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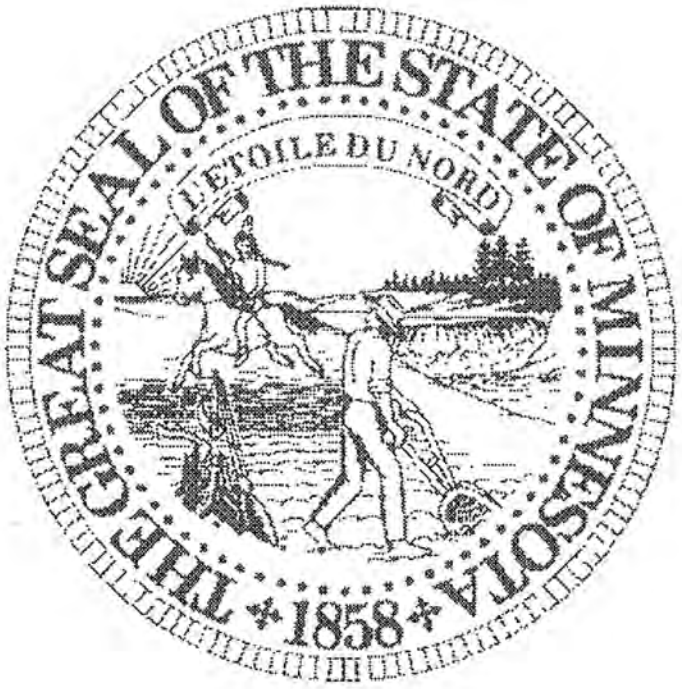
RESERVES AND SURPLUS



Office of Minnesota Attorney General
Mike Hatch

VOLUME I: RESERVES AND SURPLUS

EXECUTIVE SUMMARY

The BCBSM Corridor. Prior to 2004, BCBSM could not have a surplus (net worth) that was less than an amount equal to two months of claims and related expenses nor more than an amount equal to four months of claims and expenses. In the industry, this was known as the "corridor."

Restrictions on maximum amounts of surplus are intended to make sure that BCBSM and other nonprofit health care insurers keep premiums down and not stockpile excess revenue. BCBSM's management, however, did not focus on keeping premiums down or using excess surplus to do so. Management's view, as reflected in a BCBSM document discussing a type of investment that provides a guaranteed--but less than market--rate of return, is reflected in the following quote:

> . . . [I]n a situation in which BCBSM's surplus is in danger of exceeding the maximum, we could enter into a transaction like that illustrated to achieve a certain [rate of return]. The additional potential market appreciation foregone might be of little value to BCBSM if it were to trigger discussions with the Commerce Department to reduce surplus levels.

BCBSM Reported Surplus. According to BCBSM's 2005 financial statements, BCBSM's maximum amount of surplus (net worth) under the corridor was $726,372,538. BCBSM reports in its 2005 financial statements that it has a surplus (net worth) of $693,895,709.

Adjustments. BCBSM engages in a number of unusual accounting maneuvers, however, in order to arrive at its surplus figure. As discussed below, some of these adjustments appear to artificially reduce BCBSM's surplus.

HMO Subsidiaries. BCBSM excludes from its assets the value of its HMOs, which amounts to $190,784,000. According to NAIC accounting standards, BCBSM should include the value of these subsidiaries in determining its surplus. For reasons not explained, the Department of Commerce permits BCBSM to exclude these assets. If these assets were included, BCBSM's net worth jumps to $884,679,709--far above BCBSM's 2004 corridor.

Over-Reserved Claims. In each year of the review, BCBSM significantly over-reserved for claims which were estimated to be unpaid at the end of each calendar year. Over the past five years, the average overage was 11.7%. In its 2005 financial statement, BCBSM states that unpaid claims at year end 2005 amounted to $288,104,351. Applying the 11.7% average, this means that BCBSM is claiming $36,818,000 more in unpaid 2005 claims than will actually be paid. If this amount is deducted from BCBSM's liabilities, there is an increase in surplus (net worth) of $36,818,000.

Policy Reserves. In addition, in 2005 BCBSM claimed $136,900,000 in "policy reserves." BCBSM claims that these monies need to be set aside--and therefore deducted from surplus--because existing policies have a guaranteed renewable rate that will not permit adequate premium increases to pay for future claims. For instance, as part of the "policy reserves," BCBSM claims that $19.4 million is necessary to cover claims on "rated group policies." BCBSM neglects to point out that it does not have to renew such policies nor are rates fixed for these policies. This reserving practice is not consistent with statutory accounting practices, which permits such reserves only where claims are expected to exceed premiums "for the remainder of the contract." In this case, there is no fixed price contract in place that covers future claims.

Foundation. BCBSM regularly contributes to BCBSM Foundation, Inc. amounts far in excess of the grants made by the Foundation. Because these contributions lower the asset value of BCBSM, and because the purpose of this review is to determine the true "net worth" of the company at a time when health premiums are skyrocketing, the value of the Foundation, or $51,395,639, is included in determining BCBSM's surplus.

Adjusted Surplus. BCBSM's surplus, with the above adjustments, is as follows:

BCBSM's Stated Surplus:	$ 693,895,709
HMO Subsidiaries:	$ 190,784,000
Over-Reserved Claims:	$ 36,818,000
Policy Reserves:	$ 136,900,000
Foundation Equity:	$ 51,395,639
TOTAL	**$1,109,793,348**

If the 2004 corridor were applied, BCBSM's surplus (net worth) of $1,109,793,348 would be $383,420,810 above the corridor limit of $726,372,538. This means BCBSM's surplus would be 152% of the maximum permitted by statute.

Risk-Based Capital. In 2004, the legislature changed the financial restrictions applicable to BCBSM. It eliminated the BCBSM minimum/maximum corridor and adopted a risk-based capital methodology. The risk-based capital ("RBC") of BCBSM is reported to be $92,199,281. BCBSM is required by law to maintain a surplus equal to 200% of its RBC, or $184,398,562. BCBSM's surplus, as adjusted by this report, exceeds 1200% of its RBC.

Conclusion. There has been considerable controversy in other states where Blues' companies report a net worth nearly 800% above their RBC (Michigan) or five times higher than the required level (California). BCBSM's ratio between its RBC and its current net worth, as adjusted by this report, appears to be the largest in the country.

This report raises a number of concerns regarding BCBSM's stockpiling of funds, the Department of Commerce's oversight of BCBSM and BCBSM's failure to lower or even attempt to control premium growth. In fact, in its review of the tens of thousands of documents produced by BCBSM in this audit, the AGO found no reference to any attempt by BCBSM to keep premiums down to make health insurance more affordable for Minnesotans.

RESERVES AND SURPLUS

INDEX

I. INTRODUCTION.

The Nonprofit Health Service Plan Corporations Act, Minnesota Statutes, chapter 62C, *et seq.*, explicitly defines the purpose of a nonprofit health service plan corporation. Such a corporation must "promote a wider, more economical and timely availability of hospital, medical-surgical, dental and other health services for the people of Minnesota, through nonprofit, prepaid health service plans, and thereby advance public health and science of medical and healthcare within the State ...."[1] The Act exists to *"reasonably regulat[e]* the formation, continuation, operation, and termination of *such service plans by establishment and enforcement of reasonable and practical standards of administration, investment, surplus and reserves.*"[2] Accordingly, as part of this compliance review, the reserves and surplus of BCBSM were reviewed to determine whether they are "reasonable and practical".

As discussed below, it appears that by creating a series of questionable categories of "reserves," BCBSM may have understated its surplus by approximately $173 million as of December 31, 2005. In addition, it appears that BCBSM understated its assets by $190,784,000. When these amounts are included in BCBSM's financial statements, its total net worth, or "surplus," is over $1 billion.

II. BCBSM'S ADMITTED ASSETS.

An insurer's surplus, or net worth, is generally determined by taking the amount of its "admitted assets" and deducting the total amount of the insurer's liabilities. "Admitted assets"

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[1] Minn. Stat. § 62C.01, subd. 2 (2004) (emphasis added).
[2] *Id.*

are generally defined under statutory accounting principles as assets which can be readily used to fulfill policyholder obligations.[3]

BCBSM does not include as admitted assets, and therefore in its surplus, its investments in subsidiary HMOs. (Exhibit 26). While BCBSM acknowledges that the National Association of Insurance Commissioners Accounting Practices and Procedurals Manual ("NAIC SAP") has been adopted for use by the State of Minnesota and that the NAIC SAP requires that such investments and surplus notes be included as admitted assets, it states:

> BCBSM, with permission from the Minnesota Department of Commerce, reports its investments in affiliated HMOs as a non-admitted asset instead of admitting those investments pursuant to NAIC SAP. These affiliated HMOs include: Blue Plus, Atrium Health Plan and First Plan of Minnesota. If these investments were to be admitted, statutory surplus at December 31, 2005 would be increased by $190,784,000 ...

(*Id.*)

It makes no sense why the Department of Commerce would allow BCBSM to exclude these amounts from its calculation of surplus. In a letter dated March 15, 1994 from the Department to BCBSM, the Department stated:

> In certain cases BCBSM has been carrying the net worth (reserves) of nonprofit affiliates as an admitted asset. In instances where BCBSM owns no stock of, or holds no executed notes from these affiliates, the Department feels that their net worth should not be carried as an admitted asset.

(Exhibit 4).

More recently, in a letter dated April 22, 2005, the Department granted BCBSM "permission to non-admit investments in nonprofit HMO affiliates in its 2004 Annual Statement." (Exhibit 9).

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[3] *See* Statements of Statutory Accounting Principles ("SSAP") No. 4, as amended by SSAP No. 87.

There is no analysis in these letters why this practice should be permitted. There further is no analysis in the letter as to why BCBSM should be permitted to account for its investments in a manner inconsistent with national insurance standards. Because there is no basis for excluding these investments in affiliates from the calculation of BCBSM's surplus and because the NAIC requires such assets to be included in the calculation of surplus, this review includes the value of these investments of $190,784,000 in BCBSM's surplus.

III. RESERVES

A. Claims Reserves.

The largest expense category of an HMO or health plan is claims. During a policy year, a health insurer agrees to cover the cost of all health care received by the policyholder during the year.[4] Even though a health plan may not receive a bill for services by the end of a policy year, it is required to pay the bill if the covered treatment was rendered during the policy year. Generally speaking, all of these bills (except those for patients hospitalized at year end) will be received within 30-45 days of year end, which is prior to the completion of the insurer's year end financial statements. As a result, the "reserves" for these claims are generally known at the time that the insurer's financial statements are prepared. The larger the estimated unpaid claims costs, the smaller the profit or the larger the loss reported on an insurer's financial statements. The amount of estimated unpaid claims is recorded on an insurer's balance sheet as an increased liability, thereby reducing the surplus or net worth of the company.

[4] This is, of course, subject to the deductibles and exclusions contained in any particular policy.

In the public financial statements filed by BCBSM with the Minnesota Department of Commerce, this estimated expense category is entitled "Claims Unpaid."[5] (Exhibit 1). In the insurance industry, this estimated expense category includes "IBNR", meaning expenses that are "incurred but not reported."

It is well known that insurers may use IBNR as an expense category to "smooth" a financial statement from one year to the next. If a health insurer performs poorly, it may underestimate IBNR claims to make its financial performance appear better than it is -- this is because the amount of liability for unpaid claims will be underestimated. In contrast, in highly profitable years, an insurer or health plan will try to "over reserve," or overestimate, its unpaid claims so that its financial profits appear to be less than what they actually are.

For each year reviewed in this compliance review, BCBSM over reserved its claims by tens of millions of dollars. The amount over reserved for each year cannot be determined until the following year, after all claims have been paid from the amounts reserved. Accordingly, BCBSM's 2004 financial statements show the amounts that claims were over reserved in 2003, its 2003 financial statements show over-reserves for 2002, and so on. As reflected in Table 1, BCBSM over reserved its *prior year claims* by $26,616,000 in 2001; by $22,145,000 in 2002; by $39,880,000 in 2003; by $20,002,000 in 2004; and by $14,194,000 in 2005.

[5] BCBSM also includes in "Claims Unpaid" claims that were submitted during the policy year but not yet paid.

Table 1.

BCBSM, Inc.	2005	% Over	2004	% Over	2003	% Over	2002	%Over	2001	% Over
Claims Incurred in Prior Years	$288,104,351		$223,189,907		$189,423,445		$199,674,317		$214,868,965	
Reserves at December 31 Prior Year	$302,298,351		$243,191,907		$229,303,445		$221,819,317		$241,484,965	
Reserve (Over) Under Claims at December 31 of Prior Year	($14,194,000)	4.93%	($20,002,000)	8.96%	($39,880,000)	21.05%	($22,145,000)	11.09%	($26,616,000)	12.39%

*Source: Annual Statements of Blue Shield, Inc. d/b/a Blue Cross Blue Shield of Minnesota for the years ended December 31, 2001 -- December 31, 2005.

On average, BCBSM over reserved its claims 11.7% per year from 2000 through 2004. Based on this average, BCBSM held an estimated $36,818,000 in over-reserves at December 31, 2005.[6] This practice resulted in BCBSM understating its income from approximately $6.5 million to $39.9 million for each year reviewed.

This understatement was particularly significant prior to 2004, when HMOs and nonprofit health service plans were subject to statutory net worth limits.[7] Because these organizations operate on a nonprofit basis, Minnesota law limited the amount of money that the organizations could accumulate as net worth, or "surplus." While the legislature repealed the caps on net worth in 2004, the overstating of claims reserves should be a concern in that it allows health plans to overstate their loss ratios and to impose premium increases which are not supported by actual claims experience.

[6] The average results from taking BCBSM's actual 2005 claims reserve of $314,682,889 and multiplying it by 11.7% -- the average percent over-reserved by BCBSM during the past five years.

[7] *See* Minn. Stat. § 62C.09 (2002).

B. Policy Reserves.

1. What are Policy Reserves?

Policy reserves are established for individual and group accident and health contracts where constant or level premiums are assumed for certain noncancellable or guaranteed renewable contracts.[8] For example, the amount of premium for some insurance policies is based on the insured's age at the time that the policy is issued, and the insured is allowed to continue to renew the policy at the same rate for 20 years. As a person ages, however, his or her related morbidity, risk of loss and the actual cost of coverage may increase over time even though the premium remains the same during the period in which the policy may be renewed. Many term life insurance policies fall into this category -- the insured pays an annual premium based on his or her age when the policy is first issued and is able to continue to pay that amount of premium to annually renew the policy. The premium remains the same even though the insured's likelihood of death, and the insurer's risk of loss, increases with age. Because the policy has increased risk but generates a level premium in later years, insurers may establish reserves to be set aside from the early years' premiums to pay for the claims that experience indicates are more likely to be incurred as the policyholder ages and the policy continues in force.

In addition to permitting general policy reserves, statutory accounting principles also allow the establishment of a "premium deficiency reserve" when the expected claims payments and related costs exceed the premiums to be collected for the remainder of the policy or contract.[9] A premium deficiency reserve is recognized by recording a liability for the deficiency on the insurer's balance sheet and recording an expense on the insurer's income statement.

