

Introduction

We are pleased to submit the enclosed responses to comments offered by the various Commentors.

Sherlock Company has been engaged to review the comments of the Pennsylvania Medical Society, IMR Health Economics, LLC (consultants to Consumers Union and others) and The Insurance Federation of America, Inc. (collectively “the Commentors”). In addition, we read the comments of The Hospital & Healthsystem Association of Pennsylvania, Community Legal Services, Pennsylvania Health Law Project and Community Justice Project and Pennsylvania Medical Society on an earlier related matter as of September 4, 2002. We have been asked to respond to the following market issues raised by the commentors:

- The Commissioner should supercede market forces and establish the maximum level of surplus that should be retained by the Pennsylvania Blue Plans.
- The Commissioner should compel the Blue Cross Blue Shield Plans to “disgorge the excess surplus” to fund certain activities.
- Regulatory intervention is necessary since the Blues’ accumulation of surplus results from an inefficient, uncompetitive market, one aspect of which stems from the lack of investors who would otherwise force management to pay dividends, thereby reducing surplus.

The various Commentors do not agree, however, on how to measure excess surplus or to whom it should be distributed.

Sherlock Company believes that, in the absence of inefficient markets, decisions regarding the maximum level of surplus are most efficiently executed by those closest to the markets, the Blues themselves. The Commentors provide no evidence that the market is in fact inefficient. To the contrary, the presence of numerous and often well-capitalized competitors, competitive premium rates, plus the relatively modest margins of the Blue plans, are all indicative that the health insurance market is competitive in Pennsylvania especially in Central Pennsylvania and the Lehigh Valley, where two Blue Plans compete directly on a branded basis.

The Commentors are correct that non-profit organizations do not have shareholders, and accordingly do not pay dividends. For-profit health plans, like non-profits, typically do not pay dividends to shareholders either, and those that do, pay modestly. Accordingly, the surplus levels of the Blues reflect the significant competitive disadvantage of their lack of access to external sources of equity capital, resulting in their need to retain capital for all future contingencies.

We believe that, in view of the lack of any evidence of inefficiency, regulatory intervention to reduce the level of surplus creates risks for the non-profit purpose that Blue plans are intended to serve. For example, if in the extreme case the Blues in

Pennsylvania were to lose their rights to use the Blue name and mark, and if the Pennsylvania Medical Society is correct that the value of the mark is worth 10-15% of premium, their ability to fulfill their non-profit mission would be compromised. 1

We also believe that regulatory intervention would be a disturbing precedent for other non-profit operating organizations, such as hospitals. Finally, we believe that distribution of assets in the way suggested by the Commentors would create the similar accountability issues as it would purport to solve since it would amount to a dedicated tax.

Framework

Non-profit Blue Cross Blue Shield Plans are similar to other for-profit health plans, with the important exception that they do not have access to the equity capital markets. The issues that surround the levels of capital stem from this similarity and this difference, but generally these firms operate with the same responsibilities to their mission as are found in public companies.

Capital BlueCross has a Mission for which it is Accountable

The mission of Capital BlueCross is to operate a non-profit health plan under similar constraints and the same competitive environment facing for-profit insurers. Capital BlueCross' other activities, including voluntary community commitment, are conditioned upon and contribute to, the success of this mission. Like other insurers, it enrolls members, responds to member inquiries, pays claims and manages provider relationships. Similar to the hospital market, "for profit" and "non-profit" health insurance companies are subject to comparable economic forces.

Accordingly, Capital BlueCross' profits are limited by its competitive environment. It competes in labor markets for administrative employees, its provider contracts are subject to the relative bargaining power of providers, especially in some of the thinly populated regions in its service area, its premium rates are subject to the intensity of competition that it faces from other health insurers, both commercial and Blue. The level of profits earned by Capital BlueCross is determined by its ability to effectively manage its costs and appropriately price its services. For instance, excessive premium rates will attract additional competition and excessively low rates will harm earnings. The amount of capital that is retained is a manifestation of its mission since it must be sufficient to meet operating and investment needs.

