nonprofits’ surplus because the funds are generated wholly or in large part out of subscriber dollars. While maintaining sufficient capital on hand to deal with potential financial difficulties is universally acknowledged as an essential aspect of consumer protection, accumulating more surplus than is necessary may impose an unwarranted financial burden on subscribers.

When collected premiums exceed medical claims and administrative expenses, the difference (profit) is added to surplus.

Subscribers contribute to surplus by paying a “risk and margin” component of their monthly premiums, sometimes referred to as a “contribution to surplus” or “contingency load.” The amount of premium targeted as a contribution to surplus usually is between 1% and 6% of premium, although it may be higher or lower in individual cases. Thus, a contribution to surplus is built into subscribers’ rates. When, in actual experience, the rates result in premiums exceeding medical claims and administrative expenses, the difference (profit) is added to surplus. Subscribers may also fund surpluses indirectly. When a health plan invests its profits in a portfolio of stocks and bonds or generates capital gains or losses on other business investments, these activities add to or reduce surplus. In sum, almost all surplus of nonprofit plans originates from subscriber dollars.⁵

State insurance regulators who oversee surplus funds typically have as their primary objective financial safety, namely protecting the solvency of insurance companies – making sure that plan subscribers and health care providers are not left with unpaid claims. As a result, their main focus is on setting and monitoring minimum surplus levels. And while all can agree that financial safety is of pre-eminent importance, regulators also need to become more attuned to the affordability of health insurance for consumers. They will have to broaden the scope of their financial review to make sure that accumulated surplus funds provide good value and are no more costly than necessary to provide reasonable financial safeguards.

How Is Surplus Currently Regulated?

The essential reason that nonprofit BCBS plans amass surplus is to protect their subscribers and health care providers against the risk of the plans' default, arising, primarily, through a sustained under-estimate of claims expenses. According to Scott Serota, the President and Chief Executive Officer of the Blue Cross and Blue Shield Association, "Blue Cross and Blue Shield companies maintain strong financial capital for one purpose – to ensure their ability to pay members' medical claims in good times and bad times..."⁶ This purpose – hedging against unpredictable and unanticipated claims – is commonly called solvency protection.

Safeguards against the insolvency of insurance plans have long been at the forefront of regulatory policy toward surplus requirements. The insolvency of the West Virginia nonprofit BCBS plan in 1989-1990 galvanized intense efforts by state regulators to develop financial benchmarks, analytic tools, and reporting requirements to assure capital adequacy and provide an early warning of impending financial distress. The goal was to institutionalize a series of graduated regulatory responses that would address potential insolvencies before they boiled over.

The National Association of Insurance Commissioners (NAIC) took the lead, putting in place a set of model statutes and regulations incorporating a formula for minimum capitalization requirements, a tracking and enforcement system, and early warning triggers. With technical support from actuarial professionals, the NAIC developed a framework for determining minimum requirements for risk-based capital (RBC) for various types of insurers. The NAIC promulgated the Risk-Based Capital for Health Organizations Model Act in 1998 to link minimum surplus requirements to each carrier's unique risk and operational profile. Since then, more than 30 states have adopted statutes, regulations or bulletins that follow or are similar to the NAIC model for minimum surplus.⁷

Under the NAIC model, a company is assigned a minimum RBC level (i.e., a minimum amount of surplus) based on its exposure to various types of risk. If surplus for a company ever falls to this minimum RBC level, regulators are authorized to take control of the company – thus, the level is referred to as the "authorized control level" or RBC-ACL.

State regulators use five action levels to monitor the company's risk-based capital: (1) when capital and surplus is 200% or more of RBC-ACL, no action is taken; (2) when it is between 150% to 200% of RBC-ACL, the company must submit a financial plan to regulators describing what actions it will take to increase surplus and improve financial strength; (3) when it is between 100% and 150% of RBC-ACL, regulators have authority to examine the company and issue corrective orders to address financial problems; (4) at 70% to 100% of RBC-ACL regulators have authority to take control of the company; (5) if total capital and

surplus is less than 70% of RBC-ACL, regulators are mandated to take control of the company.

Applying those risk-monitoring levels, 200% of RBC-ACL is commonly known as the minimum level of surplus that a health insurance company must hold because it is the point above which no regulatory action will be taken. The Blue Cross and Blue Shield Association requires BCBS companies to hold at least 375% of RBC-ACL to avoid triggering more active monitoring by the Association. If RBC-ACL falls below 200%, the Association may revoke the company's right to use the Blue Cross Blue Shield trademarks.⁸

The NAIC and the developers of the RBC system have consistently taken the position that the capital benchmark represents a minimum index of safety, not an optimal amount of surplus for health insurers. They have also argued that one carrier's RBC score cannot be compared directly with another's to reflect relative degrees of financial security. The RBC "score" represents, as a percentage, each company's actual surplus compared to RBC-ACL, the minimum required amount of surplus.