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[8] Statements of Statutory Accounting Principles ("SSAP") No. 54.
[9] *Id.*

2. BCBSM's Policy Reserves.

BCBSM established significant policy reserves over the review period. Table 2 reflects the policy reserves set aside by BCBSM for each year from December 31, 2001 through December 31, 2005. The amount of policy reserves retained by BCBSM has consistently grown over the review period. Most recently, BCBSM increased policy reserves by $6,750,000 in 2005, with the total amount of policy reserves at December 31, 2005 equaling $146,350,000.

Table 2.

BCBSM's Five Year Policy Reserve Analysis*

Description	2005	2004	2003	2002	2001
Policy Reserves	$136,900,000	$131,300,000[10]	$102,600,000	$94,300,000	$88,700,000
Reserve for Rate Credits or Experience Rating Refunds	9,450,000	8,300,000	6,300,000	4,533,000	5,599,000
Aggregate Policy Reserves	146,350,000	139,600,000	108,900,000	98,833,000	94,299,000
Increase (Decrease) Over Prior Year	6,750,000	30,700,000	10,067,000	4,534,000	

*Source: "Underwriting and Investment Exhibit, Part 2D -- Aggregate Reserve for Accident and Health Contracts Only," BCBSM's Annual Statements for the Years Ended December 31, 2001 through December 31, 2005.

3. Comparison of BCBSM's Policy Reserves With Other Health Plans.

It is extraordinarily rare for a health insurer to issue a level premium, multi-year health insurance policy. As a result, it is unusual for a health insurer to establish policy reserves, let alone policy reserves of the amount reported by BCBSM. Table 3 compares the aggregate health

[10] Includes a $19,400,000 premium deficiency reserve; a $59,400,000 gross premium valuation reserve -- individual; a $6,000,000 gross premium valuation reserve -- medicare supplement; and a $46,500,000 gross premium reserve -- portability. (Exhibit 2).

policy reserves of BCBSM with the other two major health plans in Minnesota -- HealthPartners and Medica. As illustrated in Table 3, neither HealthPartners nor Medica had *any* health policy reserves as of December 31, 2004. In fact, during the past four years, Medica had established policy reserves only once, in the amount of $11,000,000, when premiums received from the State of Minnesota for its Medicaid Program were estimated to be inadequate to cover the expected health care costs. HealthPartners had established a policy reserve in each of 2001, 2002 and 2003, but the maximum amount of the reserve at any one time was only $10,063,000.

Table 3.

Aggregate Health Policy Reserves	2004	2003	2002	2001
Blue Cross Blue Shield Minnesota	$139,600,000	$108,900,000	$98,833,000	$94,299,000
HealthPartners, Inc.	$0	$10,063,000	$9,000,000	$9,000,000
Medica Health Plan, Inc.	$0	$0	$11,000,000	$0
*Source: BCBSM, HealthPartners and Medica 2001 to 2004 Annual Reports.				

4. Premium Deficiency Reserves.

BCBSM claims that the $19.4 million "premium deficiency reserve," identified in Table 2, n.10 as part of BCBSM's policy reserves, is needed for its rated group policies[11] because future losses and expenses are expected to exceed future premiums.[12] (Exhibit 2). These policies, however, do not have a level premium nor is BCBSM required to renew them.

[11] Rated group policies are generally policies issued to employers which have at least 51 employees but are too small to self-insure.

[12] The analysis of BCBSM's rationale for premium deficiency reserves focuses on the amounts reserved in 2004; 2005 data was not available to be timely analyzed.

Thus, BCBSM can charge a premium in future years that is commensurate with any future increased risk or can simply choose not to renew the policies if losses are too high.

BCBSM seems to state that it established this reserve so that it has the ability to set future premiums at a rate below cost. (Exhibit 3). As noted in BCBSM's documents:

> An aggressive pricing strategy is in place for rated group to promote additional enrollment growth and retain existing members ... a premium deficiency reserve of $12 million will be required in 2003 due to competitive pricing strategies in 2004.

(Id.)

By establishing a premium deficiency reserve for this line of business, BCBSM sets aside funds today which can be used to subsidize future premiums. These amounts are then recorded as a "loss" or expense on BCBSM's current financial statements. BCBSM is, in effect, using (and deducting from its income) today's premiums to pay tomorrow's claims.

This practice does not appear to be consistent with statutory accounting principles. As noted above, premium deficiency reserves may be established when claims and costs are expected to exceed premiums "to be collected for the remainder of a contract." Here, there is no contract which limits the amount of premiums BCBSM can charge in the future; rather, BCBSM is simply creating a "loss" or expense on its financial statements by claiming that it will renew or issue policies in the future at an inadequate rate -- even though it has no obligation to charge the inadequate rate.

5. Reserve for Rate Credits or Experience Rating Refunds.

BCBSM also posts in its December 31, 2004 financial statements, $8,300,000 in a category entitled "reserve for rate credits or experience rating refunds." This amount appears to have increased to $9,450,000 in 2005. (Exhibit 27). BCBSM indicates that these funds are a "premium stabilization reserve" for the State of Minnesota Retiree Account. (Exhibit 2).

BCBSM further indicates that this account is experience-rated[13] and, therefore, "BCBSM holds a reserve for any excessive premium over claims and expenses for this account." (*Id.*) BCBSM further states that "depending on the needs of the group, the reserve can be used to reduce premiums paid for the following year, or may grow with interest for use by the State in a subsequent year." (*Id.*) In other words, as of December 31, 2005, BCBSM was holding $9,450,000 which should be refunded to the State of Minnesota because the State overfunded the policies issued to its retirees.

It is not clear why the amount of refund has consistently grown over the past three years from $4,533,000 in 2002 to $9,450,000 in 2005 rather than being used toward premium reductions or returned to the State. These funds should be refunded to the State of Minnesota rather than held in a reserve account on the books of BCBSM.

6. Gross Premium Valuation Reserves.

The largest portion of the policy reserves is, according to BCBSM, "gross premium valuation reserves," which totaled $111.9 million at December 31, 2004.[14] (Table 2, n.10). BCBSM has established these reserves for its individual policies, its Extended Basic Medicare Supplement product, and its portability product.

(a) Reserve for extended basic Medicare Supplement.

BCBSM indicates that policy reserves are needed for this product because the product is guaranteed renewable and the "indicated rate need for the product is greater than regulators are willing to approve, resulting in a product that is underpriced". (Exhibit 2).

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[13] An experience-rated policy is one where the premium is based on the insured's loss history. Experience rating may result in a premium surplus if the insured's actual losses are less than estimated. In those cases, the surplus may be refunded to the insured or offset future premiums.

[14] The analysis of BCBSM's gross premium valuation reserves focuses on the amounts reserved in 2004; 2005 data was not available to be timely analyzed.

BCBSM claimed in 1998 that it needed to establish a reserve for this block of business because the business was "closed" -- meaning that the company was no longer offering this coverage to new subscribers. (Exhibit 24). According to BCBSM, rates must increase over time for this business because members age but that rate increases for "some" closed blocks of business have "been higher than the Department [of Commerce] has been willing to approve." (*Id.*) The Department of Commerce thereafter authorized the establishment of reserves for BCBSM's "closed blocks of Medicare Supplement policies". (Exhibit 5).

BCBSM now admits, however, that it "released the reserve on closed blocks" in 2004 and that the current reserve is for its "open blocks of business," which are also "substantially underpriced". (Exhibit 2). No Department approval appears to have been obtained for the establishment of reserves for open blocks of business. Nor does there appear to be any legal basis for the establishment of such reserves.

It is not clear why reserves for BCBSM's Medicare Supplement business were permitted by the Department of Commerce in 1998, even if they represented a closed block of business. While BCBSM's Medicare Supplement policies are guaranteed renewable, their price is not fixed and could be increased if necessary.

And even if there were a basis to allow reserves for a "closed" book of business, there is no similar basis to establish them for an open book of business. While BCBSM claims that the premiums for its Medicare Supplement policies are "underpriced," its internal documents show that BCBSM's Senior Products are a "steady performer," generating profit "both in recent years and over the longer term". (Exhibit 25). There is simply no justifiable reason for these reserves.

(b) Reserve for individual policies.

BCBSM indicates that it received approval from the Department of Commerce in 1994 to establish a gross premium valuation reserve for its individual policies. (Exhibit 2). In that regard, the Department stated in a letter that "the gross premium valuation method of establishing reserves, as outlined in [BCBSM's] letter of December 16, 1993 is an acceptable alternative under statutory accounting as applied by [BCBSM].". (Exhibit 4).

Interestingly, BCBSM's letter of December 16, 1993 appears to respond to concerns expressed by the Department that BCBSM's surplus (net worth) would exceed the maximum surplus permitted under Minnesota law at December 31, 1993. (Exhibit 23). In other words, the Department was concerned that BCBSM was accumulating too much money. To address the Department's concern, BCBSM adopted a "detailed plan of action" that would ensure that BCBSM complied with Minnesota's surplus limits. (*Id.*) BCBSM's "plan of action" was simple -- it increased its reserves. (*Id.*) Specifically, BCBSM established two new "gross premium reserve" accounts and one "rate stabilization reserve" account. (*Id.*) By creating $71 million in new reserves, BCBSM reduced its surplus (net worth) by approximately $71 million and it no longer exceeded the maximum set forth in Minnesota law.

It is not clear why the Department approved this $71 million in reserves and consequent reduction in surplus, particularly since the approval was based solely on BCBSM's claim that gross premium reserve accounts are appropriate whenever "future outflows" exceed "future income".[15] BCBSM cited no accounting principles which supported the establishment of

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[15] This is not an accurate description of when a premium deficiency reserve is appropriate. As stated in SSAP No. 54, a premium deficiency reserve is appropriate when the expected claim payments and related costs exceed the premiums to be collected *for the remainder of a policy or contract*. Such a reserve is not necessary where the costs of coverage are expected to increase in
(Footnote Continued on Next Page)

reserves under these circumstances. Nor did BCBSM provide any actuarial support for these reserves.

The individual policies issued by BCBSM are guaranteed renewable.[16] The rates charged, however, are not fixed. Indeed, individual rates can be adjusted by 50% based on age alone,[17] and BCBSM has consistently increased rates for its individual policies. (Exhibit 11). In fact the average premium increase ranged from 9.25% to 17.75% over the period reviewed.[18] (Table 7 and Exhibit 11). BCBSM has set forth no legitimate basis for the establishment of these reserves and the coinciding deduction of these monies from its income.

(c) Reserve for portability product.

BCBSM's portability product is an individual policy BCBSM must issue to persons who "convert" from group coverage to individual coverage, as provided under Minnesota law.[19] BCBSM indicates that "a reserve is needed for [its portability] product because the rates may not exceed 100% of the Minnesota Comprehensive Health Association rates, although this rate isn't sufficient for this product." (*Id.*) BCBSM increased the reserve for this product by $6,700,000 from 2003 to 2004. Yet, if the rate charged for this product is insufficient to pay the claims and costs associated with it as asserted by BCBSM, BCBSM would not have had $6.7 million of "excess" premiums available in 2004 to set aside for future claims. In other words, there would

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the future, but future premiums can be increased to offset any such costs or policies can be nonrenewed.

[16] *See* Minn. Stat. § 62A.65, subd. 2 (2004).

[17] *See* Minn. Stat. § 62A.65, subd. 3 (2004).

[18] This increase pertained just to the "indexed rate". Variations are permitted to the indexed rate so that the actual premium increase for an individual may have exceeded these increases in any one year. *See* Minn. Stat. § 62A.65, subd. 3 (2004).

[19] *See* Minn. Stat. § 62A.17, subd. 6 (2004).

be no monies remaining, after payment of current claims and costs, to set aside for any future claims.

The facts are inconsistent with BCBSM's explanation of why this reserve is needed. BCBSM provided no actuarial or accounting support for its claim that rates for this product are insufficient to cover claims. And further, it does not appear that even the Department of Commerce ever approved this reserve.

7. Summary.

With the exception of the $9,450,000 refund due to the State of Minnesota, which ought to be refunded, amounts set aside by BCBSM as policy reserves in Table 2 are questionable. If these amounts had not been designated as reserves, they would have increased BCBSM's net income for the year in which they were initially set aside. By removing these amounts as liabilities from BCBSM's 2005 annual statement, BCBSM's net worth, or "surplus," would increase by the total amount of these reserves, or $136,900,000.[20]

IV. BCBSM'S EXCESS SURPLUS.

A. Requirements of Minnesota Law.

Chapter 62C sets forth specific requirements regarding a nonprofit health service plan corporation's financial condition. Prior to 2004, Minnesota Statutes, section 62C.09 established both minimum and maximum surplus requirements. (Exhibit 6). If a service plan corporation failed to meet the minimum level of surplus, or if its surplus exceeded the maximum permitted under law, a service plan was required to submit a plan to the Commissioner of Commerce to correct the condition. Where a service plan corporation did not propose measures to correct its

[20] This amount results from deducting the $9,450,000 due to the State of Minnesota from BCBSM's aggregate policy reserves of $146,350,000 as reported in its 2005 Annual Statement.

surplus within a reasonable time, or if a corporation violated the plan which had been approved, the Commissioner could take legal action against the health service plan corporation to bring it into compliance with Minnesota law.

In 2004, the legislature amended Minnesota Statutes, section 62C.09 to repeal the requirements establishing minimum and maximum levels of surplus.[21] In its place, the legislature permitted health service plan corporations to determine their financial solvency pursuant to risk-based capital requirements contained in Minnesota Statutes, sections 60A.50 and 60A.592.[22]

Risk-based capital requirements assess the adequacy of a company's capital by comparing its total adjusted capital, or net worth, with its risk-based capital, or "RBC" -- an amount of capital that reflects the unique level of risk the company has assumed.[23] The greater the company's total risk, the greater its financial cushion or net worth, must be.[24] Under Minnesota law, the minimum requirement is that an insurer's total adjusted capital must be 200% of its RBC.[25]

RBC calculations are used by insurance regulators to monitor the solvency of health organizations. Unlike the provisions of Minnesota law which existed prior to 2004, however, the RBC standards do not set forth any maximum amount of capital or surplus which may be retained by an insurer.

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[21] *See* Minn. Session Laws 2004, c. 285, art. 3, § 11.

[22] *See* Minn. Stat. § 62C.09, subd. 5 (2004).

[23] *Insolvencies/Guarantee Funds,* Insurance Information Institute, *http://iiidev.iii.org/media/hottopics/insurance/insolvencies.*

[24] *Id.*

[25] If an insurer's capital falls below 200% of its RBC, such an incident is considered a "company action level event," and the insurer must take certain remedial actions under the direction of the Commissioner of Commerce. *See* Minn. Stat. §§ 60A.50, subd. 10 and 60A.62 (2004).

Accordingly, as a result of legislative changes made in 2004, no longer is BCBSM subject to any specific maximum amount of surplus it may accumulate. Nonetheless, because it is a nonprofit health service plan corporation with a unique responsibility to the people of Minnesota,[26] BCBSM's surplus must still be "reasonable and practical".