¹ The Pennsylvania Medical Society seems to be of two minds on the value of the Blue name and mark. In footnote 16 on page 18, it states that "there is no real reason why the Blues would have to continue to be members of the Association if continuing membership contravenes Pennsylvania public policy." However, on page 7, it acknowledges that membership is valuable, noting that "Blue Cross firms enjoy a 10% to 15% pricing advantage over other health insurers engaged in head-to-head competition."

On a day-to-day basis the management team is accountable to the Board for fulfilling its statutory and corporate mission, and the Board is in turn responsible for the well-being of the organization. As a practical matter, this is identical to the situation facing not only other non-profit operating organizations, such as hospitals, but also for-profit health plans as well.

The similarities between non-profit and for-profit health plans is also illustrated in the extreme case in which the respective businesses are liquidated. In the for-profit case, the duty of the Board is to maximize shareholder value. In the same way, were Capital BlueCross to be liquidated, the proceeds would likely be contributed to a surviving non-profit entity to continue its historic mission, as closely as possible. The greater the amount of value, either in the form of tangible or intangible assets, the greater the value to the surviving entity to continue the mission. Put a different way, because of the prohibitions against inurement, the “objective function” of maximization of value is present in non-profits as in for-profits.

Note that in both the non-profit form and the for-profit form, the intensity of external oversight depends on the circumstances. In the normal course of business, management and the Board have oversight over the operations. This is because only the management team has the ability to fully understand the competitive environment that it faces, is aware of its own competitive capabilities and its planned competitive responses. Only for extraordinary transactions, such as the sale of the firm, is additional oversight customary, either through representatives of shareholders or regulators, to assure that value is maximized.

The delegation of responsibilities, in the normal course of business, to Boards and managements is a time-honored practice, creating accountability by matching responsibilities with authority.

The Capital Structure Difference

While non-profit health plans are similar in many respects to for-profits, they are unique in their inability access external equity capital. Non-profits cannot raise new capital or exchange shares with other organizations as a currency for merger. This is a significant competitive disadvantage in that, for non-profits, only equity can be used to support the company’s current and future operations. So, while for-profit firms have the ability to add to equity through equity issuances and earnings, non-profits are limited exclusively to earnings.

Regarding earnings, all firms, including non-profits, balance their desired levels of earnings against their growth. For instance, while high prices may increase earnings, they also invite competition. Accordingly, as discussed above, their accountability for their long-term achievement of their missions is reflected in their financial results.

There are two implications of the absence of external sources of equity capital. First, a non-profit must plan for a long horizon, without access to external equity. This requires them to retain sufficient capital to meet any contingency. The second implication is more

theoretical: In principle, for-profits should expect heightened pressure to operate more efficiently since ultimately they would face the risk of hostile takeovers if dissatisfied shareholders respond to suitors who believe that they can operate the business to achieve greater cash flow. *However, in reality, this is a false premise, since at least 1980, there has never been an unfriendly takeover of a health plan.*

Are Blue Plans Subject to Market Constraints on Their Surplus?

The Commentors' advocacy of regulatory intervention generally rests on their assumption that Blues face an inefficient market and are therefore insulated from normal market that limit the amount of surplus that similar for-profit plans can accumulate. In the Commentors' view, this necessitates intervention to reduce what they see as excess surplus. However, they provide no evidence that this is the case, and there exists evidence of the intensity of competition in Pennsylvania.

The Insurance Federation of Pennsylvania (the Federation) remarks that, "The threshold question is whether the Blues plans (or any insurer) can have 'excess surplus,' with the Blues suggesting that they cannot. That may be true with for-profit insurers in a competitive market, where the demands of shareholders, investors and competition are the best regulators and distributors of excess capital."² The Pennsylvania Medical Society (PMS) makes a similar point that "Unlike for-profit corporations whose management and Board of Directors are accountable by the shareholders, there is no similar 'private' oversight over the decisions of managers and directors of Pennsylvania nonprofit corporations."³

We believe the Commentors are wrong and we provide evidence of competitive markets in Pennsylvania.

1. There are numerous competitors to the Blues, similar to the competitive environment facing for-profit firms. Blues must compete for provider contracts and administrative talent and, on the basis of price, for customers, with other health insurers.