In addition to minimum surplus required under the NAIC model, states may have other minimum net worth requirements. Massachusetts, for example, uses the NAIC model and, in legislation enabling the merger of Blue Cross and Blue Shield, required the company to maintain a surplus not less than five percent of all expenses and insured claims incurred in each year.⁹

As stated above, there is a growing concern that current levels of surplus amounting to multiples of the NAIC benchmark (200% RBC-ACL) have gotten out of hand – more so in certain plans than others. For this report, we collected data for the period 2001 to 2009 for a mix of ten nonprofit BCBS plans that are incorporated as traditional public charities. The plans selected are of various sizes (ranging from large, statewide plans such as Blue Cross Blue Shield of Alabama to small sub-state plans such as Blue Cross of Northeastern Pennsylvania) and from a mix of states from Oregon to Massachusetts.

Table 1 presents the surplus in millions of dollars and RBC scores maintained by the ten plans in our sample. Each score can be compared against the NAIC minimum benchmark of 200% RBC-ACL, the point of triggering increased regulatory monitoring. In 2009, at the top of the range, the Arizona plan held surplus more than seven times the NAIC benchmark level; at the bottom, Alabama had about 2.5 times the NAIC's benchmark for RBC.

TABLE 1 - TOTAL SURPLUS (\$ MILLIONS) AND RBC SCORES (PERCENTAGES) OF TEN NONPROFIT BCBS PLANS, 2001-2009

BCBS Plan	2001	2002	2003	2004	2005	2006	2007	2008	2009
Alabama	433.7	452.3	514.6	554.4	587.2	694.6	744.5	656.4	649
	754%	694%	720%	673%	664%	747%	773%	581%	497%
Arizona	159.9	213.7	294.9	367.1	438.5	573.9	648.3	653.3	717.1
	904%	1112%	1256%	1451%	1464%	1567%	1568%	1565%	1455%
Massachusetts	525.7	616.1	887.6	1091	465.4 ¹⁰	628.2	705.7	614.2	723.9
	481%	491%	616%	620%	543%	695%	708%	640%	724%
Michigan	1300.6	1532.3	1898.1	2243.7	2461	2501.4	2406.1	2227.4	2562.2
	493%	573%	633%	793%	892%	787%	691%	659%	650%
New York (Excellus)	393.9	473.2	629	777.8	960.8	1132.3	1187.2	857.9	965.1
	361%	441%	507%	563%	640%	664%	643%	472%	542%
North Carolina	439.1	485.7	743.2	865.5	980.2	1110.9	1285.9	1258.7	1423.8
	580%	648%	963%	930%	916%	893%	936%	857%	911%
Oregon (Regence)	266.3	235.6	282.2	366.4	466.9	533.5	552.2	486.1	565.2
	446%	385%	478%	706%	964%	820%	745%	563%	724%
Pennsylvania (Northeastern)	409.2	370.9	404.7	393.4	409.9	461.7	462.3	338.7	250.7
	1051%	1103%	1007%	946%	921%	876%	814%	711%	557%
Tennessee	614.1	602.5	648.4	787.2	908	936.1	1152.6	903.9	1137.1
	1098%	1022%	1181%	1198%	1206%	1100%	1311%	891%	1024%
Wyoming	68.4	67.1	81.1	87	94.9	109.6	118.5	112.1	144
	1154%	1153%	1129%	1101%	1136%	1222%	1170%	1237%	1411%
Average RBC Score	732%	762%	849%	898%	935%	937%	936%	818%	850%

Note: Moderating RBC scores from 2007 to 2008 primarily reflect falling levels of investment income and shifts in non-admitted assets in insurers' portfolios.

We can see from Table 1 that some plans are holding large amounts of surplus relative to their required minimum risk-based capital.¹¹ In 2001, the ten plans held a total of \$4.61 billion in surplus, for an average of \$32.90 per member per month. By 2009, surplus had risen sharply to \$9.14 billion. This represented an average of \$71.23 per member per month.

There is currently no widely-accepted standard for determining when a health insurer's surplus is excessive and inefficient.

While the NAIC has established a protocol and system for regulating minimum surplus requirements, it has yet to address the corresponding question of appropriate maximum levels. There is currently no widely-accepted standard governing the level at which a health insurer's surplus would become excessive and inefficient. In recent years, however, the idea of enacting a reasonable surplus ceiling as the logical counterpart of a minimum surplus benchmark has begun to gain traction. Growing interest in a surplus ceiling has emerged from an amalgam of factors:

- The first factor is that surplus is accumulated from subscriber dollars, thereby contributing to rising premiums. Some experts had expected higher surpluses to function as a rate stabilizer; regrettably, there has been little evidence to support this proposition.
- The second stems from the growing gap between actual surplus levels and the much lower minimum surplus levels designated by the NAIC's model system. In some instances actual BCBS plan surpluses have exceeded the NAIC "safe" level by 5-6 fold or more, thereby raising questions about excessive surpluses. A related concern is the amount of the cushion between surplus levels and losses actually experienced by insurers.
- A third factor is that as nonprofit BCBS plan surpluses have trended higher, not all of those plans, particularly those chartered as charitable and benevolent organizations, have made commensurate contributions to certain charitable needs, especially affordable healthcare for the uninsured.

A handful of states have moved to limit "excessive" surplus. Pennsylvania pioneered one approach in 2005. In an opinion regarding the surplus of the state's four BCBS plans, the state Insurance Department developed what it viewed as sufficient RBC ratio ranges for each nonprofit BCBS insurer. The Department found that a sufficient surplus range for the two larger BCBS plans was 550% to 750% of RBC-ACL, while a sufficient range for the two small plans was 750% to 950%. Under the Department's order, the plans are not permitted to incorporate a contribution to surplus into premiums when they are operating within these ranges.