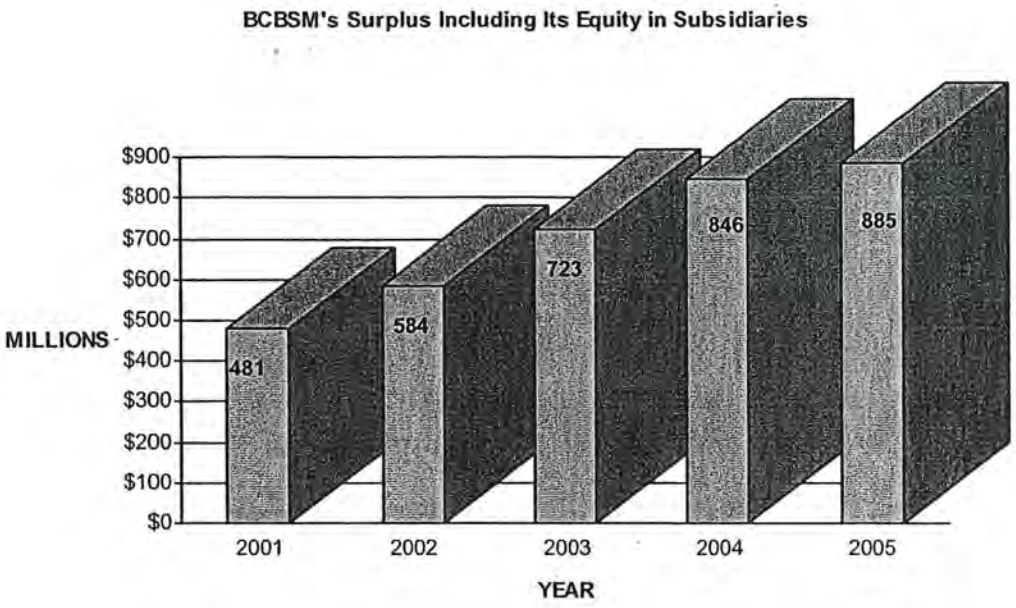
B. BCBSM's Surplus.

BCBSM's net worth, or surplus, has increased dramatically from 2002 to 2005. As of December 31, 2005, BCBSM's total adjusted capital,[27] as reported in its annual statement filed with regulators, was $693,895,709. BCBSM's minimum net worth, required under Minnesota's RBC standards, was $184,398,562. Consequently, under its own calculation, BCBSM had approximately $509,497,000 more in surplus than required under Minnesota law.

As discussed above, however, BCBSM does not include in its surplus calculation the amount of equity it has in its HMO subsidiaries, which totaled $190,784,000 at December 31, 2005. BCBSM's total surplus, with this adjustment, is reflected in Table 4. With this addition, BCBSM's surplus capital at December 31, 2005 was $884,679,709.

[26] *See* Minn. Stat. § 62C.01, subd. 2 (2004).
[27] An insurer's total adjusted capital is roughly the same as its net worth.

Table 4.



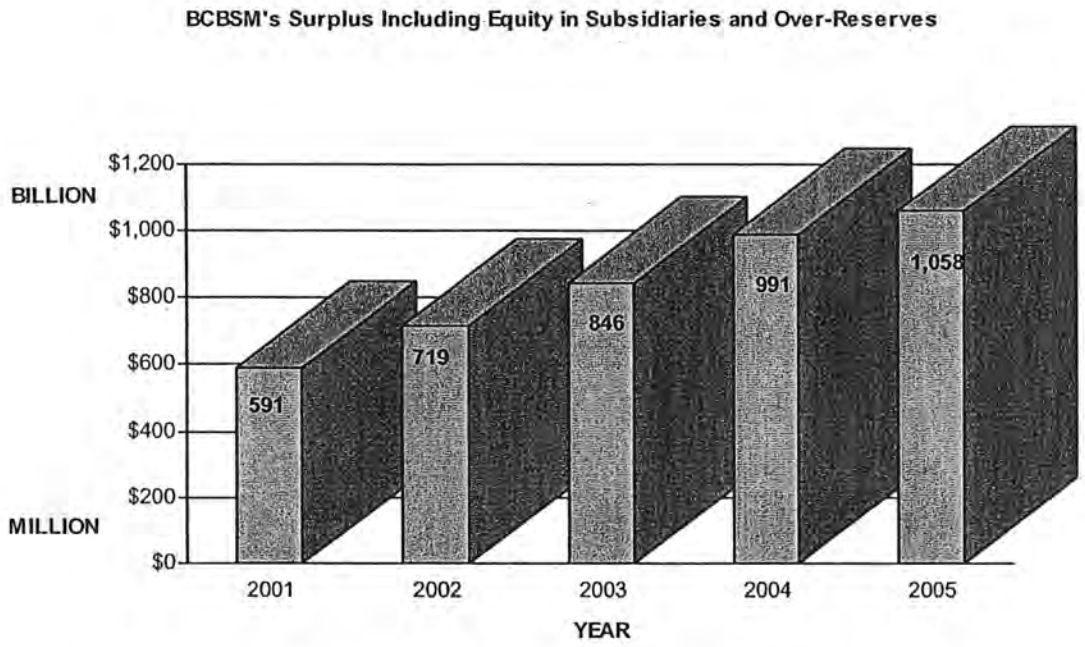
*Source: BCBSM's Annual Statement for the Year Ended December 31, 2005 Five-Year Historical Data and BCBSM's Notes to Financial Statements for Years 2001 to 2005, n.1.

Further, Table 4 does not take into account the amounts which appear to represent over-reserves, as discussed in Section III.B. If BCBSM's claims reserves at December 31, 2005 exceed claims by the average amount of over-reserves during the past five years, an excess reserve of $36,818,000[28] exists. Further, elimination of the policy reserves which do not appear to be authorized under Minnesota law results in an additional $136,900,000 in excess funds. Removing these amounts as "liabilities" of BCBSM and adding them to surplus results in a total

[28] This average results from taking BCBSM's actual 2005 claims reserve of $314,682,889 and multiplying it by 11.7% -- the average percent over reserved by BCBSM during the past five years.

net worth or surplus, of over $1 billion. BCBSM's surplus with these adjustments is reflected in Table 5.

Table 5.



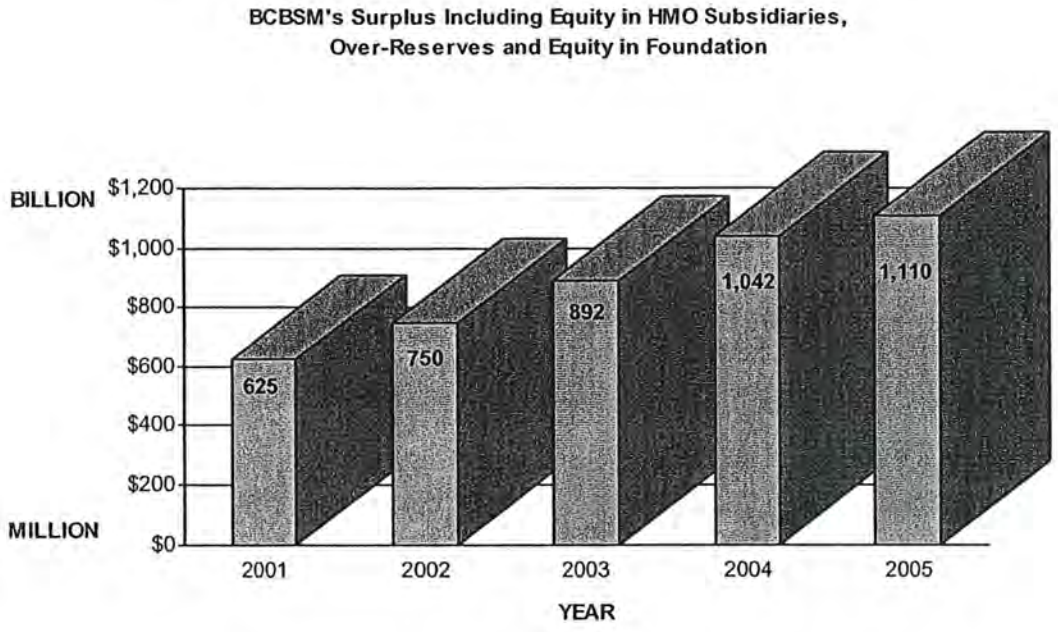
Finally, as noted in the volume of this report entitled "Affiliate Transactions and Administrative Expenses," BCBSM entirely funds its affiliated foundation, BCBSM Foundation, Inc. (the "Foundation").[29] Not only does BCBSM finance the Foundation, but nine of the 13 members of the Foundation's board of directors are BCBSM employees. At December 31, 2004, the equity of the Foundation totaled $51,395,639. (Exhibit 28).

If BCBSM did not fund the Foundation, those monies would have been included in BCBSM's surplus. Accordingly, for purposes of determining BCBSM's surplus -- or the amounts by which BCBSM's revenues exceeded the cost of claims and other related liabilities --

[29] While BCBSM funds the Foundation almost entirely, its largest vendor, American Healthways, contributed $22,000 to the Foundation during the review period.

the AGO calculated the amount of BCBSM's surplus to include the equity of the Foundation. That calculation of surplus is reflected in Table 6.

Table 6.



With this addition, BCBSM's surplus totals more than $1.1 billion and reflects an increase of approximately 75% in just four years.

As discussed previously, the minimum surplus an insurer must have under Minnesota law is 200% of its RBC. Table 7 reflects BCBSM's surplus at December 31, 2005 with the adjustments discussed above and compares it to the minimum level of surplus required under Minnesota law.

Table 7.

BCBSM's Surplus and Excess Surplus As Adjusted	
Description	2005
Total Adjusted Capital-BCBSM	$693,895,709
Plus Investments in HMOs	$190,784,000
Plus Avg. Amt of Claims Over-reserves	$ 36,818,000
Plus Policy Reserves	$136,900,000
Plus Foundation Equity	$ 51,395,639
Total Surplus Capital	$1,109,793,348
Amount of Risk-Based Capital (RBC)	$ 92,199,281
Authorized Control Level at 200% of RBC	$184,398,562
Surplus Capital Above 200%	$925,394,786
Risk-Based Capital Percentage	1203%[30]

The Table shows that BCBSM had surplus of more than $900 million in excess of that required under Minnesota law and more than 1200% of its RBC.

C. Excess Surplus Over Pre-2004 Standards.

Prior to 2004, Minnesota law set a limit on the amount of surplus that could be accumulated by a nonprofit health service plan corporation. Specifically, it provided:

> ...The surplus shall not exceed 33-1/3 percent of the sum of all health service claims incurred, and administrative expenses in connection therewith, during the most current calendar year...[31]

In its 2005 financial statements filed with the Department of Commerce, BCBSM reported total medical and hospital claims of $1,898,625,420 and total administrative and claims adjustment expenses of $280,492,193, for a sum of $2,179,117,613. One-third of this amount is $726,372,538 and, accordingly, that is the maximum amount of surplus that BCBSM could have

[30] BCBSM's risk-based capital percentage is determined by dividing BCBSM's total surplus capital ($1,109,793,348) by its amount of risk-based capital ($92,199,281).
[31] Minn. Stat. § 62C.09, subd. 3 (2002).

had under the pre-2004 law. Factoring in the adjustments described above, BCBSM had almost $400 million more in surplus than was legally permitted under the pre-2004 law.

D. While BCBSM's Surplus Increased, so did its Premiums.

It is difficult to determine the precise premium increases imposed by BCBSM for each of its products over the review period. BCBSM's health products include rated group products for larger businesses, Medicare supplement insurance policies, individual insurance policies, small group policies, and plan administration for self-insured businesses.

The Minnesota Department of Commerce maintains data with respect to premium increases for certain products offered by BCBSM and other health plans. Specifically, pursuant to Minnesota Statutes, chapter 62L, the Departments of Health and Commerce are required to maintain data with respect to the premiums charged to individuals and to small employers -- which are defined to be those employers with 50 or fewer employees.[32] Information obtained from the Department of Commerce with respect to premium increases imposed by BCBSM since 2000 is attached. (Exhibit 11). A summary of this information is set forth in Table 8.

[32] *See* Minn. Stat. § 62L.02, subd. 26.

Table 8.

BCBSM Indexed Premium Increases for Individuals and Small Groups						
Description	**2005**	**2004**	**2003**	**2002**	**2001**	**2000**
Average Increase for Individual Policy[33]	NA	10.95%	9.25%	16%	11.80%	17.75%
Average Increase for Small Business Policy	9.6%	3.55%	13.65%	NA	15.2%	NA

As the above shows, even though BCBSM has been accumulating record levels of surplus, it continues to significantly increase premiums. Further, with respect to the individuals BCBSM insures, BCBSM appears to be holding a portion of the premiums paid by these individuals for claims in future years, as previously discussed. There is no reason why a portion of today's skyrocketing premiums should be held in reserve when BCBSM can later adjust premiums to pay for any increase in future claims.

BCBSM continues to increase premiums. For instance, BCBSM increased its Medicare Supplement insurance rates for 2006 by almost 13 percent. (Exhibit 13).

One of the primary responsibilities of a nonprofit health service plan, as specifically set forth in Minnesota law, is to promote the more economical availability of health care through its prepaid health service plans.[34] BCBSM is ignoring this responsibility. Instead of focusing on making health care more economical and affordable through its health service plans, BCBSM appears more intent on increasing its surplus through the sale of these plans.

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[33] The increases do not include "InstaCare" products which are generally in effect for less than a year.

[34] Minn. Stat. § 62C.01, subd. 2 (2004).

This fact is aptly illustrated by a BCBSM staff presentation to the BCBSM's board of directors' investment committee in 2003. At the meeting, staff were discussing the benefits of participating in an investment program which would provide a guaranteed, but "capped," return on investment. The staff noted that, even if the guaranteed investment return is less than the market rate of return, there was a benefit to BCBSM because a high market rate of return would result in too much net worth or surplus, which might draw the regulators' attention to the fact that BCBSM has too much money:

> The additional potential market appreciation foregone might be of little value to BCBSM if it were to trigger discussions with the Commerce Department to reduce surplus levels.

(Exhibit 14). Staff doesn't mention, let alone analyze, whether the foregone investment return could be used to reduce premiums for subscribers. Instead, BCBSM was focused on "flying under the regulatory radar," even if it meant foregoing a higher rate of return on its investments, which could potentially have been used to reduce premiums.

E. Growing Nationwide Concern over Blues' Excess Surplus.

The dramatic increase in the surplus of Blues' organizations throughout the country has sparked criticism from regulators in other states. For unknown reasons, the Minnesota Department of Commerce has been strangely silent on this issue. Indeed, the Department's actions as described in this compliance review appear to be complicit with BCBSM in glossing over this issue.