The position of the Pennsylvania Medical Society is that "market entry would be extremely unlikely."⁴ However, as shown in Figure 1 there are at least 13 competitors to the four non-profit Blue plans. Seven of them are publicly traded companies, which can readily enter or expand their penetration to the markets in Pennsylvania through acquisition. Interestingly, in addition to the four Blues that employ the Blue Cross Blue Shield name and mark, the two largest Blue plans also operate minor operations in Pennsylvania.

² Samuel R. Marshall, "Comments on the applications of the four Blues plans," The Insurance Federation of Pennsylvania, Inc., September 24, 2004, pg. 1.

³ Dennis L. Olmstead, "Comments of The Pennsylvania Medical Society Regarding Reserve and Surplus Levels of Hospital Plan and Professional Health Services Plan Corporations," Pennsylvania Medical Society, September 24, 2004, pg. 5.

⁴ *Ibid.*, 8.

Additionally, the Pennsylvania Blue Plans compete among themselves. Pennsylvania is one of the few states in which Blues compete with each other, and do so in Central Pennsylvania and the Lehigh Valley using the name and mark, but they also are permitted to compete with each other using non-branded products.

Figure 1. Response to Comments
Competitor Membership Data

	<u>Membership</u>
Coventry - HealthAmerica PA	588,537
Aetna Health Inc.	584,385
UPMC Health Plan	510,547
Geisinger Health Plan	241,376
Gateway Health Plan	235,441
Three Rivers Health Plans	195,349
Health Partners	135,129
United - AmeriChoice of PA	127,628
CIGNA HealthCare of Pennsylvania	44,412
Health Net of the Northeast, Inc.	25,169
United - Mid-Atlantic Medical Services*	15,423
WellPoint*	4,909
Anthem*	25

** Membership estimated by Sherlock Company from statutory statements.*
 (Source: Interstudy Competitive Edge HMO Directory, Spring 2004.)

2. Many of these competitors are financially strong. Among the firms competing in Pennsylvania are subsidiaries of large publicly traded firms. These firms include such multibillion firms such as Aetna and CIGNA, whose key operations and headquarters are respectively in Pennsylvania. The largest of the publicly traded firms is UnitedHealth Group - while small in Pennsylvania, the company has successfully acquired a niche business serving Medicaid beneficiaries. United recently acquired the Maryland-based Fidelity Insurance Group, which has a license to operate in Pennsylvania. The size of the publicly traded firms is magnified by their flexibility in that they can invest earnings from other markets into Pennsylvania, while benefiting from geographic diversification not available to Pennsylvania Blue Plans. Note also that Pennsylvania is served to a modest degree by publicly-traded Blues such as Anthem and WellPoint. WellPoint has in the past made beachhead acquisitions of non-Blue operations in its markets that it targets.

Figure 2. Response to Comments
Market Capitalization and Equity (000's)

	Market Cap.	Net Worth
Aetna Inc.	\$14,821,180	\$8,308,200
Anthem, Inc.	11,633,568	6,563,100
CIGNA Corporation	9,351,813	4,272,000
Coventry Health Care, Inc.	4,585,434	1,003,207
Health Net, Inc.	2,943,152	1,321,566
UnitedHealth Group	42,257,070	7,118,000
WellPoint Health Netorks, Inc.	15,822,983	6,126,545
Total	\$101,415,200	\$34,712,618

(Source: PULSE September 2004.)

3. High profits are not evident, as would be the case in inefficient markets. As shown in Figure 3, profit margins for Blues in Pennsylvania were lower than those of other Blues nationwide. Notably, they were also below that of publicly traded for-profit companies.

4. Rates do not appear to be excessive, as would be the case in inefficient markets. The Pennsylvania Medical Society argues, without support, that, "It should be clear that nonprofit health insurers generation of high levels of surplus (stemming from premium increases) has increased the number of residents of the Commonwealth who do not have health insurance."⁵

However, IMR Health Economics (IMR), does not appear convinced of the inefficiency of the Pennsylvania health insurance market, though it is concerned about the possibility. It states that "*To the extent that Plans charge premiums which are higher than necessary to maintain reasonable (but not excessive) amounts of surplus, policyholder premiums are, by definition excessive.*"⁶ IMR provides no evidence that the Pennsylvania health plan market with respect to Blue Cross Blue Shield Plans is actually inefficient. Instead, it argues that powers already held by the insurance commissioner that "approving surpluses ... (is) firmly grounded in its obligation to disapprove rates which it finds excessive..."⁷

Moreover, The Insurance Federation of Pennsylvania, Inc. offers a conflicting view stating, "From the information in these applications, as well as in the past rate filings of the Blues plans, the problem is not one of excessive rates."⁸

⁵ Ibid., 8.