Specifically, the Department established four categories related to these ranges: surplus in excess of the plan-specific sufficient range is defined as "inefficient" or "excessive" and, unless justified, the plan must reduce surplus to the sufficient range; one step down, when surplus is within the "sufficient" range, no "risk and contingency factors" (i.e., contributions to surplus) will be permitted in premium rates; a step below the sufficient range, surplus will be deemed "efficient" and the plans will be allowed to incorporate contributions to surplus in rates; and below that, surplus will fall under benchmark levels and the plans will be exposed to regulatory intervention.¹²

Maryland has enacted a statute which authorizes its Insurance Commissioner to determine if a nonprofit company's surplus is "excessive" and to order the company to create a plan for distributing any excess surplus to subscribers.¹³ Michigan has capped surplus for BCBS of Michigan at 1000% of RBC-ACL, but advocates have argued that the cap is not an appropriate standard for adequate surplus.¹⁴

In addition to these efforts to control surplus growth, some states with legal authority to approve or disapprove rate increases for certain types of BCBS business (e.g. coverage for individuals not insured by employer plans) have used their rate review process to zero in on the component of premium that goes directly to build surplus or profit. In Rhode Island, regulators have repeatedly denied Blue Cross and Blue Shield of Rhode Island's request for contributions to surplus of 2.5%. In two examples in 2007 and 2008, the state's Health Insurance Commissioner held that such contributions were not necessary when the non-group subscribers subject to the increase were "particularly vulnerable to the high costs of health care," and when Blue Cross surplus was above minimum requirements at more than 24% of premium revenue for the prior year.¹⁵

Similarly, as part of a recent rate decision, the Maine Insurance Commissioner denied Anthem Blue Cross and Blue Shield of Maine a profit margin in its proposed rate increase on the grounds that previously accumulated surpluses were sufficient to absorb any potential underwriting losses and that it was appropriate to balance Anthem's profit expectation against the financial hardship the increase would impose on subscribers. The Commissioner's decision was affirmed on appeal.¹⁶

Outside of those actions, most states do not put limits on how much surplus insurers can accumulate and most do not have an explicit mandate to consider whether surplus levels are sufficient or too high when deciding to approve or disapprove a requested rate increase.

Besides Insolvency Protection, What Other Purposes For Surplus Do Insurers Name? How Do They Affect Premiums?

While regulators view the core objective of surplus as providing protection from insolvency, insurers and their actuaries argue that they also need surplus to provide capital for much broader business purposes. Most insurers internally develop target levels for their surplus. In those few cases in which state proceedings have led to a disclosure of those target levels, it has become clear that insurers are aiming to build and maintain very high levels of surplus, well beyond the regulatory minimums, to provide for a range of risk factors as well as for business purposes such as technological upgrades, new product development, and business acquisition. For example, in surplus proceedings in the District of Columbia and Maryland, actuaries for CareFirst Blue Cross Blue Shield argued that the company's D.C.-based affiliate needed to maintain surplus between 750% and 1050% of RBC-ACL.¹⁷

Thus, for insurers, the purpose of surplus appears to have expanded, prompting legitimate concern that insurers' target surplus levels have become virtually limitless. Moreover, those target levels appear to be developed without regard to affordability for consumers.

Table 2 shows definitions of the scope and purposes of surplus funds used by actuarial firms that have developed target levels for insurers or analyzed surplus levels for state officials over the past five years. While still designed to provide a "margin of safety," surplus has morphed into funding in amounts sufficient to virtually guarantee plan solvency under any set of contingencies and to provide unspecified amounts of equity capital for business growth and development. More recently, the proposed purpose has expanded again: this time to guarantee plan "vitality," a proxy for the ability of each plan to respond to potential competitive pressures.

TABLE 2 – INSURERS’ DEFINITIONS OF SURPLUS REQUIREMENTS

<p>2005 Lewin Group Report to Pennsylvania General Assembly¹⁸</p>	<p>“Most insurers contend, as the Blues in Pennsylvania have done, that insurers need an adequate margin of safety so that the company can endure periods of adverse experience without triggering regulatory intervention...Beyond protecting against adverse claims experience, insurers also require capital for competitive, service, and regulatory response purposes.”</p>
<p>2008 Milliman Report to CareFirst, Inc., GHMSI (CareFirst BCBS)¹⁹</p>	<p>Beyond traditional solvency needs, surplus should provide “equity capital to enable periodic investments in technology, product development, building or acquisition of complementary business capacity, and growth in business in force without jeopardizing the company’s risk capital position.”</p>
<p>2009 Lewin Group Report to GHMSI (CareFirst BCBS)²⁰</p>	<p>“In addition to the above risk-based outcomes associated with solvency objectives, a working surplus range must include an allocation of surplus required to maintain the <i>vitality</i> of an insurer’s operations. These are not necessarily current liabilities, and may be somewhat flexible in terms of timing and scope. However, they characterize known future allocations of surplus required to maintain a specific insurer’s role in health care insurance and delivery” (emphasis added).</p>

Generally, the proportion of a health plan’s surplus that is earmarked for the risk of insolvency – a mandatory, perpetual purpose – versus other more discretionary items, such as technology upgrades or new product development, cannot be determined from a plan’s annual regulatory filings or other public documents. Therefore, it is difficult to determine what portion of a company’s surplus is held for these “non-solvency” purposes.