In the State of Michigan, for example, lawmakers threatened to revoke Blue Cross Blue Shield of Michigan's nonprofit status because of its excess surplus. Like Minnesota, Michigan law requires the Blues to have surplus at least equal to 200% of its RBC. At the end of 2004, Blue Cross Blue Shield of Michigan had surplus which was nearly 800 percent of its RBC. (Exhibit 17). As noted by one Michigan legislator:

> We have a crisis when it comes to health care in this State. This is a non-profit company sitting on this amount of surplus. If they want to continue sitting on their non-profit status, now is the time for them to become part of the solution.[35]

By comparison, BCBSM's surplus, including its over-reserves and equity in HMO and Foundation affiliates, is more than 1200% of its RBC.

Legislators and regulators in other states have expressed similar concerns about the excess surplus of various Blues organizations:

- **California:** "Regulators to Examine Reserves at Blue Cross; The Amount is About Five Times the Required Level, Attracting Attention in Light of Recent Premium Hikes Being Investigated", *Los Angeles Times*, May 18, 2005. (Exhibit 15).

- **Maryland:** "Legislators and advocates have complained over the past few years ... that CareFirst [Blue Cross Blue Shield], the largest health insurer in the State, was making too much money and not fulfilling its mission as a non-profit," *The Baltimore Sun*, March 15, 2005. (Exhibit 16).

- **Montana:** "The state insurance commissioner requires Blue Cross Blue Shield to carry a minimum of $28 million in reserves. Helena nurse-practitioner Beth Sirr called the company's $90 million surplus 'excessive'", "Blue Cross Critic: Surplus Excessive", *Billings Gazette*, October 17, 2004. (Exhibit 18).

Concerns about "excess surplus" in nonprofit Blues plans have also been raised in **Delaware, Hawaii, North Carolina, Pennsylvania, Washington** and **Washington, D.C.** (Exhibits 19, 20 and 21). In addition, three non-profit Blue Cross Blue Shield plans -- those in **New Jersey, Rhode Island** and **Tennessee** -- have announced they would be issuing refunds to members in response to growing criticism from regulators about their excess surplus and reserve accounts. (Exhibit 22).

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[35] "Blues Told to Give up Surplus," *The Detroit News*, June 17, 2005. (Exhibit 17).

Interestingly, there has been no regulatory action or public debate in Minnesota regarding BCBSM's excessive surplus. Certainly, BCBSM's surplus cannot be deemed to be "reasonable" as required under Minnesota Statutes, section 62C.01, subdivision 2. If the excess surplus were returned to Minnesota subscribers, the impact would be significant. For example, if the potential $925 million in excess surplus were returned to BCBSM's approximately 740,000 fully-insured members, each member would receive roughly $1,250. Viewed another way, BCBSM's excess surplus could be used to provide MinnesotaCare coverage to every uninsured adult in Minnesota for *almost three years.*[36]

V. RECOMMENDATIONS.

BCBSM's stockpiling of surplus is reprehensible. As disturbing is the Department of Commerce's failure to take any action to curtail BCBSM's accumulation of surplus. In fact, the Department appears to have in many instances facilitated BCBSM's surplus growth. The AGO recommends that the following steps be taken to address the problem.

1. The Department of Commerce should not permit BCBSM to exclude the value of its HMO subsidiaries in deviation from statutory accounting principles.

2. The Department of Commerce should not permit BCBSM to book policy reserves when BCBSM does not issue long-term, fixed rate contracts which have a premium deficiency.

3. The Department of Commerce should order BCBSM to refrain from excessive contributions to its Foundation at a time when subscribers' premiums are skyrocketing.

4. Minnesota law should be amended to establish a specific maximum level of surplus that BCBSM and HMOs may accumulate. If BCBSM or an HMO reaches the maximum level of surplus, the law should require it to immediately reduce premium levels or refund monies to subscribers.

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[36] Based on the estimate of 259,497 uninsured adults in Minnesota ("Characteristics of the Uninsured: A View from the States", Prepared for the Robert Wood Foundation by the State Health Access Data Assistance Center, University of Minnesota), and on the average estimated annual premium of $1,308 for single coverage ("MinnesotaCare Premium Table, July 2005 through June 2006").

5. BCBSM's excess surplus should be drawn down and returned to subscribers.

AG: #1543829-v1

LIABILITIES, CAPITAL AND SURPLUS

		Current Year			Prior Year
		1 Covered	2 Uncovered	3 Total	4 Total
	Claims unpaid (less $..... reinsurance ceded)	302,298,351		302,298,351	243,191,907
2.	Accrued medical incentive pool and bonus amounts				
3.	Unpaid claims adjustment expenses	49,738,839		49,738,839	45,033,556
4.	Aggregate health policy reserves	139,600,000		139,600,000	108,900,000
5.	Aggregate life policy reserves				
6.	Property/casualty unearned premium reserves				
7.	Aggregate health claim reserves				
8.	Premiums received in advance	103,961,736		103,961,736	98,878,430
9.	General expenses due or accrued	68,779,691		68,779,691	85,924,162
10.1	Current federal and foreign income tax payable and interest thereon (including $.....2,586,000 on realized capital gains (losses))	12,929,449		12,929,449	17,834,599
10.2	Net deferred tax liability				
11.	Ceded reinsurance premiums payable				
12.	Amounts withheld or retained for the account of others	2,888,414		2,888,414	2,768,206
13.	Remittance and items not allocated	4,493,194		4,493,194	3,809,654
14.	Borrowed money (including $.....21,599 current) and interest thereon $.....178,398 (including $.....178,398 current)	2,821,306		2,821,306	2,842,905
15.	Amounts due to parent, subsidiaries and affiliates	41,974,768		41,974,768	41,664,863
16.	Payable for securities	503,021		503,021	1,928,268
17.	Funds held under reinsurance treaties with ($..... authorized reinsurers and $..... unauthorized reinsurers)				1,463,214
	Reinsurance in unauthorized companies				
	Net adjustments in assets and liabilities due to foreign exchange rates				
20.	Liability for amounts held under uninsured accident and health plans	116,222,728		116,222,728	114,050,137
21.	Aggregate write-ins for other liabilities (including $.....3,897,264 current)	158,841,900		158,841,900	148,744,301
22.	Total liabilities (Lines 1 to 21)	1,005,053,397		1,005,053,397	917,034,202
23.	Common capital stock	XXX	XXX		
24.	Preferred capital stock	XXX	XXX		
25.	Gross paid in and contributed surplus	XXX	XXX		
26.	Surplus notes	XXX	XXX		
27.	Aggregate write-ins for other than special surplus funds	XXX	XXX		
28.	Unassigned funds (surplus)	XXX	XXX	691,771,117	608,412,061
29.	Less treasury stock, at cost	XXX	XXX		
	29.1 ..... shares common (value included in Line 23 $.....)	XXX	XXX		
	29.2 ..... shares preferred (value included in Line 24 $.....)	XXX	XXX		
30.	Total capital and surplus (Lines 23 to 28 minus Line 29)	XXX	XXX	691,771,117	608,412,061
31.	Total Liabilities, capital and surplus (Lines 22 and 30)	XXX	XXX	1,696,824,514	1,525,446,263
DETAILS OF WRITE-INS					
2101.	RETIREE HEALTH	29,283,795		29,283,795	24,541,979
2102.	FEP	54,410,841		54,410,841	49,256,028
2103.	NON ADMIN ACCRUED EXPENSES	3,897,264		3,897,264	3,696,294
2198.	Summary of remaining write-ins for Line 21 from overflow page	71,250,000		71,250,000	71,250,000
2199.	TOTALS (Lines 2101 through 2103 plus 2198) (Line 21 above)	158,841,900		158,841,900	148,744,301
2701		XXX	XXX		
2702		XXX	XXX		
2703		XXX	XXX		
2798.	Summary of remaining write-ins for Line 27 from overflow page	XXX	XXX		
	TOTALS (Lines 2701 through 2703 plus 2798) (Line 27 above)	XXX	XXX		

AG Administrative Audit – BCBSM Response to Request Number 100 (second supplement)

The following information is provided in response to Request Number 100 (Second Supplement) in letter dated October 20, 2005 to include the following accounts:

10/20/05 Additional Accounts Requested				
Account Number	Description	2004	2003	Change
27123	Res-Excess Refund	$(8,300,000)	$(6,300,000)	$(2,000,000)
27124	Gross Premium Valuation Reserve –Individual	$(59,400,000)	$(52,200,000)	$(7,200,000)
27127	Gross Premium Valuation Reserve – Med Sup	$(6,000,000)	$(1,600,000)	$(4,400,000)
27208	Gross Premium Valuation Reserve – Portability	$(46,500,000)	$(39,800,000)	$(6,700,000)
27252	Rated Group Premium Deficiency Reserve	$(19,400,000)	$(9,000,000)	$(10,400,000)

Account 27123 is a premium stabilization reserve for the State of Minnesota Retiree account. This account is considered to be fully experience rated and therefore BCBSM holds a reserve for any excess of premium over claims and expenses for this account. The reserve is calculated as the sum of the premiums for the group, the previous year's balance of the Premium Stabilization Reserve and its investment income less incurred claims and expenses. The level of the Premium Stabilization Reserve is considered in the yearly rate renewal process. Depending on the needs of the group, the reserve can be used to reduce premiums paid for the following year, or may grow with interest for use by the State in a subsequent year. **Attachment 1** provides documentation of the calculation of the reserve as of 12/31/2003 and 12/31/2004.

Account number 27124 is a Gross Premium Valuation Reserve for BCBSM's Individual product. The reserve is needed for this guaranteed renewable product because premiums are level by policy duration, while the claims and administrative expenses are increasing by policy duration. This results in a mismatch of revenues, claims, expenses, and profits. The gross premium reserve corrects for this mismatch of revenue and expense by holding extra revenue back in early policy years when claims plus expenses are low, and releasing it in later policy years when total expenses are high. This reserve was first established in 1993. A March 15, 1994 letter from the Charles Nettell of the Department of Commerce to Dean Heinle of Blue Cross confirming the acceptability of this reserve under statutory accounting is included as **Attachment 2**.

Account number 27127 is a Gross Premium Valuation Reserve for BCBSM's Extended Basic Medicare Supplement. A reserve is needed for this guaranteed renewable product because BCBSM is experiencing adverse selection on this product. The indicated rate need for the product is greater than regulators are willing to approve, resulting in a product that is underpriced. BCBSM is holding gross premium reserve equal to the present value of the future premium deficiencies to

recognize these losses, as BCBSM does not expect to recover them in future premium increases. These reserves were first established in 1998. A November 12, 1998 letter from Julia Phillips of the Department of Commerce to Nancy Nelson of Blue Cross providing confirmation of the actuarial validity of the reserve is provided in **Attachment 3**. In 2004, BCBSM released the reserve on closed blocks and established a reserve for our open extended Basic Plan, which is substantially underpriced.

Account number 27208 is a Gross Premium Valuation Reserve for BCBSM's Portability product. A reserve is needed for this guaranteed issue product because the rates may not exceed 100% of the MCHA rates, although this rate is insufficient for this product. BCBSM is holding a gross premium reserve equal to the present value of the future premium deficiencies in order to recognize these expected losses.

Account number 27252 is a Premium Deficiency Reserve for rated group product. This reserve must be established when future losses and direct expenses exceed expected future premiums. Indirect expenses must also be considered if operating results from other market segments are not adequate to cover these costs. The intent of this reserve is to reflect this expected future shortfall in the current year's financial statement. Documentation of the calculation of this reserve as of 12/31/03 and 12/13/04 is provided in **Attachment 4**.

As additional background on these reserves, please see the following items:

Attachment 5 - A December 1, 2004 letter from Deloitte Consulting to Aileen Lyle of Blue Cross which summarizes Deloitte's review of BCBSM's methodology to calculate the Individual and Portability reserves. Deloitte found that the reserve level and the calculations were reasonable.

Attachment 6 - Statement of Statutory Accounting Principles (SSAP) Number 54 – Individual and Group Accident and Health Contracts and Appendix A-010.

Attachment 7 - The Actuarial Standard of Practice for Determining Health and Disability Liabilities Other Than Liabilities for Incurred Claims.

Attachment 8 - Section VI Premium Deficiency Reserves of the NAIC Health Reserves Guidance Manual.

Attachment 9 - An article by Robert Cummings and Leigh Wachenheim of Milliman USA from the June 1998 newsletter of the Health Section of the Society of Actuaries titled "A Simplified Method for Calculating Contract Reserves."

Attachment 10 - A Milliman USA Research Report by Robert W. Beal on Premium Deficiency Reserve Requirements for Accident and Health Insurance. Milliman USA is a leading actuarial consultancy.

This Exhibit Contains Confidential Information

STATE OF MINNESOTA

OF THE COMMISSIONER — DEPARTMENT OF COMMERCE

133 EAST 7th STREET
ST. PAUL, MN 55101
612/296-4026
FAX: 612/296-4328

March 15, 1994

Mr. Dean Heinle
Vice President Controller of Finance
Blue Cross Blue Shield of Minnesota
Post Office Box 64179
St. Paul, MN 55164-0174

Dear Mr. Heinle:

This letter is intended to confirm the Department's position with regard to the first two issues covered in Norm Storbakken's letter of February 15, 1994 (see attached).

GROSS PREMIUM VALUATION

The Department believes that the gross premium valuation method of establishing reserves, as outlined in the Blue Cross Blue Shield ("BCBS") letter of December 16, 1993, is an acceptable alternative under statutory accounting as applied by BCBS. Therefore the Department does not object to its use. Please be advised that the Department did not perform a detailed review of the assumptions and data used to determine the effect of this method as outlined in the December 16th letter. Consequently, we can make no statements regarding the financial statement impact of this reserving method.

BLUE PLUS AND HMO MIDWEST RESERVES

In certain cases BCBS has been carrying the net worth (reserves) of non-profit affiliates as an admitted asset. In instances where BCBS owns no stock of, or holds no executed notes from these affiliates, the Department feels that their net worth should not be carried as an admitted asset.

If you have any further questions on these issues please do not hesitate to call me at 297-7037.

Sincerely,

Charles Nettell

Charles Nettell
Assistant Commissioner

Post-it™ brand fax transmittal memo 7671	# of pages ▸
To Dean Heimle	From Chuck Nettell
Co.	Co. Commerce
Dept.	Phone # 297-7037
Fax # 683-2164	Fax #

cc: Patrick Nelson

BCBSM 116733

MINNESOTA DEPARTMENT OF COMMERCE

November 12, 1998
Nancy F. Nelson, FSA, MAAA
Vice President & Chief Actuary
BCBSM, Inc.
P.O. Box 64560
St. Paul, MN 55164-0560

RE: Gross premium reserves for Medicare Supplement closed blocks

Dear Ms. Nelson:

As you requested, this letter contains confirmation of my opinion of the actuarial validity of the reserves that BCBSM, Inc. has set up on its statutory financial statements to reflect the future expected deficiency of premium rates for its closed blocks of Medicare Supplement policies. My opinion is based on the information provided in your letters dated May 19, 1998 and July 8, 1998.

In my opinion, and to the best of my knowledge and belief, these reserves are actuarially valid, and represent a liability of BCBSM, Inc.

I have not reviewed the actual calculations, and have not established an opinion as to the accuracy of the amounts that have been set up.