⁶ Larry Kirsch, "Report to the Pennsylvania Insurance Department Concerning the Applications of Blue Cross Plans for the Approval of Reserves and Surplus," IMR Health Economics, LLC., September 23, 2004, pgs. 14-15. Italics added.

⁷ Ibid., 7.

⁸ Marshall, 11.

Figure 3. Response to Comments

<u>2003 Operating and Pre-tax Margins</u>	<u>Operating Margin</u>	<u>Pre-tax Margin</u>
BlueCross of Northeastern PA	-2.2%	2.3%
Capital BlueCross	-4.1%	-1.1%
Independence Blue Cross	3.0%	2.0%
Highmark Inc.	0.2%	1.2%
Pennsylvania Blues	-0.8%	1.1%
Aetna Inc.	6.2%	9.3%
Anthem, Inc.	6.4%	7.4%
CIGNA Corporation	3.2%	10.0%
Coventry Health Care, Inc.	8.1%	8.7%
Health Net, Inc.	4.5%	4.7%
Humana Inc.	1.9%	2.8%
Oxford Health Plans, Inc.	10.0%	11.5%
PacifiCare Health Systems, Inc.	3.8%	3.6%
Sierra Health Services, Inc.	7.7%	8.6%
UnitedHealth Group	9.4%	9.9%
WellChoice, Inc.	5.3%	7.8%
WellPoint Health Networks Inc.	6.9%	6.5%
Average Public	6.1%	7.6%
All Blue Cross Blue Shield Plans	3.2%	4.5%

*(Source: Public companies from PULSE March 2004.
 "All Blue Cross Blue Shield Plans" data from BCBS Association.
 Data for individual Blue plans from PULSE June 2004 Insert.)*

Determining the intensity of competition involves subjective judgments, however, based on the number of competitors, their financial strength, their margins and the assessment of The Insurance Federation of Pennsylvania, the case for inefficiency is not proven.

Would Blue Plans Be Forced by Shareholders to Reduce their Capital, if They Were For Profit?

The Commentors also assert that Blue Plans, if they were for-profit, would operate at lower levels of capital due to the actions of shareholders. This is not necessarily the case since dividends to shareholders are unusual among health plan firms and shareholders have traditionally not exerted their desire to for greater cash flow through hostile takeovers.

According to the Pennsylvania Medical Society, non-Blues are “subject to shareholder discipline if they fail to make the appropriate distribution of profits.”⁹ As shown in Figure 4, the “demand of shareholders” is not manifest in dividend policy: Only four of the public firms pay any dividends at all, and they pay only a nominal amount. While some have completed significant share buy-backs, they are completed infrequently and at the discretion of the management, suggesting that the “demand of shareholders” is outweighed by board and management discretion.

Figure 4. Response to Comments
Dividends as a Percent of Earnings - 2003 (000's)

	Common	2003 Dividends as Pct.
	Dividends	Net Income
		of Net Income
Aetna Inc.	\$ 6,100	\$ 933,800 0.7%
Anthem, Inc.		774,300 0.0%
CIGNA Corporation*	14,059	668,000 2.1%
Coventry Health Care, Inc.		250,145 0.0%
Health Net, Inc.		234,030 0.0%
Humana Inc.		228,934 0.0%
PacifiCare Health Systems, Inc.		242,748 0.0%
Sierra Health Services, Inc.		62,326 0.0%
UnitedHealth Group	9,000	1,825,000 0.5%
WellChoice, Inc.		201,100 0.0%
WellPoint Health Networks Inc.		935,229 0.0%
	\$ 29,159	\$ 6,355,612 0.3%

* Reflects CIGNA's 1st Q. '04 dividend reduction to \$0.025 / share / quarter.
 Oxford is omitted as it was acquired by UnitedHealth Group
 (Source: PULSE May 2004, SEC Reports.)