For this study, we asked the question: What would the premium impact be if surplus were restricted to solvency protection, and funds allocated to business growth and competitive purposes were freed up for rate relief? For example, what would be the effect if these funds were released as a premium refund or put aside in a rate stabilization fund designed to offset future premium increases for individual and group markets?

Although precise data on the value of the non-solvency component of surplus are not publicly reported, for study purposes we chose 15% to 25% of surplus as a hypothetical non-solvency component and modeled the impact of using that to offset an illustrative 10% rate increase. That is, we examined what proportion of an illustrative 10% premium increase across all lines of business could be offset by a rate stabilization reserve equal to 15%, 20% and 25% of surplus, assuming this reflected the amount that insurers hold or target for growth and development.

As illustrated in Table 3, applying 15% of surplus for rate relief to our sample of ten BCBS plans could offset between 23% and 94% of a 10% across-the-board rate increase for most plans; at the higher end of the range, a 25% allocation could offset between 38% and 157% of the same 10% premium increase.²¹

TABLE 3 – PERCENT OF A 10% RATE INCREASE THAT COULD BE OFFSET BY APPLYING PORTIONS OF SURPLUS TO RATE STABILIZATION AT THREE ILLUSTRATIVE LEVELS

Percent of Total Surplus	15%	20%	25%
Alabama	23	30	38
Arizona	73	97	122
Massachusetts	47	62	78
Michigan	55	73	92
New York (Excellus)	30	39	49
North Carolina	45	60	75
Oregon (Regence)	35	46	58
Pennsylvania (Northeastern)	307	409	512
Tennessee	54	72	90
Wyoming	94	126	157

Note: Based on 2009 insurer data.

Reducing each plan’s surplus by up to 25% would not result in surplus dropping below 200% of RBC-ACL for any of the ten plans. Alabama would be the plan with the lowest RBC score with a 25% reduction at 373%, just slightly below the BCBSA trigger for increased monitoring. Of the ten plans, Arizona would maintain the highest RBC ratio – 1093% – if it applied 25% of surplus to offset an across-the-board 10% rate increase.

One significant takeaway from this hypothetical is the importance of specifying the purpose surplus is meant to serve and of clearly identifying which categories of risk are to be covered by surplus funds.

As a matter of policy, state legislators and insurance regulators have the option of returning to basics and stipulating that surplus is meant to deal, exclusively, with the solvency protection mission – not with “business vitality,” or other factors not directly related to plan solvency risks. This is not meant to imply that nonprofit BCBS plans should be starved for growth and development funds. The plans obviously require funds for legitimate technology upgrades, business expansion, etc. However, non-solvency-related investments could be funded as distinct line items in the operating and capital budgets of the plans where they would tend to receive greater scrutiny and would compete with other priorities.

Another option would be to bifurcate surplus, and targeted contributions to surplus in rate increases, into its solvency and non-solvency components – clearly identifying and quantifying the respective components. Then, as a matter of policy, regulators could routinely give more immediate priority to the non-discretionary solvency components and could evaluate and approve the other pieces, annually, in light of their impact on premiums and other factors. In periods when rate pressure was relatively modest, funding of surplus for potential business development or competitive responses could be permitted; when premiums were under intense pressure, allowances for such potentials could be ratcheted down.

Calculations of Target Surplus Ranges: Is the Methodology Out of Date? Are There Signs of Excess in the System?

As described above, starting in the 1990s, the NAIC, with technical support from actuarial professionals, developed a framework for determining minimum requirements for RBC, which is also referred to as health risk-based capital (HRBC) when applied to health insurers. The purpose was to quantify the risks associated with each insurer's book of health insurance business and to establish early warning "trip wires" and graduated regulatory interventions to deal with impending difficulties. The data-based, actuarial models developed for and approved by the state insurance commissioners were based on 1990-era claims patterns, risk distributions and prevailing market practices.

It is not clear whether insurers and regulators continue to use 1990s-era loss patterns when they develop target surplus ranges. For example, when actuaries for an affiliate of CareFirst Blue Cross Blue Shield recommended in 2008 that the company hold surplus between 750% to 1,050%, the company stated: "That range is designed to allow [the affiliate] to withstand a realistic sustained period of underwriting losses without its reserves falling below the 375% BCBSA early warning monitoring threshold."²² Yet, in the same report, the company presented data showing that it sustained no underwriting losses between 1999 and 2009.

Today, the question of how much cushion is prudent and necessary once again needs to be answered. Table 4 illustrates the magnitude of the ratio between surpluses held and actual underwriting losses experienced in the plans we studied. For every dollar of loss actually experienced, most plans held between approximately \$7 and \$18 of surplus funds.