The appropriateness of recognizing the liability is based on two assumptions: (1) the current deficiency of the premium rate relative to claim cost and administrative expenses will continue, and (2) the deficiency of the premium rate will increase substantially due to aging and antiselection.

Both of these assumptions are very likely to be true in the foreseeable future, and will lead to significant premium deficiencies. Even if the company were willing to ask for large rate increases, the Commerce Department would be unlikely to approve them, due to the impact on the policyholders. The result of a rate increase much higher than a trend level is usually that many policyholders lapse, thereby losing valuable protection against high medical bills.

Also, I expect that BCBCM, Inc. will find it necessary to review the calculation of this reserve in the future to see what changes should be made because of the tobacco cessation spending that will presumably lead to decreased claim costs in the future.

Please let me know if you have any further questions.

Sincerely,

Julia T. Philips

Julia T. Philips, FSA, MAAA
Life and Health Actuary

133 East Seventh Street, St. Paul, MN 55101
Tel. (612) 296-4026 • Toll Free (800) 657-3602 • Fax (612) 296-4328 • TTY/TDD (612) 296-2860
e-mail: commerce@state.mn.us

incorporators and directors. Proof of publication shall be filed with the secretary of state within ten days after publication. If a corporation fails to comply with this subdivision, it shall forfeit $50 to the state.

Subd. 4. [Repealed, 1984 c 618 s 61]

History: *1971 c 568 s 6; 1976 c 181 s 2; 1986 c 444; 1989 c 304 s 137*

62C.07 DIRECTORS; MANAGEMENT.

Subdivision 1. The articles of incorporation or the bylaws of a service plan corporation shall provide that the authority and responsibility for election of officers and proper and lawful operation of the corporation shall be in a board of not less than 12 directors with powers and authority as necessary for or instrumental to complete execution of the purposes of the corporation as provided by law, its articles and bylaws. The number of directors shall be fixed by the articles or bylaws.

Subd. 2. The directors shall be selected in accordance with the bylaws and at least one-third shall be individuals who are not practicing or engaged in providing health services, and who before their retirement did not practice or engage in providing health services, are not spouses of such persons, and are not employed by or directors of a provider.

History: *1971 c 568 s 7*

62C.08 CERTIFICATE OF AUTHORITY.

Subdivision 1. No service plan corporation shall enter into subscriber contracts or solicit applications therefor, until it has secured a certificate of authority from the commissioner. Application for a certificate of authority shall be made upon forms prescribed by the commissioner.

Subd. 2. The commissioner may grant a certificate of authority after determining that the applicant is in compliance with Laws 1971, chapter 568 with regard to the applicant's stated purpose, its articles and bylaws and its financial condition, that it has met the filing requirements of Laws 1971, chapter 568 relating to subscribers' contracts and service agreements and that the service plan corporation has knowledgeable, responsible management.

Subd. 3. A foreign service plan corporation applying for a certificate of authority in this state shall be deemed to be a corporation which is organized under Laws 1971, chapter 568, and such foreign corporation shall be required to meet the same requirements as an existing domestic corporation provided that no foreign corporation shall be denied a certificate of authority because its corporate powers exceed those which are permitted by the laws of this state, although its activities in this state may not exceed the powers of a domestic service plan corporation.

Subd. 4. No certificate of authority shall be required for a foreign service plan corporation whose activities in this state are limited to servicing members of covered groups whose contracts have been issued in another state, or for a foreign service plan corporation whose activities in this state are conducted pursuant to a contract or agreement with a licensed domestic service plan corporation if such contract or agreement is authorized by section 62C.13.

History: *1971 c 568 s 8; 1986 c 444*

62C.09 FINANCIAL REQUIREMENTS.

Subdivision 1. The commissioner shall not issue a certificate of authority to any service plan corporation hereafter organized unless the corporation has met all legal requirements and, if organized on a capital stock basis unless the corporation has paid up capital stock of not less than $200,000 and an initial surplus of not less than $200,000, or, if organized on a membership basis, unless the corporation has an initial surplus of not less than $400,000.

Subd. 2. A service plan corporation in existence on August 1, 1971, or hereafter formed shall establish and maintain reserves for claims in process, incomplete and

unreported claims, retroactive cost adjustments to providers, allowances for subscription charges received from subscribers but not yet earned and all other accrued liabilities in accordance with section 60A.12 as it relates to accident and health insurance companies.

Subd. 3. If organized on a capital stock basis, a service plan corporation shall never reduce its capital, and both capital stock and membership corporations shall maintain a surplus, in addition to all reserves established, of not less than the greater of the initial surplus reduced by $100,000 or 16-2/3 percent of the sum of all health service claims incurred, and administrative expenses in connection therewith, during the most recent calendar year. Corporations whose service plans are limited to the provision of dental services or vision care service only and all of whose service plan contracts have limits for specified benefits and limits for average maximum benefits of not greater than $1,000 per year per insured, shall maintain a surplus, in addition to all reserves established, of not less than the greater of the initial surplus reduced by $100,000 or ten percent of the sum of all health service claims incurred, and administrative expenses in connection therewith, during the previous calendar year; but the minimum shall not be required to exceed the financial requirements for surplus required for insurance companies operating upon the stock plan under section 60A.07, subdivision 5a as to those companies described in section 60A.06, subdivision 1, clause 5(a). The surplus shall not exceed 33-1/3 percent of the sum of all health service claims incurred, and administrative expenses in connection therewith, during the most current calendar year unless such amount is less than the initial surplus reduced by $100,000. The percentage amounts shall be determined from a financial statement and certified audit filed annually and subject to verification of an examination by the commissioner.

Subd. 4. If the surplus is less than the required minimum or more than the required maximum, or if a service plan corporation does not have the required reserves or its reserves are not properly computed, operations shall be adjusted to correct the condition, according to a written plan proposed by the corporation and approved by the commissioner. If a service plan corporation does not propose measures to correct its reserve or surplus within a reasonable time, if a corporation violates the plan which has been approved, or if there is evidence that an improper reserve or surplus status cannot be corrected within a reasonable time, the commissioner may take action against such corporation under chapter 60B, or under the suspension and penalty provisions of Laws 1971, chapter 568.

History: *1971 c 568 s 9; 1977 c 261 s 1; 1977 c 405 s 1*

62C.10 INVESTMENT.

Funds of a corporation subject to this chapter shall be invested only in securities and property designated by law for investment by domestic life insurance companies. Notwithstanding any limitations set forth in chapter 61A, an organization which has received a certificate of authority from the commissioner to operate under this chapter may invest up to 20 percent of its admitted assets in corporations whose business is the arrangement for, management of, or provision of health care services, including dental and related managed care and administrative services. Any amounts so invested shall, for purposes of section 62C.09, be added to the minimum and maximum reserve requirements as calculated for a service plan corporation.

History: *1971 c 568 s 10; 1993 c 70 s 1; 1994 c 425 s 12*

62C.11 FINANCIAL STATEMENTS AND EXAMINATIONS.

Subdivision 1. A service plan corporation shall annually on or before the last day of March, file with the commissioner a financial statement, in such form as the commissioner shall prescribe, verified by not less than two of its principal officers, showing the financial condition of the corporation as of December 31 of the preceding year.

Subd. 2. The commissioner shall examine a service plan corporation to ascertain its financial condition, its ability to fulfill its obligations, and its compliance with Laws

Notes to Financial Statement

1. **Summary of significant accounting policies.**

A. Accounting Practices.

The financial statements of BCBSM are presented on the basis of accounting practices prescribed or permitted by the Minnesota Department of Commerce.

The Minnesota Department of Commerce recognizes only statutory accounting practices prescribed or permitted by the State of Minnesota for determining and reporting the financial condition and results of operations and for determining solvency under state law. The National Association of Insurance Commissioners' (NAIC) Accounting Practices and Procedures manual, (NAIC SAP) has been adopted as a component of prescribed or permitted practices by the State of Minnesota.

BCBSM, with permission from the Minnesota Department of Commerce, reports its investments in affiliated HMOs as a nonadmitted asset instead of admitting those investments pursuant to NAIC SAP. These affiliated HMOs include: Blue Plus, Atrium Health Plan and First Plan of Minnesota. If these investments were to be admitted, statutory surplus at December 31, 2004 would be increased by $143,269,000 with no impact on the 2004 income statement.

Also, with the permission of the Minnesota Department of Commerce, BCBSM does not admit its surplus note investments in Blue Plus and First Plan of Minnesota as required by NAIC SAP. If these investments were admitted, statutory surplus would increase $9,700,000 at December 31, 2004 with no impact on the 2004 income statement.

B. Use of Estimates in the Preparation of the Financial Statements.

The preparation of financial statements of insurance companies requires management to make estimates and assumptions that affect amounts reported in the financial statements and accompanying notes. Such estimates and assumptions could change in the future as more information becomes known, which could impact the amounts reported and disclosed herein.

C. Accounting Policies

Fixed Assets

Land is reported at cost. Real estate occupied by BCBSM and real estate held for the production of income are reported at depreciated cost net of related obligations. Real estate that BCBSM has the intent to sell is reported at the lower of depreciated cost or fair value, net of related obligations.

Depreciation is calculated on a straight-line basis over the estimated useful lives of the properties.

Realized Capital Gains and Losses

Realized capital gains and losses are determined using the specific identification basis. Declines in the fair value of any investments below cost that are deemed other than temporary, are recorded as realized losses resulting in a new cost basis for the investment. Changes in admitted asset carrying amounts of bonds, common and nonredeemable preferred stocks are credited or charged directly to unassigned surplus.

MINNESOTA
DEPARTMENT OF
COMMERCE

85 7th Place East, Suite 500
St. Paul, Minnesota 55101-2198
651.296.4026 FAX 651.297.1959 TTY 651.297.3067

April 22, 2005

1st time noncash with the HMO's was 1993.

Timothy A. Schultz, Vice President – Finance
BCBSM, Inc.
P.O. Box 64560
St Paul, MN 55164-0560

Re: Statement of Position 94-1
Investment in Nonprofit HMO Affiliates

Dear Mr. Schultz:

We have reviewed your request that BCBSM, Inc. be permitted to continue non-admitting its investments in nonprofit HMO affiliates, consisting of HMO Minnesota (dba Blue Plus), Atrium Health Plan and First Plan of Minnesota as of December 31, 2004.

The Department hereby grants the Company permission to non-admit investments in nonprofit HMO affiliates in its 2004 Annual Statement.

If you have any questions regarding this letter, please contract Ann Grundl, Senior Analyst, at (651)297-8940.

Sincerely,

Jacqueline L. Gardner

Jacqueline L. Gardner
Assistant Commissioner
Financial Examinations – Insurance/Actuarial

JG:amg
55026-3266

Aware Integrated, Inc.
Condensed Consolidating Balance Sheet

December 31, 2004
(In Thousands)

	BCBSM, Inc.	First Plan	Blue Plus	Atrium	MII, Inc.	Eliminating Entries	Consolidated BCBSM	For-Profit Entities	Aware Integrated
Assets									
Investments available for sale:									
Fixed maturities	$ 565,026	$12,697	$175,509	$21,650	$69,528	$ –	$ 844,410	$ –	$ 844,410
Equity securities	373,377	–	30,213	–	15,957	–	419,547	–	419,547
	938,403	12,697	205,722	21,650	85,485	–	1,263,957	–	1,263,957
Cash and cash equivalents	326,970	9,697	20,278	2,522	(3,196)	–	356,271	21,637	377,908
Accounts receivable	263,867	3,718	41,576	1,081	9,515	–	319,757	1,616	321,373
Property and equipment, net	190,512	6,378	5,633	–	–	–	202,523	–	202,523
Other assets	251,961	1,266	46,302	–	4,429	(269,297)	34,661	11,642	46,303
Deferred income taxes	52,806	–	–	–	124	–	52,930	(4,094)	48,836
Total assets	$2,024,519	$33,756	$319,511	$25,253	$96,357	$(269,297)	$2,230,099	$30,801	$2,260,900
Liabilities and equity									
Liabilities:									
Claims and claim adjustment expenses	315,130	4,601	84,168	7,722	4,553	–	416,224	–	416,224
Policy reserves	131,300	1,400	29,700	–	–	–	162,400	–	162,400
Advance premiums	123,121	2,932	42,920	3,151	911	–	173,035	897	173,932
Accounts payable and accrued expenses	318,464	3,427	1,690	219	32,637		356,437	415	356,852
Other liabilities	57,748	1,106	4,778	970	149	(46,464)	18,287	117	18,404
Notes payable	2,643	5,647	2,643	–	–	(1,552)	9,381	–	9,381
Tobacco settlement liabilities	71,250	–	–	–	–	–	71,250	–	71,250
Total liabilities	1,019,656	19,113	165,899	12,112	38,250	(48,016)	1,207,014	1,429	1,208,443
Minority interest in net assets of subsidiaries	–	6,222	–	–	12,000	–	18,222	–	18,222
Equity:									
Paid-in capital	–	–	–	–	12,229	(12,229)	–	402	402
Accumulated earnings (deficit)	–	–	–	–	33,878	(33,878)	–	30,570	30,570
Equity in not-for-profit affiliates	968,699	8,421	153,612	13,141	–	(175,174)	968,699	(1,600)	967,099
Accumulated other comprehensive income	36,164	–	–	–	–	–	36,164	–	36,164
Total equity	[redacted]	8,421	153,612	13,141	46,107	(221,281)	[redacted]	29,372	1,034,235
Total liabilities and equity	$2,024,519	$33,756	$319,511	$25,253	$96,357	$(269,297)	$2,230,099	$30,801	$2,260,900