The traditional safeguard of investor interests in the distribution of corporate cash flows is that they can sell their shares to a suitor, accelerating their cash flows. This is called a “hostile takeover” in that, if successful, it replaces the management and board to achieve this change. While at there have been at least 37 acquisitions of publicly traded health plans since 1980, not one has been hostile. Again, we think that management discretion has prevailed in the for-profit health insurance industry.

Why Do Blues Retain Surplus?

Pennsylvania Blues appear to operate in a competitive market. In effect, they also operate under no more requirements to pay dividends than do for-profit firms.

We believe that the level of surplus is a strategy to overcome their competitive disadvantage in lack of access to external capital sources. In other words, they must

⁹ Olmstead, 17.

“bank” earnings because they will never have significant access to external capital.¹⁰ Blues are handicapped by this not only when they make normal capital investments, but also in acquisitions since share exchanges, which conserve cash, are unavailable.

In contrast to for-profits, including those that are Blue, Non-profit Blue Plans use cash to make acquisitions. From 1994 to 2003, for-profit health plans have completed 98 acquisitions, for a total consideration of \$36.5 billion.¹¹ For many for-profits, acquisition is their principle means of entering new markets. Acquisitions can also enhance their competitive positions through economies of scale, regionally through administrative savings, and locally through improved bargaining power with providers. On December 31, 1993, publicly traded health plans served 16.7 million insured members. They now serve over 46 million insured members plus numerous members under ASO agreements.

Another factor in the relative amount of surpluses retained by public companies is share repurchases. Over the past four years, health plans have repurchased shares worth \$13.0 billion. However, these are episodic and subject to the discretion of the companies’ boards. Of the eleven health plans in continuous existence from 2000 through 2004, only three made significant repurchases in all four years.¹²

Finally, some of the Blue competitors, for-profit and non-profit, are start-up enterprises, with little opportunity to have generated capital. For instance, Gateway Health Plan, Health Partners, Three Rivers Health Plan and UPMC Health Plan are all under nine years old.

The Cost of Regulatory Intervention on the Value of the Blues

In the absence of evidence to support the existence of inefficient markets, regulatory management of maximum levels of capital produces outcomes that are untested and potentially seriously disruptive. This is because, the remedy for this so-called problem entails, to paraphrase PMS, to supplant private for government preference.¹³ The effect will certainly be to reduce the capabilities and value of the Blue Plans, both in their mission and ultimately upon liquidation.

Both IMR and PMS propose the regulatory setting of maximum levels of surplus, IMR through the use of “financial ruin-type models, scenario testing and proforma projections,”¹⁴ and PMS suggests a balance sheet metric.¹⁵ We cannot precisely know

¹⁰ Equity capital is the focus here since long-term debt, unless secured by fixed assets, is only available in limited amounts. Also, since many of the potential capital investments would not result in admitted assets, debt financing can reduce statutory net worth.

¹¹ Sherlock Company, “Health Plan Capital Market Activity,” *PULSE*, March 2004.

¹² *Ibid.*

¹³ Olmstead, 8.

¹⁴ Kirsch, 10.

¹⁵ Olmstead, 19.

what they advocate but some elements can be inferred from their comments regarding the lower bounds.

The Commentors believe that the maximum amounts requested by the Blue are too high. PMS argues that its days of surplus metric shows that “Pennsylvania’s nonprofit health insurers hold three times more surplus than the other competing Pennsylvania health insurers”¹⁶ and further argues that the Blue Cross Blue Shield Association standards “should be accorded little weight.”¹⁷ IMR believes that “A 375% ACL minimum standard is excessive”¹⁸ and that the 200% ACL “will provide reasonable and adequate protection.”¹⁹

However, the immediate effect will be diminished value to the mission, in the sense of its capability to fulfill its mission, to the degree that cash is withdrawn. In addition, the ability of Capital BlueCross to invest in other business opportunities in support of its mission would also be compromised.

Second Cost of Regulatory Intervention: Precedent

Regulatory intervention sets a worrisome precedent for public benefit organizations of all forms. Regulatory involvement of this depth, especially in the absence of clear evidence of inefficient markets, blurs the distinction between private non-profit activities and activities of governments, diminishing any singular loyalty that non-profits might enjoy, as well as their characteristic long-term commitment to their mission.