One question to ask is whether a plan that has a margin of, for example, 15:1 provides meaningfully greater protection than another with coverage of 13:1 or 14:1. Some health actuaries, such as Corwin Zass of Actuarial Risk Management,

have raised questions about the incremental value of surplus as a fiscal safety indicator above some level.²³ The former Pennsylvania Insurance Commissioner, in her decision establishing surplus ranges for the state’s BCBS plans, acknowledged “the diminishing nature of the marginal reduction in probability of ruin or default from successive dollars of surplus” and the need to “balance this marginal reduction in risk against the benefits of using these same surplus funds in an alternative fashion.”²⁴

TABLE 4 – RATIO OF AVERAGE SURPLUS TO AVERAGE UNDERWRITING LOSS FOR PLANS EXPERIENCING LOSSES IN TWO CONSECUTIVE YEARS OR MORE

Plan	Loss Years	Average Surplus/Loss
Alabama	2008-2009	10:1
Michigan	2007-2009	12:1
New York (Excellus)	2008-2009	66:1
Oregon (Regence)	2001-2003	11:1
Oregon (Regence)	2007-2009	18:1
Pennsylvania (Northeastern)	2002-2005	12:1
Pennsylvania (Northeastern)	2007-2009	7:1

Note: Ratios are rounded.

While a technical comparison of all the relevant differences between the profile of health insurance risks in the 1990s and today is outside the scope of this report, below is a summary of some indications that insurers’ methodologies and metrics of risk assessment are now due for comprehensive review.

DECREASED VOLATILITY OF UNDERWRITING GAINS AND LOSSES

The foundational reason for building surplus funds is to protect carriers against the risk of running unanticipated deficits in premium collections. Particularly problematic for insurers are premium shortfalls that endure for prolonged periods. If these underwriting deficits are sufficiently large and sustained, losses can cascade to the point where the solvency of the carrier is seriously endangered. Surplus funds are, therefore, maintained to provide ballast against that contingency.

Historically, underwriting gains (profits) and underwriting losses have fluctuated on a cyclical basis. As far back as the 1960s and on through the end of the

1980s, aggregate underwriting gains tended to fluctuate fairly regularly with underwriting losses – three years up and three years down. In a 2003 study, Richard Kipp, John Cookson and Lisa Mattie presented data summarizing these cyclical patterns for BCBS plans from 1976 to 2002.²⁵ Through the late 1980s their graph depicts regular three-year swings with gains (profits) mainly in the range of 1% to 4% of revenue and losses ranging between 1% to 6%. Beginning in 1990, the cycles decreased in volatility: the periods of gain increased in duration up to six years. Just as important, the percentage size of gains and losses declined, with gains from 1990 to 1995 and 2000 to 2002 ranging from less than 1% to more than 2% and losses from 1996 to 1999 at less than 2%. This probably reflected a combination of changing practice patterns (e.g. shorter durations of hospitalization), improved systems for processing and information gathering, and improved cost, utilization, and financial management by the plans.

Other research shows that nonprofit BCBS plans have had aggregate underwriting gains since 2001, with a peak of over 4% in 2004 and 2005.²⁶ Moderation of the cycle tends to reduce the financial risk of unanticipated premium shortfalls, thereby lowering surplus requirements.

In our sample of ten nonprofit BCBS plans, 2001-2009, we examined each plan separately to obtain further insight into underwriting cycles and trends.

We found that:

- Four of the ten plans studied experienced no periods of underwriting loss during the nine-year period (Arizona, North Carolina, Tennessee, and Wyoming). Annual gains among those plans varied, on average, from 2.9% (North Carolina) to 7.7% (Arizona).
- Four other plans experienced periods of underwriting loss between one and three years long. However, the average loss for the periods was modest, ranging from .02 percent of revenue (Massachusetts in 2009) to 1.8% (Oregon from 2001-2003).
- The two remaining plans (Michigan and Pennsylvania) experienced heavier average underwriting losses during periods of loss, with Michigan at 3% from 2007-2009 and Pennsylvania at 10.2% from 2002-2005 and 26.8% from 2007-2009.

That shows that in at least four of the ten plans studied, the underwriting cycle was far tamer than that on which the NAIC and its consultants relied to develop the original RBC metrics and on which insurers and regulators may still rely today to develop target surplus ranges. Arguably, this is also the case among the four plans that experienced modest downside losses. As a result, this more recent experience would suggest that solvency protection might be attained with less surplus than the levels recommended by insurers and their actuaries. Also, as part of a re-examination of RBC, the NAIC or other regulators could determine the causes of severe losses among health insurers and incorporate those findings in revising the RBC metrics to avoid plans building too much surplus when they are not actually at risk for severe adverse experience.

CHANGES IN CORPORATE STRUCTURE

Another type of change having risk implications is the growing importance among BCBS plans of the holding company business model. Many plans have affiliated with one another in an insurance holding company design where complex, reciprocal solvency protection agreements are a common feature. As a result, it is now far less common for an individual BCBS plan to be “out on its own.” And it is not clear just how fully insurers’ target surplus ranges account for the reciprocal risk protection aspects of the holding company arrangement. Another by-product of the holding company design is the growing tendency of plans to invest in subsidiaries outside their main line of business. Just as individual investors are advised to diversify their portfolios as a strategy for reducing risk, some plans as well have engaged in this practice.²⁷

In addition, as further protection against insolvency, some plans use reinsurance to hedge against risk or participate in guaranty funds, in which certain insurers in a state contribute to a reserve that would be used to pay claims if one insurer becomes insolvent. Those factors should also be considered when determining an appropriate surplus range for an insurer.