BCBSM Individual Market Index Rates

	Date started	########	########	########	########	% change 2001-2002	% change 2002-2003	% change 2003-2004	2001 low	2001 hi	2001 Index	2002 lo	2002 hi	2002 Index	2003 lo	2003 hi	2003 Index
Insta Care																	
$300 Ded no chemical dependency		148.22	148.22	147.75	147.75	0.0%	-0.3%	0.0%	74.06	222.38	148.22	74.06	222.38	148.22	74	221.5	147.75
$300 Ded w/chemical dependency		150.92	150.92	152.19	152.19	0.0%	0.8%	0.0%	75.41	226.43	150.92	75.41	226.43	150.92	76.38	228	152.19
$500 Ded no chemical dependency		115.01	115.01	114.71	114.71	0.0%	-0.3%	0.0%	57.46	172.55	115.005	57.46	172.55	115.005	57.57	171.85	114.71
$500 Ded w/chemical dependency		117.36	117.36	118.15	118.15	0.0%	0.7%	0.0%	58.64	176.08	117.36	58.64	176.08	117.36	59.29	177	118.145
$1000 Ded no chemical dependency	Apr-02	N/A	94.88	94.73	94.73	N/A	-0.2%	0.0%				47.41	142.35	94.88	47.54	141.91	94.725
$1000 Ded w/chemical dependency	Apr-02	N/A	96.83	97.57	97.57	N/A	0.8%	0.0%				48.38	145.27	96.825	48.96	146.17	97.565
$150 Ded, 80/20% Coinsurance																	
Option 1, non-smoking no chem. Dep.		281.50	326.50	364.75	397.75	16.0%	11.7%	9.0%	141	422	281.5	163.5	489.6	326.5	183	546.5	364.75
Option 2, non-smoking w/chem dep		285.75	331.50	375.75	409.50	16.0%	13.3%	9.0%	143	428.5	285.75	166	497	331.5	188.5	563	375.75
Option 3, smoking no chem dep		337.00	391.00	458.50	517.00	16.0%	17.3%	12.8%	168.5	505.5	337	195.5	586.5	391	230	687	458.5
Option 4, smoking w/chem dep		343.50	396.50	472.25	532.50	16.0%	18.5%	12.8%	172	515	343.5	199.5	597.5	398.5	237	707.5	472.25
$300 Ded, 80/20% Coinsurance																	
Option 1, non-smoking no chem. Dep.		262.00	304.00	339.75	370.50	16.0%	11.8%	9.1%	131	393	262	152	456	304	170.5	509	339.75
Option 2, non-smoking w/chem dep		266.75	309.50	349.75	381.50	16.0%	13.0%	9.1%	133.5	400	266.75	155	464	309.5	175.5	524	349.75
Option 3, smoking no chem dep		313.75	364.00	426.75	481.25	16.0%	17.2%	12.8%	157	470.5	313.75	182	546	364	214	639.5	426.75
Option 4, smoking w/chem dep		320.00	371.00	439.50	496.00	15.9%	18.5%	12.9%	160	480	320	185.5	556.5	371	220.5	658.5	439.5
$500 Ded, 80/20% Coinsurance																	
Option 1, non-smoking no chem. Dep.		203.50	236.25	264.75	288.50	16.1%	12.1%	9.0%	102	305	203.5	118.5	354	236.25	133	396.5	264.75
Option 2, non-smoking w/chem dep		206.00	239.00	272.25	297.00	16.0%	13.9%	9.1%	103	309	206	119.5	358.5	239	136.6	408	272.25
Option 3, smoking no chem dep		243.00	282.00	332.50	375.00	16.0%	17.9%	12.8%	121.5	364.5	243	141	423	282	167	498	332.5
Option 4, smoking w/chem dep		248.50	288.25	342.50	386.25	16.0%	18.8%	12.8%	124.5	372.5	248.5	144.5	432	288.25	172	513	342.5
$750 Ded, 80/20% Coinsurance																	
Option 1, non-smoking no chem. Dep.		189.00	219.25	238.25	259.75	16.0%	8.7%	9.0%	95	283	189	110	328.5	219.25	119.5	357	238.25
Option 2, non-smoking w/chem dep		193.00	224.00	245.25	267.75	16.1%	9.5%	9.2%	96.5	289.5	193	112	336	224	123	367.5	245.25
Option 3, smoking no chem dep		226.75	263.00	299.50	337.75	16.0%	13.9%	12.8%	113.5	340	226.75	131.5	394.5	263	150.5	448.5	299.5
Option 4, smoking w/chem dep		230.00	266.75	308.50	347.75	16.0%	15.7%	12.7%	115	345	230	133.5	400	266.75	155	462	308.5
$1000 Ded, 80/20% Coinsurance																	
Option 1, non-smoking no chem. Dep.		159.25	184.75	199.50	217.50	16.0%	8.0%	9.0%	80	238.5	159.25	93	276.5	184.75	100	299	199.5
Option 2, non-smoking w/chem dep		160.75	186.50	205.50	224.00	16.0%	10.2%	9.0%	80.5	241	160.75	93.5	279.5	186.5	103	308	205.5
Option 3, smoking no chem dep		190.50	221.00	250.75	282.75	16.0%	13.5%	12.8%	95.5	285.5	190.5	111	331	221	126	375.5	250.75
Option 4, smoking w/chem dep		192.50	223.25	258.25	291.25	16.0%	15.7%	12.8%	96.5	288.5	192.5	112	334.5	223.25	129.5	387	258.25
$1500 Ded, 80/20% Coinsurance																	
Option 1, non-smoking no chem. Dep.		135.00	156.75	164.00	178.75	16.1%	4.6%	9.0%	67.5	202.5	135	78.5	235	156.75	82.5	245.5	164
Option 2, non-smoking w/chem dep		136.75	158.75	169.00	184.25	16.1%	6.5%	9.0%	68.5	205	136.75	79.5	238	158.75	85	253	169
Option 3, smoking no chem dep		162.75	188.75	206.25	232.25	16.0%	9.3%	12.6%	81.5	244	162.75	94.5	283	188.75	103.5	309	206.25
Option 4, smoking w/chem dep		165.00	191.50	212.25	239.25	16.1%	10.8%	12.7%	83	247	165	96.5	286.5	191.5	106.5	318	212.25
$2000 Ded, 80/20% Coinsurance																	
Option 1, non-smoking no chem. Dep.		123.75	143.50	150.50	164.00	16.0%	4.9%	9.0%	62	185.5	123.75	72	215	143.5	75.5	225.5	150.5
Option 2, non-smoking w/chem dep		127.00	147.00	154.75	169.00	15.7%	5.3%	9.2%	63.5	190.5	127	73.5	220.5	147	77.5	232	154.75
Option 3, smoking no chem dep		147.00	170.75	189.00	213.25	16.2%	10.7%	12.8%	73.5	220.5	147	85.5	256	170.75	95	283	189
Option 4, smoking w/chem dep		152.50	177.00	194.50	219.50	16.1%	9.9%	12.9%	77	228	152.5	89.5	264.5	177	97.5	291.5	194.5
$3000 Ded, 80/20% Coinsurance																	
Option 1, non-smoking no chem. Dep.	Apr-02		125.75	132.25	144.25		5.2%	9.1%				63	188.5	125.75	66.5	198	132.25
Option 2, non-smoking w/chem dep	Apr-02		129.75	136.25	148.50		5.0%	9.0%				65	194.5	129.75	68.5	204	136.25
Option 3, smoking no chem dep	Apr-02		150.50	166.25	187.25		10.5%	12.6%				75.5	225.5	150.5	83.5	249	166.25
Option 4, smoking w/chem dep	Apr-02		156.00	171.25	193.00		9.8%	12.7%				79	233	156	86	256.5	171.25
$5000 Ded, 80/20% Coinsurance																	
Option 1, non-smoking no chem. Dep.		92.75	107.50	112.75	123.25	15.8%	4.9%	9.3%	47	138.5	92.75	54.5	160.5	107.5	56.5	169	112.75
Option 2, non-smoking w/chem dep		95.50	110.75	116.50	126.75	16.0%	5.2%	8.8%	48	143	95.5	55.5	166	110.75	58.5	174.5	116.5
Option 3, smoking no chem dep		111.75	129.75	141.75	160.25	16.1%	9.2%	13.1%	56	167.5	111.75	65	194.5	129.75	71	212.5	141.75
Option 4, smoking w/chem dep		115.00	133.50	146.25	164.75	16.1%	9.6%	12.6%	58	172	115	67.5	199.5	133.5	73.5	219	146.25
$5000 Ded, 100/0% Coinsurance																	
Option 1, non-smoking no chem. Dep.		98.50	114.25	120.25	131.25	16.0%	5.3%	9.1%	49.5	147.5	98.5	57.5	171	114.25	60.5	180	120.25
Option 2, non-smoking w/chem dep		102.00	118.25	123.75	135.25	15.9%	4.7%	9.3%	51.5	152.5	102	59.5	177	118.25	62	185.5	123.75
Option 3, smoking no chem dep		118.75	137.75	151.25	170.50	16.0%	9.8%	12.7%	59.5	178	118.75	69	206.5	137.75	76	226.5	151.25
Option 4, smoking w/chem dep		122.50	142.25	155.50	175.50	16.1%	9.3%	12.9%	62	183	122.5	72	212.5	142.25	78	233	155.5

BCBSM Individual Market Index Rates

	Date started	########	########	########	########	% change 2001-2002	% change 2002-2003	% change 2003-2004	2001 low	2001 hi	2001 index	2002 lo	2002 hi	2002 index	2003 lo	2003 hi	2003 index
$10000 Ded, 100/0% Coinsurance																	
Option 1, non-smoking no chem. Dep.		68.50	79.50	83.50	91.00	16.1%	5.0%	9.0%	34.5	102.5	68.5	40	119	79.5	42	125	83.5
Option 2, non-smoking w/chem dep		70.75	82.00	86.00	93.75	15.9%	4.9%	9.0%	35.5	106	70.75	41	123	82	43	129	86
Option 3, smoking no chem dep		82.75	96.00	104.75	118.25	16.0%	9.1%	12.9%	41.5	124	82.75	48	144	96	52.5	157	104.75
Option 4, smoking w/chem dep		85.00	98.75	108.00	121.75	16.2%	9.4%	12.7%	43	127	85	50	147.5	98.75	54	162	108
$1750 Ded, 80/20% Coinsurance – Single ($1700 ded prior to 4/1/04)																	
Option 1, non-smoking no chem. Dep.	Apr-02		144.75	153.50	167.50		6.0%	9.1%				72.5	217	144.75	77	230	153.5
Option 2, non-smoking w/chem dep	Apr-02		148.00	158.25	172.50		6.9%	9.0%				74	222	148	78.5	237	158.25
Option 3, smoking no chem dep	Apr-02		172.50	193.00	217.50		11.9%	12.7%				86.5	258.5	172.5	97	289	193
Option 4, smoking w/chem dep	Apr-02		178.75	198.50	224.25		11.0%	13.0%				90.5	267	178.75	99.5	297.5	198.5
$1750 Ded, 100/0% Coinsurance – Single ($1700 ded prior to 4/1/04)																	
Option 1, non-smoking no chem. Dep.	Apr-02		161.25	170.50	186.00		5.7%	9.1%				81	241.5	161.25	85.5	255.5	170.5
Option 2, non-smoking w/chem dep	Apr-02		165.00	175.50	191.50		6.4%	9.1%				82.5	247.5	165	88	263	175.5
Option 3, smoking no chem dep	Apr-02		191.75	214.25	241.75		11.7%	12.8%				96	287.5	191.75	107.5	321	214.25
Option 4, smoking w/chem dep	Apr-02		198.75	220.50	249.00		10.9%	12.9%				100.5	297	198.75	110.5	330.5	220.5
$2150 Ded, 80/20% Coinsurance – Single ($2100 ded prior to 4/1/04)																	
Option 1, non-smoking no chem. Dep.	Apr-02		139.25	147.25	160.50		5.7%	9.0%				70	208.5	139.25	74	220.5	147.25
Option 2, non-smoking w/chem dep	Apr-02		143.00	151.50	165.25		5.9%	9.1%				71.5	214.5	143	76	227	151.5
Option 3, smoking no chem dep	Apr-02		165.75	185.00	208.50		11.6%	12.7%				83	248.5	165.75	93	277	185
Option 4, smoking w/chem dep	Apr-02		171.75	190.50	215.00		10.9%	12.9%				87	256.5	171.75	95.5	285.5	190.5
$2150 Ded, 100/0% Coinsurance – Single ($2100 ded prior to 4/1/04)																	
Option 1, non-smoking no chem. Dep.	Apr-02		152.25	161.50	176.00		6.1%	9.0%				76.5	228	152.25			0
Option 2, non-smoking w/chem dep	Apr-02		156.00	166.25	181.25		6.6%	9.0%				78	234	156			0
Option 3, smoking no chem dep	Apr-02		181.00	203.00	229.00		12.2%	12.8%				90.5	271.5	181			0
Option 4, smoking w/chem dep	Apr-02		187.75	209.00	235.75		11.3%	12.8%				95	280.5	187.75			0
$2500 Ded, 80/20% Coinsurance – Single																	
Option 1, non-smoking no chem. Dep.	Apr-02		134.50	142.50	155.25		5.9%	8.9%				67.5	201.5	134.5	71.5	213.5	142.5
Option 2, non-smoking w/chem dep	Apr-02		138.00	146.75	160.00		6.3%	9.0%				69	207	138	73.5	220	146.75
Option 3, smoking no chem dep	Apr-02		160.00	179.00	202.00		11.9%	12.8%				80	240	160	90	268	179
Option 4, smoking w/chem dep	Apr-02		166.00	184.25	208.00		11.0%	12.9%				84	248	166	92.5	276	184.25
$2500 Ded, 100/0% Coinsurance – Single																	
Option 1, non-smoking no chem. Dep.	Apr-02		144.50	153.25	167.00		6.1%	9.0%				72.5	216.5	144.5	77	229.5	153.25
Option 2, non-smoking w/chem dep	Apr-02		148.00	157.50	172.00		6.4%	9.2%				74	222	148	79	236	157.5
Option 3, smoking no chem dep	Apr-02		172.00	192.50	217.00		11.9%	12.7%				86	258	172	96.5	288.5	192.5
Option 4, smoking w/chem dep	Apr-02		178.25	198.25	223.50		11.2%	12.7%				90	266.5	178.25	99.5	297	198.25
$3500 Ded, 80/20% Coinsurance – Family ($3400 ded prior to 4/1/04)																	
Option 1, non-smoking no chem. Dep.	Apr-02		122.75	130.25	141.75		6.1%	8.8%				61.5	184	122.75	65.5	195	130.25
Option 2, non-smoking w/chem dep	Apr-02		126.00	133.75	146.25		6.2%	9.3%				63	189	126	67	200.5	133.75
Option 3, smoking no chem dep	Apr-02		146.00	163.50	184.25		12.0%	12.7%				73	219	146	82	245	163.5
Option 4, smoking w/chem dep	Apr-02		151.50	168.50	190.00		11.2%	12.8%				76.5	226.5	151.5	84.5	252.5	168.5
$3500 Ded, 100/0% Coinsurance – Family ($3400 ded prior to 4/1/04)																	
Option 1, non-smoking no chem. Dep.	Apr-02		139.50	147.50	160.75		5.7%	9.0%				70	209	139.5	74	221	147.5
Option 2, non-smoking w/chem dep	Apr-02		143.00	151.75	165.50		6.1%	9.1%				71.5	214.5	143	76	227.5	151.75
Option 3, smoking no chem dep	Apr-02		165.75	185.25	209.00		11.8%	12.8%				83	248.5	165.75	93	277.5	185.25
Option 4, smoking w/chem dep	Apr-02		172.00	191.00	215.25		11.0%	12.7%				87	257	172	96	286	191
$4300 Ded, 80/20% Coinsurance – Family ($4200 ded prior to 4/1/04)																	
Option 1, non-smoking no chem. Dep.	Apr-02		117.75	124.50	135.75		5.7%	9.0%				59	176.5	117.75	62.5	186.5	124.5
Option 2, non-smoking w/chem dep	Apr-02		121.00	128.50	140.00		6.2%	8.9%				60.5	181.5	121	64.5	192.5	128.5
Option 3, smoking no chem dep	Apr-02		140.00	156.50	176.50		11.8%	12.8%				70	210	140	78.5	234.5	156.5
Option 4, smoking w/chem dep	Apr-02		145.25	161.50	182.00		11.2%	12.7%				73.5	217	145.25	81	242	161.5