The Pennsylvania Medical Society summarizes the issue noting that “If the Blues decision to (hold surplus funds) is not subject to public debate or accountability, the Blues will have supplanted public with private preference regarding the use of the assets.”²⁰ This sweeping statement is remarkable in that it does not claim the Blues are engaged in personal or private inurement, rather only that it is inappropriate that the decisions be made by those who are the custodians of these non-profit assets. The logic behind the proposed regulatory intervention, over the objections of the Board members and managers of these plans who are intimately aware of their competitive environments and obligations to the organization, is as applicable to non-profit hospitals as it is to non-profit insurers.

Recall that having high surpluses is, in most instances, a measure of the successful execution of carefully crafted strategies. It is an indicator of financial success and the ability of the plan to honor its obligations to customers, creditors, vendors and owners. In other words, in a competitive market, it has achieved all it could be expected of them.

¹⁶ Ibid., 17.

¹⁷ Ibid., 12.

¹⁸ Kirsch, 6.

¹⁹ Ibid., 13.

²⁰ Olmstead., 8.

The result of this is, in the non-profit sphere, greater value is retained for the benefit of the community.

Non-profit Blues see their obligations to their missions as analogous to those of non-profit hospitals. As Blues operate, their responsibilities are first to their customers, in accordance with their mission, as hospitals' responsibilities are to their patients. In both cases, responsibilities to other stakeholders, including managements, employees and vendors are secondary. Similarly, in the event of liquidation both non-profits would contribute all of the value of its assets, after liabilities, to successor non-profits, which would carry on the historic mission in as close a way as possible.

Blurring the differences between the responsibilities of private non-profit organizations and governments can lead to the loss of value to the public of these independent non-profit organizations. In its extreme form, this was evident at the time that Empire Blue Cross converted to for-profit status. The transaction was finally structured to allocate the proceeds of the conversion to certain hospital employees. As a result, it was impossible for the surviving foundation to carry on the non-profit mission for which Empire Blue Cross was originally formed.

Consumers Union has been rightly critical of this and non-profit hospitals should be similarly concerned about a similar logic as applied here. In its press release of March 21, 2004, Consumers Union objected that "this law gave Empire an exclusive right to convert and an exclusive duty to turn its assets over to another non-profit organization when it stopped operating as a charitable organization."²¹

Why These Other Activities Matter: Diversification and Economies of Scale

The Pennsylvania Medical Society lists several considerations that it considers to be "inappropriate considerations in the evaluation of appropriate surplus levels."²² While its comments presume regulatory intervention, we believe that these are reasonable considerations for the Board and management of non-profit Blue Plans.

- Blue Cross and Blue Shield Association Standards. The management of Capital BlueCross and the Pennsylvania Medical Society agree that the use of the name and mark is valuable. The loss of the name and mark could compromise Capital BlueCross's ability to fulfill its mission. Accordingly, since use of the name and mark are subject to the approval of the Association, we think that it is appropriate for Capital BlueCross to consider the effect of the loss of this valuable asset.
- "Speculative" business ventures and future "growth." The use of assets to fund operations which are "not related to health insurance or ... out-of-state

²¹ Consumers Union, "Appellate Division Rules consumers Union Can Go to Trial in Constitutional Challenge to 2002 Empire Blue Cross Conversion Legislation," May 21, 2004, available at www.consumersunion.org/pub/core_health_care/001142.html.

²² Olmstead, 12.

ventures” can be highly beneficial to the mission of the plans. Diversification into other business lines can create valuable synergies as well as moderate the effects of cyclicalities in the health plan industry.

- Capitalization. We believe that health plans are more capital intensive than does the Pennsylvania Medical Society. Excluding computers and other information and communication systems resident in functional areas, Blue Cross Blue Shield Plans are estimated to have nearly \$24,873²³ in annual, per employee, information systems costs, much higher than the \$7,342 per year found in other businesses. Of the approximately one-half that is non-labor, much of this represents rapidly amortizing assets of limited value for reserve calculations.