Venues for Addressing Surplus Regulation

THE STATES

States have traditionally exercised exclusive regulatory jurisdiction over health insurance for non-self-funded plans. As noted above, the handful of states that have attempted to address BCBS plan surplus in recent years have generally used two different approaches: the “Pennsylvania approach” establishes a sufficient insurer-specific range of surplus which determines when the insurer may build contributions into surplus and when the insurer may be required to divest excess surplus. The other approach incorporates consideration of surplus into rate review and allows for denial of contributions to surplus when surplus appears sufficient for solvency protection.

The “Pennsylvania Approach” – Efficient, Sufficient, and Inefficient Ranges

In theory, the comprehensive strategy, which establishes a permissible range of surplus, offers a certain amount of financial incentive for BCBS plans to maintain adequate, but not excessive, surplus funds. The approach should also be attractive administratively because after the initial criteria and ranges are set, it becomes relatively easy for regulators to determine ongoing compliance.²⁸ In practice, the approach will require transparency around the methods, metrics, and data used to establish target surplus levels.

With health reform in full effect in 2014, states need to pay close attention to surplus as insurers seek rate increases.

Surplus Levels As a Factor in Rate Review

With health reform in full effect by 2014, states need to begin now to pay closer attention to surplus levels and contributions to surplus as insurers seek rate increases. A few states have already acted to expand their regulators’ rate review authority to incorporate surplus and balance the need for surplus against the hardship of rate increases on consumers. Oregon, for example, enacted provisions in 2009 that allow (although do not require) regulators to consider, among other factors, the insurer’s “financial position, including but not limited to profitability, surplus, reserves and investment savings” when determining whether small group or individual market rate increases are “reasonable, and not excessive, inadequate, or unfairly discriminatory.”²⁹ More states should consider adopting such measures as tools for controlling rising premiums.

A further question for policymakers is what to do with existing excess surplus, should such a finding be made. States may want to consider a range of options, depending on local circumstances, community needs, and a particular plan’s history. One solution, as indicated earlier, could be to set up a rate stabilization fund with excess surplus designed to moderate premium increases going forward. Another approach would be to refund policyholders the amount that they “overpaid” in premiums that contributed to the excessive surplus. That solution might be complicated to calculate, as some subscribers who overpaid may have dropped coverage, and the plan would need to develop a formula for reimbursing subscribers with different policy levels and durations. In addition, excess surplus could be used to support community health programs or affordable coverage initiatives.

THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

The NAIC, on behalf of state insurance regulators, also plays a role in evaluating and defining surplus. Although the NAIC has periodically initiated refinements to the basic RBC procedure (e.g. trend testing), those have generally been technical in nature. In June 2008, the NAIC began a Solvency Modernization Initiative (SMI) described as “a critical self-examination of the United States’ insurance solvency regulation framework.”³⁰ Work to date appears to have focused mainly on harmonizing United States and international approaches to the regulation of capital adequacy, but the NAIC committee charged with studying the issue also appears willing to undertake a reexamination of the RBC formula for various types insurers. The SMI offers a potential vehicle for

spearheading a comprehensive and critical re-examination of health insurance risk protection.

To make that venue a successful and viable forum for consumer-friendly outcomes, however, the NAIC would need to give the topic immediate priority and make a commitment to bring the industry and consumer representatives, plus actuarial and economic experts for consumer interests, fully into the process with assurances of full transparency.³¹ Health reform and its promise of affordable health insurance policies warrant consideration of whether the NAIC's 15-year-old RBC model and insurers' target surplus levels fit the current environment.

FEDERAL DEPARTMENT OF HEALTH AND HUMAN SERVICES

Federal regulatory guidance is currently under development to establish a process mandated under the Patient Protection and Affordable Care Act for annual rate review for health insurance (see PPACA Section 1003). A cornerstone of the PPACA is encouraging states to implement stronger rate review processes. Creating a new mechanism for reining in excessive surplus funds is consistent with that goal, to strengthen regulatory oversight of premiums that appear unreasonable or unnecessarily high.

Federal grants are available to states to implement their rate review systems; to be eligible for the second round of these grants, states must comply with the upcoming federal guidance. The Secretary of Health and Human Services should ensure that the federal guidance requires consideration of insurer surplus, as described in this report, as a priority factor in qualifying for the grants and as a part of the annual rate review process under the PPACA.

Recommendations for Action

This report describes the purposes of surplus, and examines the arc of industry trends affecting risk and safety, including the moderation of recurrent underwriting cycles. By and large, industry players have promoted the definitions referred to in this report which favor a more expansive role for surplus and thus higher permissible surplus levels. Observed industry trends, however, provide reasonable evidence of a need to determine whether a more controllable, lower-risk health insurance environment consistent with lower levels of surplus necessitates a new formula for solvency protection.

This report does not attempt to reach conclusions about the adequacy or excessiveness of current surplus levels for specific insurers, but instead strongly advocates for the need to reexamine current and anticipated risk distributions, to take advantage of opportunities to update and improve methodologies and practices, and to open issues of risk and solvency to more active public scrutiny.

Further, it is important to note that trends and practices are apt to change under the new federal health care reform law.

The prudent course of action is for policymakers to revisit surplus definitions and practices with an eye toward fundamental modernization of solvency and surplus standards. State level action, NAIC examination, and federal guidance are all logical steps for this review process.