BCBSM Individual Market Index Rates

	Date started	########	########	########	########	% change 2001-2002	% change 2002-2003	% change 2003-2004	2001 low	2001 hi	2001 Index	2002 lo	2002 hi	2002 Index	2003 lo	2003 hi	2003 Index
$4200 Ded, 100/0% Coinsurance – Family																	
($4200 ded prior to 4/1/04)																	
Option 1, non-smoking no chem. Dep.	Apr-02		130.50	138.50	151.00	6.1%	9.0%					65.5	195.5	130.5	69.5	207.5	138.5
Option 2, non-smoking w/chem dep	Apr-02		134.00	142.50	155.50	6.3%	9.1%					67	201	134	71.5	213.5	142.5
Option 3, smoking no chem dep	Apr-02		155.50	174.00	196.25	11.9%	12.8%					78	233	155.5	87.5	260.5	174
Option 4, smoking w/chem dep	Apr-02		161.25	179.25	202.25	11.2%	12.8%					81.5	241	161.25	90	268.5	179.25
$5000 Ded, 80/20% Coinsurance – Family																	
Option 1, non-smoking no chem. Dep.	Apr-02		113.25	119.75	130.75	5.7%	9.2%					57	169.5	113.25	60	179.5	119.75
Option 2, non-smoking w/chem dep	Apr-02		116.00	123.50	134.50	6.5%	8.9%					58	174	116	62	185	123.5
Option 3, smoking no chem dep	Apr-02		134.75	150.50	169.75	11.7%	12.8%					67.5	202	134.75	75.5	225.5	150.5
Option 4, smoking w/chem dep	Apr-02		139.75	155.25	175.00	11.1%	12.7%					70.5	209	139.75	78	232.5	155.25
$5000 Ded, 100/0% Coinsurance – Family																	
($4950 ded prior to 4/1/04)																	
Option 1, non-smoking no chem. Dep.	Apr-02		121.75	129.25	140.75	6.2%	8.9%					61	182.5	121.75	65	193.5	129.25
Option 2, non-smoking w/chem dep	Apr-02		125.00	132.75	144.75	6.2%	9.0%					62.5	187.5	125	66.5	199	132.75
Option 3, smoking no chem dep	Apr-02		145.00	162.25	183.00	11.9%	12.8%					72.5	217.5	145	81.5	243	162.25
Option 4, smoking w/chem dep	Apr-02		150.25	167.25	188.25	11.3%	12.6%					76	224.5	150.25	84	250.5	167.25

HSA Blue Plans

Contract Form No. F7913

$1100 Ded, 80/20% Coinsurance, first dollar preentive covg - Single		
Option 1, non-smoking no chem. Dep.	04/01/2004	215.50
Option 2, non-smoking w/chem dep	04/01/2004	222.00
Option 3, smoking no chem dep	04/01/2004	280.00
Option 4, smoking w/chem dep	04/01/2004	288.75
$1800 Ded, 80/20% Coinsurance, first dollar preventive covg - Single		
Option 1, non-smoking no chem. Dep.	04/01/2004	170.00
Option 2, non-smoking w/chem dep	04/01/2004	175.00
Option 3, smoking no chem dep	04/01/2004	221.00
Option 4, smoking w/chem dep	04/01/2004	227.50
$2600 Ded, 80/20% Coninsurance, first dollar preventive covg - Single		
Option 1, non-smoking no chem. Dep.	04/01/2004	156.25
Option 2, non-smoking w/chem dep	04/01/2004	160.75
Option 3, smoking no chem dep	04/01/2004	203.00
Option 4, smoking w/chem dep	04/01/2004	209.25
$2200 Ded, 80/20% Coinsurance, first dollar preventive covg - Family		
Option 1, non-smoking no chem. Dep.	04/01/2004	179.00
Option 2, non-smoking w/chem dep	04/01/2004	184.25
Option 3, smoking no chem dep	04/01/2004	232.75
Option 4, smoking w/chem dep	04/01/2004	239.75
$3600 Ded, 80/20% Coinsurance, first dollar preventive covg - Family		
Option 1, non-smoking no chem. Dep.	04/01/2004	144.5
Option 2, non-smoking w/chem dep	04/01/2004	148.5
Option 3, smoking no chem dep	04/01/2004	187.5
Option 4, smoking w/chem dep	04/01/2004	193.25
$5150 Ded, 80/20% Coinsurance, first dollar preventive covg - Family		
Option 1, non-smoking no chem. Dep.	04/01/2004	131.25
Option 2, non-smoking w/chem dep	04/01/2004	135.25
Option 3, smoking no chem dep	04/01/2004	170.5
Option 4, smoking w/chem dep	04/01/2004	175.5
$1100 Ded, 100/0% Coinsurance, first dollar preventive covg - Single		
Option 1, non-smoking no chem. Dep.	04/01/2004	244
Option 2, non-smoking w/chem dep	04/01/2004	251.25
Option 3, smoking no chem dep	04/01/2004	317
Option 4, smoking w/chem dep	04/01/2004	326.75

BCBSM Individual Market Index Rates

	Date started	########	########	########	########	% change 2001-2002	% change 2002-2003	% change 2003-2004	2001 low	2001 hi	2001 Index	2002 lo	2002 hi	2002 Index	2003 lo	2003 hi	2003 Index
$1800 Ded, 100/0% Coinsurance, first dollar preventive covg - Single																	
Option 1, non-smoking no chem. Dep.	04/01/2004				190.25												
Option 2, non-smoking w/chem dep	04/01/2004				196												
Option 3, smoking no chem dep	04/01/2004				247.25												
Option 4, smoking w/chem dep	04/01/2004				254.75												
$2600 Ded, 100/0% Coinsurance, first dollar preventive covg - Single																	
Option 1, non-smoking no chem. Dep.	04/01/2004				165.75												
Option 2, non-smoking w/chem dep	04/01/2004				170.75												
Option 3, smoking no chem dep	04/01/2004				215.5												
Option 4, smoking w/chem dep	04/01/2004				222												
$2200 Ded, 100/0% Coinsurance, first dollar preventive covg - Family																	
Option 1, non-smoking no chem. Dep.	04/01/2004				209.25												
Option 2, non-smoking w/chem dep	04/01/2004				215.25												
Option 3, smoking no chem dep	04/01/2004				272												
Option 4, smoking w/chem dep	04/01/2004				280												
$3600 Ded, 100/0% Coinsurance, first dollar preventive covg - Family																	
Option 1, non-smoking no chem. Dep.	04/01/2004				328												
Option 2, non-smoking w/chem dep	04/01/2004				169												
Option 3, smoking no chem dep	04/01/2004				213.25												
Option 4, smoking w/chem dep	04/01/2004				219.5												
$5150 Ded, 100/0% Coinsurance, first dollar preventive covg - Family																	
Option 1, non-smoking no chem. Dep.	04/01/2004				141.25												
Option 2, non-smoking w/chem dep	04/01/2004				145.5												
Option 3, smoking no chem dep	04/01/2004				183.5												
Option 4, smoking w/chem dep	04/01/2004				189												
$1100 Ded, 80/20% Coinsurance, w/o first dollar preventive covg - Single																	
Option 1, non-smoking no chem. Dep.	04/01/2004				212												
Option 2, non-smoking w/chem dep	04/01/2004				218.25												
Option 3, smoking no chem dep	04/01/2004				275.75												
Option 4, smoking w/chem dep	04/01/2004				284												
$1800 Ded, 80/20% Coinsurance, w/o first dollar preventie covg - Single																	
Option 1, non-smoking no chem. Dep.	04/01/2004				166.5												
Option 2, non-smoking w/chem dep	04/01/2004				171.5												
Option 3, smoking no chem dep	04/01/2004				216.25												
Option 4, smoking w/chem dep	04/01/2004				223												
$2600 Ded, 80/20% Coinsurance, w/o first dollar preventive covg - Single																	
Option 1, non-smoking no chem. Dep.	04/01/2004				152.75												
Option 2, non-smoking w/chem dep	04/01/2004				157.5												
Option 3, smoking no chem dep	04/01/2004				198.5												
Option 4, smoking w/chem dep	04/01/2004				204.5												
$2200 Ded, 80/20% Coinsurance, w/o first dollar preventive covg - Family																	
Option 1, non-smoking no chem. Dep.	04/01/2004				175.5												
Option 2, non-smoking w/chem dep	04/01/2004				181												
Option 3, smoking no chem dep	04/01/2004				228.25												
Option 4, smoking w/chem dep	04/01/2004				235												
$3600 Ded, 80/20% Coinsurance, w/o first dollar preventive covg - Family																	
Option 1, non-smoking no chem. Dep.	04/01/2004				140.75												
Option 2, non-smoking w/chem dep	04/01/2004				145.25												
Option 3, smoking no chem dep	04/01/2004				183.25												
Option 4, smoking w/chem dep	04/01/2004				188.5												
$5150 Ded, 80/20% Coinsurance, w/o first dollar preventive covg - Family																	
Option 1, non-smoking no chem. Dep.	04/01/2004				127.75												
Option 2, non-smoking w/chem dep	04/01/2004				131.5												
Option 3, smoking no chem dep	04/01/2004				166												
Option 4, smoking w/chem dep	04/01/2004				171												
$1100 Ded, 100/0% Coinsurance, w/o first dollar preventive covg - Single																	

BCBSM Individual Market Index Rates

	Date started	########	########	########	########	% change 2001-2002	% change 2002-2003	% change 2003-2004	2001 low	2001 hi	2001 Index	2002 lo	2002 hi	2002 Index	2003 lo	2003 hi	2003 Index
Option 1, non-smoking no chem. Dep.	04/01/2004				239.75												
Option 2, non-smoking w/chem dep	04/01/2004				247												
Option 3, smoking no chem dep	04/01/2004				311.75												
Option 4, smoking w/chem dep	04/01/2004				321												
$1500 Ded, 100/0% Coinsurance, w/o first dollar preventive covg - Single																	
Option 1, non-smoking no chem. Dep.	04/01/2004				185.5												
Option 2, non-smoking w/chem dep	04/01/2004				191.25												
Option 3, smoking no chem dep	04/01/2004				241.25												
Option 4, smoking w/chem dep	04/01/2004				248.5												
$2500 Ded, 100/0% Coinsurance, w/o first dollar preventive covg - single																	
Option 1, non-smoking no chem. Dep.	04/01/2004				162												
Option 2, non-smoking w/chem dep	04/01/2004				166.75												
Option 3, smoking no chem dep	04/01/2004				210.5												
Option 4, smoking w/chem dep	04/01/2004				217												
$2200 Ded, 100/0% Coinsurance, w/o first dollar preventive covg - Family																	
Option 1, non-smoking no chem. Dep.	04/01/2004				204.5												
Option 2, non-smoking w/chem dep	04/01/2004				210.5												
Option 3, smoking no chem dep	04/01/2004				266												
Option 4, smoking w/chem dep	04/01/2004				274												
$3500 Ded, 100/0% Coinsurance, w/o first dollar preventive covg - Family																	
Option 1, non-smoking no chem. Dep.	04/01/2004				159.5												
Option 2, non-smoking w/chem dep	04/01/2004				164.5												
Option 3, smoking no chem dep	04/01/2004				207.5												
Option 4, smoking w/chem dep	04/01/2004				213.75												
$5150 Ded, 100/0% Coinsurance, w/o first dollar preventive covg - Family																	
Option 1, non-smoking no chem. Dep.	04/01/2004				137.25												
Option 2, non-smoking w/chem dep	04/01/2004				141.5												
Option 3, smoking no chem dep	04/01/2004				178.5												
Option 4, smoking w/chem dep	04/01/2004				183.75												

BCBSM Small Employer Group Index Rates

	01/01/2002	#########	#########	#########	% change 2002-03	1/1/03 to 4/1/04 Total	1/1/03 to 4/1/04 Annualized	4/1/04 to 1/1/05 Total	4/1/04 to 1/1/05 Annualized	Jan 02 lo	Jan 02 hi	Jan 02 Indi	Jan 03 lo	Jan 03 hi	Jan 03 Indi
Metro Area															
Aware Gold No Co-Pay	$468.00	$523.50	$556.00	$597.50	11.9%	6.2%	4.9%	7.5%	10.1%	234	702	468	262	785	523.5
Aware Gold Ltd W/Copay/100% Inpatient	$423.00	$473.50	$497.50	$530.00	11.9%	5.1%	4.0%	6.5%	8.8%	211	635	423	237	710	473.5
BC MNCare Mandated Ded Plan	$254.00	$286.50	$290.00	$306.00	12.8%	1.2%	1.0%	5.5%	7.4%	127	381	254	143	430	286.5
BC MNCare Mandated Copay Plan	$326.50	$372.00	$400.50	$435.50	13.9%	7.7%	6.1%	8.7%	11.8%	163	490	326.5	186	558	372
CMM $15 Copay Plan - 1100 oop	$387.50	$435.50	$462.00	$492.00	12.4%	6.1%	4.8%	8.5%	8.8%	194	581	387.5	218	653	435.5
CMM $25 Copay Plan - 1300 oop	$378.00	$424.00	$451.50	$480.50	12.2%	6.5%	5.2%	8.4%	8.7%	189	567	378	212	636	424
$200 Ded - 80%	$374.00	$419.50			12.2%					187	561	374	210	629	419.5
$300 Ded - 80%	$364.00	$410.50	$432.00		12.8%	5.2%	4.2%			182	546	364	205	616	410.5
CMM 80/20, $300 ded, $25 copay				$464.50				7.5%	10.2%						
$500 Ded - 80%	$353.00	$402.50	$418.50		14.0%	4.0%	3.2%			176	530	353	201	604	402.5
CMM 80/20, $500 ded, $25 copay				$450.50				7.6%	10.3%						
$1000 Ded - 80%	$336.00	$383.50	$400.00		14.1%	4.3%	3.4%			168	504	336	192	575	383.5
CMM 80/20, $1000 ded, $25 copay				$428.50				7.1%	9.6%						
$2000 Ded - 80%			$376.00												
CMM 80/20, $2000 ded, $25 copay				$404.50				7.6%	10.2%						
$1000 Ded Options Blue Plan			$363.50												
$1500 Ded Options Blue Plan			$335.50												
$2500 Ded Options Blue Plan			$290.50												
$1500 Ded Basic Blue Plan	$283.50	$324.00	$336.50		14.3%	3.9%	3.1%			142	425	283.5	162	486	324
$2500 Ded Basic Blue Plan	$256.00	$295.50	$307.50		15.4%	4.1%	3.2%			128	384	256	148	443	295.5
$500 Ded Basic Blue Plan	$322.00	$365.50	$380.00		13.5%	4.0%	3.2%			161	483	322	183	548	365.5
$1000 Ded Basic Blue Plan	$297.50	$338.50	$354.50		13.8%	4.7%	3.8%			149	446	297.5	169	508	338.5
MSA Blue 80% Low Option	?	$296.50	$304.50		?	2.7%	2.2%					0	148	445	296.5
MSA Blue 80% Mid Option	?	$280.00	$288.00		?	2.9%	2.3%					0	140	420	280
MSA Blue 80% High Option	?	$266.00	$272.00		?	2.3%	1.8%					0	133	399	266
MSA Blue 100% Low Option	?	$342.00	$356.50		?	4.2%	3.4%					0	171	513	342
MSA Blue 100% Mid Option	?	$321.50	$333.50		?	3.7%	3.0%					0	161	482	321.5
MSA Blue 100% High Option	?	$302.00	$311.50		?	3.1%	2.5%					0	151	453	302
Options Blue - HDHP compatiable w/HRAs, 80% low option				$392.00											
Options Blue - HDHP compatiable w/HRAs, 80% mid option				$362.00											
Options Blue - HDHP compatiable w/HRAs, 80% high option				$312.50											
Options Blue - HDHP Compatible w/HSAs, 80% low option				$391.50											
Options Blue - HDHP Compatible w/HSAs, 80% mid option				$338.00											
Options Blue - HDHP Compatible w/HSAs, 80% high option				$293.50											
Options Blue - HDHP Compatible w/HSAs, 100% low option				$447.50											
Options Blue - HDHP Compatible w/HSAs, 100% low option				$390.00											
Options Blue - HDHP Compatible w/HSAs, 100% low option				$345.50											