The Pennsylvania Medical Society states that “the most capital intensive requirement for health insurers is working capital,” and they “have generated working capital by substantially increasing the level of their unpaid claims.”²⁴ We do not know that the level of unpaid claims has increased, but it would not in any case increase working capital: While cash would indeed increase in any given period, current liabilities would as well, leading to no net change in working capital.

We add that a number of the considerations are in our view wholly appropriate exercise of the care normally required of managements and directors. These include the use of expert opinions, premium subsidies necessitated by market conditions, the prospect of state and federal mandates and the risk of “force majeure.” All of these have the potential to affect the level of capital that should be retained in the Plan.

Proposed Distributions Lack Accountability

The Commentors have a number of suggestions for the use of any “disgorged” so-called “excess surplus.” These uses include the following.

²³ Sherlock Company, “The Challenge of Capital for CBC,” April 14, 2004.

²⁴ Olmstead, 15.

Figure 7. Response to Commentors Suggested Uses of “Excess Surplus”	PMS ²⁵	Philadelphia Unemployment Project ²⁶	HAP ²⁷	Insurance Federation of Pennsylvania ²⁸
Expand adultBasic Eligibility	✓	✓		
Expand CHIP Eligibility	✓			
Improve Medicaid provider payment	✓			
Support in regard to uninsured and hard to insure			✓	
Unspecified social mission contributions				✓

The funds to be “disgorged” from the Blues would be used to fund these initiatives and Commentors state that the obligation to pay for these initiatives in part stems from the Blues historic preferred tax status ²⁹ ³⁰. Accordingly, the Commentors are proposing a form of dedicated tax on the Blue Plans.

While we acknowledge that each of these proposed uses may have substantial merit, the use of Blue surplus to fund them raises the same policy issues as any other dedicated tax. That is, because the dedicated tax is not subject to reauthorization or annual appropriations, it is unresponsive to present or changing priorities of the Commonwealth.

State legislators, who are directly accountable to voters, will not be part of this process. Moreover, the larger the Blue surplus that is employed in this way, the less of a role will be assumed by state legislators in these important policy issues. Finally, especially since these are non-profit plans, this dedicated tax may artificially reward management for growth at the expense of surplus, making funding for these identified purposes short-lived.

²⁵ Ibid., 18-19.

²⁶ Jonathan M. Stein, “Comments on the Applications of the Four Blue Class Plans,” Philadelphia Unemployment Project, et al., September 24, 2004, pg. 57.

²⁷ Carolyn F. Scanlan, Comment Letter to Commissioner M. Diane Koken, Insurance Commissioner, The Hospital & Healthsystem Association of Pennsylvania, September 10, 2004, pg. 4.

²⁸ Marshall, 11.

²⁹ Marshall 10,

³⁰ Olmstead, 7.

Paradoxically, while the Commentors cite the need for improved accountability as a justification for reducing the Blue surpluses, they propose to replace it with a form of dedicated tax that is itself remarkably unaccountable.

Conclusion

In general, the commentors state that the Commissioner should compel Blue Cross Blue Shield Plans to “disgorge the excess surplus” to fund certain charitable activities. They believe that this is necessary because they believe Blues’ accumulation of surplus results from an inefficient, uncompetitive market. Commentors state that one aspect of Blue supposed inefficiency stems from the lack of investors who would otherwise force management to pay dividends, thereby reducing surplus.

In their comments, the commentors provide no evidence that the market is inefficient. However, the numerous and often well-capitalized competitors, the opinion of one of the commentors regarding the pricing environment, plus the relatively modest margins of the Blue plans, are indicative of the intensity of competition in the Commonwealth. And while it is true that non-profit organizations do not have shareholders, for-profit health plans, like non-profits, typically do not pay dividends, and those that do pay modestly. Accordingly, the high surplus levels of Blues reflect their significant competitive disadvantage of lack of excess to external sources of equity capital, resulting in their need to retain capital for all future contingencies.

We believe that, in view of the lack of any evidence of inefficiency, regulatory intervention to reduce the level of surplus creates risks for the non-profit purpose that Blue plans are intended to serve.

We also believe that regulatory intervention would be a disturbing precedent for other non-profit operating organizations, such as hospitals. Finally, we believe that distribution of assets in the way suggested by the commentors would create the similar accountability issues as it would purport to solve since it would amount to a dedicated tax.