Consumers Union recommends that the agenda for a comprehensive review of solvency and surplus should address:

- Definitions and purposes that would guide minimum and upper-range surplus requirements in light of prevailing and projected patterns of risk and other appropriate factors, including affordability for consumers.
- Business practices that reduce the need to rely on surplus, including, when appropriate, participation in guaranty associations or other reciprocal risk-sharing arrangements.
- Feasibility of defining surplus as protection against insolvency, with other needs such as growth and development to be incorporated on a stand-alone basis.
- Methods and metrics that would break surplus and target surplus into its component parts (e.g. claims risk vs. growth and development) and would be transparent to consumers, regulators, and policymakers.
- Modeling to determine the incremental value of surplus on the theory that policyholders should not be overburdened with additional contributions to surplus that actually provide declining levels of protection.
- Methods for fair and beneficial disposition of surplus in excess of upper bounds.

To realize the promise of health reform, our collective challenge is to ensure that health insurance coverage is affordable. Some nonprofit health insurance companies continue to stockpile large amounts of surplus, funded by premium dollars. Health advocates, local grassroots organizations, concerned consumers, and some policymakers need to tackle the issue of potentially excessive surplus funds. Some have begun to address the issue, but satisfactory solutions are yet to be developed and tested. Consumers Union urges policymakers, the NAIC, advocates, consumers, and industry representatives to develop appropriate standards for nonprofit health insurers' surplus levels that will adequately protect consumers against excessively high health insurance rates while minimizing the risk of the plans' insolvency.

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ENDNOTES

- 1 Throughout this report, the term “insurers” refers to all companies offering health insurance, including health maintenance organizations and preferred provider organizations. Unless otherwise noted, the term “nonprofit” in this report includes community-owned charitable organizations and subscriber-owned mutual plans.
- 2 Insurers often refer to their surplus as “reserves.” However, surplus is to be distinguished from reserves which are set aside for known liabilities, such as reserves for incurred but unpaid claims, funds containing pre-paid premiums, or funds set aside for future expected medical claims.
- 3 This includes individuals in self-funded plans whose insurance is administered by a nonprofit Blue Cross and Blue Shield plan. Calculated from data in Alliance for Advancing Nonprofit Health Care, Basic Facts and Figures: Nonprofit Health Plans, <http://www.nonprofithealthcare.org/resources/BasicFactsAndFigures-NonprofitHealthPlans9.9.08.pdf>.
- 4 A.M. Best, 2008 Market Review, August 10, 2009. While aggregate surplus for the BCBS plans dropped slightly from 2007 to 2008, this decline came after several years of growth.
- 5 For-profit health insurers build surplus with subscribers dollars and may also raise capital in financial markets.
- 6 Letter from Scott Serota, President and CEO of the Blue Cross and Blue Shield Association, to District of Columbia Insurance Commissioner Gennett Purcell, September 8, 2009, http://disb.dc.gov/disr/frames.asp?doc=/disr/lib/disr/pdf/serota_letter_re-carefirst-090809.pdf.
- 7 See *Risk-Based Capital General Overview*, National Association of Insurance Commissioners, July 15, 2009, available at www.naic.org.
- 8 The Association may require a particular BCBS company to have a minimum surplus even higher than 375% if other mechanisms for solvency protection are not in place.
- 9 See *Study of the Reserves and Surpluses of Health Insurers in Massachusetts*, Massachusetts Division of Health Care Finance and Policy, May 2010, at pg. 4.
- 10 The drop in reported surplus from 2004 to 2005 for Blue Cross Blue Shield of Massachusetts was the result of a change in company structure. Prior to 2005, HMO Blue was a division of BCBS MA and the annual financial statements of BCBS MA included the results for the HMO. In 2005, BCBS MA established HMO Blue as a wholly-owned subsidiary, and has since then filed separate financial statements for the two corporate entities. Thus, the surplus reported prior to 2005 includes HMO Blue, while the surplus since 2005 does not.
- 11 Another measure of surplus sometimes used by insurers or regulators compares the amount of surplus in a given year to total revenues for the year. This measure is commonly called SAPOR, or “surplus as a percentage of revenue.” A surplus that is 15% to 25% of revenue in a given year is sometimes considered adequate for solvency protection. For example, the Office of the Health Insurance Commissioner of Rhode Island uses surplus as a percentage of revenue at 23% as a benchmark for adequate surplus. See *In re: Blue Cross & Blue Shield of Rhode Island – Class DIR, Recommendation of the Hearing Officer*, Feb. 21, 2007.

For seven out of ten plans in our sample, the amount of surplus, measured as a percentage of revenue, increased from 2001 to 2009. In 2001, seven of the ten plans held surplus very close to or less than 25% of revenue. By 2009, only three plans held close to or less than 25%; the other seven plans held surplus as a percentage of revenue at 30% or higher.
- 12 See *In Re: Applications of Capital BlueCross, Highmark Inc., Hospital Service Association of Northeastern Pennsylvania and Independence Blue Cross for Approval of Reserves and Surplus*, Determination of the Pennsylvania Insurance Commissioner, Feb. 9, 2005, pg. 36. The Commissioner stated, “if surplus is sufficient, such that any reasonably probable “drain” will not reduce surplus below a safe operating level, then there is arguably no purpose for accumulating additional surplus from ratepayers.” (page 35).
- 13 See Maryland Insurance Code § 14-117. The District of Columbia, which, like Maryland, has regulatory authority over CareFirst BCBS passed a statute, aimed at CareFirst surplus, requiring the company to “engage in community health reinvestment to the maximum feasible extent consistent with financial soundness and efficiency.” D.C. Code § 31-3505.01.
- 14 See *e.g.*, Petition for Review, *Abraham v. Blue Cross Blue Shield of Michigan*, Brief for Petitioner Ghada Abraham, Sept. 8, 2008.

- 15 See *In re: Blue Cross & Blue Shield of Rhode Island – Class DIR*, Recommendation of the Hearing Officer, Feb. 21, 2007 and Feb. 15, 2008.
- 16 See “Anthem Sues State of Maine over Rate Hike Request Denial,” Maine Public Broadcasting Network (Oct. 5, 2009), available at <http://www.mpbn.net/>; *Anthem Health Plans of Maine, Inc. v. Superintendent of Insurance*, No. BCD-WB- AP-08-24, April 21, 2010, available at <http://www.maine.gov/pfr/insurance/>.
- 17 A decision on the appropriate range of surplus for the affiliate, Group Hospitalization and Medical Services, Inc. (GHMSI) from the D.C. Department of Insurance is reportedly still pending. The Maryland Insurance Administration adopted the recommended ranges of its consultant, which were 700% to 950% for GHMSI and 825% to 1075% for the company’s other affiliate, CareFirst of Maryland, Inc. Consumers Union objected to the levels adopted by Maryland on the grounds that they were partly derived from the analysis of the company’s own actuaries
- 18 The Lewin Group, *Considerations for Regulating Surplus Accumulation and Community Benefit Activities of Pennsylvania’s Blue Cross and Blue Shield Plans*, Prepared for the Pennsylvania General Assembly Legislative Budget and Finance Committee, June 13, 2005, at pg. iii.
- 19 Milliman USA, *CareFirst, Inc., Group Hospital and Medical Services, Inc., Need for Statutory Surplus and Development of Optimal Surplus Target Range*, Dec. 4, 2008, at pg. 24.
- 20 The Lewin Group, *Recommended Surplus Range for GHMSI: Approach and Considerations for Determining the Appropriate Range of Surplus*, Oct. 29, 2009, at pg. 8.
- 21 Our hypothetical resulted in a much higher offset for the small Pennsylvania plan because the plan holds an amount of surplus that is very high in relation to its revenues, which were \$122.6 million in 2009 compared with \$250.7 million of surplus. Thus, for Pennsylvania surplus was more than two times the amount of revenue; whereas, for the other plans in our study, surplus ranged from 15% to 63% of revenue. See also footnote 14.
- 22 Group Hospitalization and Medical Services, Inc., Pre-Hearing Report, DISB Review of GHMSI Surplus Pursuant to the Medical Insurance Empowerment Amendment Act of 2008, August 31, 2009, Attachment D, pages 21 and 24.
- 23 Mr. Zass served as an actuarial consultant to D.C. Appleseed, which challenged surplus levels of CareFirst BCBS affiliate in the District of Columbia. Consumers Union challenged the “optimal” surplus levels developed by CareFirst actuaries for the company’s affiliates in Maryland and the District of Columbia.
- 24 *In Re: Applications of Capital BlueCross, Highmark Inc., Hospital Service Association of Northeastern Pennsylvania and Independence Blue Cross for Approval of Reserves and Surplus*, Determination of the Pennsylvania Insurance Commissioner, Feb. 9, 2005, pg. 15 [“Pennsylvania Determination”].
- 25 Richard Kipp et. al., *Health Insurance Underwriting Cycle Effect on Health Plan Premiums and Profitability*, Milliman, USA Report, April 10, 2003; See also John Cookson, *Underwriting Gain and Loss Cycles*, Group Insurance (ed. William Bluhm), Actex Publications, 2007.
- 26 Matthew Borsch and Mikael Landau, Goldman Sachs Global Investment Research, Americas: *Managed Care*, September 15, 2009.
- 27 See *Pennsylvania Determination*, pg. 25-26. “[C]ompanies that have subsidiaries and affiliates protect themselves by having more than one entity generating business growth at a time. The result of this diversification is that there is less risk that the parent and all of its subsidiaries and affiliates will have irregular business growth at the same time. . . it is therefore prudent to analyze risk in recognition of that diversification.
- 28 A range or multi-tier approach limits plans’ ability to manipulate strict ceilings – that is, a hard cap would allow plans to reduce their surplus to just below the ceiling, even by a dollar, to avoid the cut-off. Nonetheless, even with a range, regulators will need broad authority, for example to look at the whole financial statement to ensure surplus is not hidden in another accounting line, or being moved to affiliates, where it may be out of sight of regulators.
- 29 Oregon Insurance Code § 743.018(5)(a).
- 30 NAIC, *Solvency Modernization Initiative*, September 2009, http://www.naic.org/documents/committees_ex_isftf_smi_overview.pdf.

- 31 The recent enhancement of the NAIC's Consumer Liaison Representative Program included the selection of seventeen consumer health experts, some funded by NAIC to support their participation. Consumers Union has a representative in that program.