Migrant Health Service, Inc.
Townsite Center, Suite 101
810 4th Avenue South
Moorhead, MN 56560-2891
218-236-6502 or 800-842-8693
FAX: 218-236-6507

October 21, 2005

Office of Minnesota Attorney General Mike Hatch
1400 Bremer Tower
445 Minnesota Street
St. Paul, MN 55101

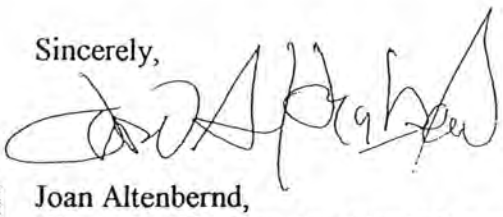
Dear Mr. Mike Hatch:

In 2004, Migrant Health Service, Inc. (MHSI) selected a health plan for our employees through Lakes Country Service Cooperative based out of Fergus Falls. Overall, we have been pleased with the plan offered through Minnesota Blue Cross Blue Shield until we received notice that the renewal rate would increase our rates by 37.4%. We have declined service from the Cooperative staring January 1, 2006 (end of our contract) The Cooperative members received a rate based on their individual group, not the members of the cooperative.
]
MHSI is not able to absorb that kind of an increase and would have to pass along a large part of the increase to staff, resulting in few employees having health insurance coverage. The explanation I received from Lakes Country Service Cooperative was: MHSI had high utilization putting us at around 24% increase, plus 3-4 staff who moved or would move to the next age band resulting in a 37.4% increase.

MHSI joined the cooperative thinking it was offering group rate for members, not individual rates for each group. I believe our contract with Lakes Country Service Cooperative has a 50% increase maximum (frightening).

With respect the health insurance, the word cooperative indicates that group members would have better purchasing powers. I would appreciate it if your office would investigate the methodology used for rate increases from the Lakes Country Service Cooperative. I am not comfortable with their explanation.

Sincerely,



Joan Altenbernd,
jaltenbernd@migranthealthservice.org
Executive Director

BlueCross BlueShield
BluePlus
of Minnesota

[redacted]

November, 2005

[redacted]

[redacted]

P.O. Box 64560

St. Paul, MN

55164-0560

I want to thank you for choosing Blue Cross and Blue Shield of Minnesota. As a member we want to make sure you are satisfied with your service and coverage. This letter includes information about your 2006 rate, as well as other important details regarding Medicare and your health coverage with Blue Cross.

As you may recall, Senior Gold has not had a rate increase over the past two years. We were pleased to be able to keep your rates the same for two years in a row. In order to continue to offer you the same level of coverage an increase is needed this year. We are aware that this may put a strain on your budget, therefore we encourage you to read further to find out more about lower cost health plan options.

Please refer to the table below to determine how your rates will be changing for 2006. The new rate will take effect with your first 2006 bill:

Your current Blue Cross plan	*2005 Rate Tobacco-free*	*2006 Rate Tobacco-free*	*2005 Rate Standard*	*2006 Rate Standard*
Senior Gold (Medicare Select w/ Preventive)	**$119.00**	**$134.00**	**$156.00**	**$176.00**

New drug coverage options available

Beginning January 1, 2006 new prescription drug coverage will be available to all people with Medicare. The government helps pay for this drug coverage so it is now more affordable than ever before. Blue Cross is proud to offer this new drug coverage through **MedicareBlue Rx***, a Medicare-approved prescription drug plan. Even if you don't currently take medications, MedicareBlue Rx can offer valuable protection against any future out-of-pocket prescription drug costs.

For coverage in 2006, you may enroll any time between November 15, 2005 and May 15, 2006. However, if you want this coverage to begin on January 1, 2006 you will need to enroll by December 31, 2005. You should have recently received a MedicareBlue Rx enrollment kit from Blue Cross, that has everything you need to enroll. Best of all, you can enroll in MedicareBlue Rx for drug coverage and keep your existing Blue Cross Medicare Supplement plan for medical coverage.

Lower cost health plan options available from Blue Cross*

Although your current plan offers some of the best coverage available, Blue Cross realizes the needs of people change over time. If you want to explore less expensive Medicare plan options, Blue Cross has a variety of plans available. New plan options include MedicareBlue PPO and VantageBlue with rates starting as low as $29 per month. To learn more about these options talk to your agent or call Blue Cross sales at **1-877-662-2583** (TTY/TDD users should call **1-888-878-0137**), Monday through Friday, 8:00 a.m. to 5:00 p.m.

Find out how Blue Cross protects your privacy

Enclosed with this letter is information about how Blue Cross complies with federal legislation known as the Gramm-Leach-Bliley Act. The Act helps stop the practice in the banking community of selling customer information for marketing purposes. Please rest assured that, although we are considered a financial institution under this legislation, *we have never participated in the practice of selling member information to marketing companies*. We value our relationship with you. We treat your information as confidential and recognize the importance of protecting it.

General provider payment methods

In compliance with the Patient Protection Act, all health plans are required to disclose how they pay providers. Enclosed you'll find an insert describing various payment methods Blue Cross may use.

Please feel free to contact your Blue Cross agent or our Customer Service team with any questions. We're available Monday through Thursday, 8:00 a.m. to 5:00 p.m. and 9:00 a.m. to 4:30 p.m. on Friday. Our Customer Service numbers are **651-662-5020** or toll free **1-800-531-6686** (TTY/TDD users should call **1-888-878-0137**).

Sincerely,

Deborah B. Madson

Deborah B. Madson
Vice President, Government Programs

Enclosures

P.S. Reminder: This is not a bill so please do not send payment at this time.

* MedicareBlue Rx is a regional Medicare Prescription Drug Plan with a Medicare contract. MedicareBlue PPO is a regional Medicare Advantage Plan with a Medicare Contract. You must be a permanent resident of Minnesota, Montana, Nebraska, North Dakota, South Dakota or Wyoming to enroll in MedicareBlue MedicareBlue PPO. VantageBlue is a Medicare Cost product offered by Blue Cross and Blue Shield of Minnesota. You must be a permanent resident of Minnesota to enroll in VantageBlue. You must continue to pay your Medicare Part B premium.

Attachment to Hedging Issues Paper

For the following examples of various equity protection (hedge) programs, assume that $50 million of equity principal is hedged. The pricing of the hedge instruments is based on pricing as of January 10, 2003.

- Sale of Price Cap

BCBSM could realize a premium of 5.08 % of principal ($2,540,000) in return for foregoing price appreciation in the relevant index in excess of 10 % for a one-year period. At a 15 % "strike price", the premium is 3.55 % ($1,775,000). Staff believes a transaction such as this could be attractive itself in certain conditions, without any other complementary transactions.

For example, in a situation in which BCBSM's surplus is in danger of exceeding the maximum, we could enter into a transaction like that illustrated to achieve a certain premium. The additional potential market appreciation foregone might be of little value to BCBSM if it were to trigger discussions with the Commerce Department to reduce surplus levels.

- Purchase of Price Floor

Although downside equity portfolio protection is highly desirable, it almost always comes at a price too dear to purchase without complementary hedge transactions. The purchase of a price floor on January 10, 2003 was 7.51 % to protect against index depreciation in excess of 5 % for a one-year period (a 5 % strike price) and 5.78 % to protect against index depreciation in excess of 10 %. Staff recommends price floors be purchased only in concert with complementary hedge transactions in order to maintain price affordability.

- Complementary Hedge Transactions

In concert, a combination of hedge transactions can be structured at a reasonable cost and provide appropriate risk protection. For example, here is the result of three hedge transactions entered into simultaneously, covering a one-year period:

#1—Purchase a price floor at a 10 % strike price, thereby protecting against equity index depreciation in excess of 10 %.

Cost = $50 million X 5.78 % **$ (2,890,000)**

#2—Sell a price cap at a 15 % strike price, thereby foregoing the benefit of equity index appreciation in excess of 15 %.

Premium=$50 million X 3.55 % **$ 1,775,000**

#3—Sell a "re-entry" price floor at a 25 % strike price, thereby voiding the downside protection purchased once the relevant index depreciates in excess of 25 %.

Premium=$50 million X 2.38 % **$ 1,190,000**

Net cost of program = positive cash flow of $75,000
In this example, there is no immediate dollar cost, but rather a $75,000 cash inflow.

The substance of the combined transactions is that BCBSM would be protected against all equity index depreciation for one year between 10 % and 25 % on $50 million of its equities. In return, BCBSM would forego potential price appreciation on the equity index in excess of 15 % for the ensuing year.

In more bullish pricing environments, such programs could be cost neutral and provide downside protection at lower strike prices than those in the example.

California; Regulators to Examine Reserves at Blue Cross; The amount is about five times the required level, attracting attention in light of recent premium hikes being investigated.; [HOME EDITION]

Debora Vrana. **Los Angeles Times**. Los Angeles, Calif.: May 18, 2005. pg. C.2

Subjects:	Insurance premiums, Investigations, Reserve requirements, Acquisitions & mergers
Locations:	California
Companies:	Blue Cross of California (NAICS: 524114, Sic:6324, Duns:10-291-9008), Department of Insurance-California (NAICS: 926150), WellPoint Inc (NAICS: 524114)
Author(s):	Debora Vrana
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Abstract (Document Summary)

California doesn't impose limits on the amount of money health insurers can have in reserve, and it's not uncommon for them to have more than the state requires. But the reserves at Blue Cross, which has 7.6 million California policyholders, are drawing particular attention in light of premium increases recently imposed by the insurer.

According to state records, other major California health insurers also maintain reserves well in excess of state requirements, which vary for each company. Nonprofit Kaiser Permanente has the largest reserve with $10.2 billion, 13 times the required level.

"Right now, the level of reserves we have is dictated by the state and the bond rating agencies. We're getting pressured by the rating agencies to have higher levels of reserves to get better ratings on our debt and lower borrowing costs," he said.

Full Text (604 words)

State regulators, already probing recent rate hikes by Blue Cross of California, on Tuesday also pledged to scrutinize the health insurer's reserve fund, which is five times as big as required by law.

Blue Cross had capital reserves of $1.7 billion as of March 31, according to documents filed with the state by Blue Cross on Monday. Under state rules designed to provide a cushion against insolvency by insurers, Blue Cross was required to have about $307 million in reserves.

California doesn't impose limits on the amount of money health insurers can have in reserve, and it's not uncommon for them to have more than the state requires. But the reserves at Blue Cross, which has 7.6 million California policyholders, are drawing particular attention in light of premium increases recently imposed by the insurer.

At a hearing in Sacramento on Friday, regulators said they would step up their investigation into the rate hikes, which consumer activists allege are being used to cover an estimated $4 billion in costs related to the insurer's acquisition last year by Indianapolis- based Anthem Inc.

Cindy Ehnes, director of the state Department of Managed Health Care, said the state would now look into Blue Cross' reserves as well.

"Consumers looking at these kinds of reserves have the question - - 'Why is a rate increase needed?' " she said. "So it will certainly be part of our investigation."

Jerry Flanagan, a consumer activist with the Santa Monica-based Foundation for Taxpayer and Consumer Rights, said that "the effect of these overhead costs is that people pay more for healthcare."

A report from an actuary to be hired by the state to assist in the Blue Cross probe is expected in the next 60 days, a department spokeswoman said.

Blue Cross spokesman Michael Chee said the large capital reserves were needed to weather any spike in claims that might occur and to ensure that the company is financially sound.

"We sympathize with consumers' point of view -- it's difficult to understand the various factors of financing healthcare," he said. "But we are acting in their best interests. We want to demonstrate long-term financial stability."

Anthem completed its purchase of Thousand Oaks-based WellPoint Health Networks Inc. last year in a deal valued at $21 billion. The combined company, WellPoint Inc., is the nation's largest health insurer, with 28 million members.

According to state records, other major California health insurers also maintain reserves well in excess of state requirements, which vary for each company. Nonprofit Kaiser Permanente has the largest reserve with $10.2 billion, 13 times the required level.

"It's standard practice. You can't have too much in reserve," said David Olson, a spokesman for Woodland Hills-based insurer Health Net Inc., whose $317-million reserve is double its required amount.

"Right now, the level of reserves we have is dictated by the state and the bond rating agencies. We're getting pressured by the rating agencies to have higher levels of reserves to get better ratings on our debt and lower borrowing costs," he said.

Cypress-based PacifiCare Health Systems Inc.'s $462.8- million reserve is, like Blue Cross', five times the mandated level. "If we let that capital go, it would be a one-time Band-Aid," said PacifiCare Chief Financial Officer Greg Scott. It would not, he added, be a solution to "the problem of escalating healthcare costs."

Adam L. Miller, healthcare analyst with Williams Capital Group, said Wall Street liked insurers to maintain healthy reserves.

"It's a fine balancing act. Reserves are a big issue across the industry," said Miller. "What the appropriate level is -- there's still a lot of debate."

Credit: Times Staff Writer

CareFirst says profit rose 4.4% in 2004 to $178.8 million; revenue up 8% ; Insurer's 3.8% margin trails for-profit rivals; [FINAL Edition]

M. William Salganik. **The Sun**. Baltimore, Md.: Mar 15, 2005. pg. 1.E

Companies:	CareFirst Inc (NAICS: 551112, 524114, Sic:6311, 6324)
Author(s):	M. William Salganik
Section:	*BUSINESS*
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Document URL:	http://proquest.umi.com/pqdweb?did=807723641&sid=1&Fmt=3&clientId=44132&RQT=309&VName=PQD

Abstract (Document Summary)

Despite the higher earnings, CareFirst's margin - earnings as a percentage of revenue - is lower than that of its for-profit competitors. CareFirst's margin was 3.8 percent for the year. The average for commercial plans is 6.9 percent, according to Sherlock Co., a financial advisory company that publishes newsletters on industry performance. The largest for-profit Blue Cross plan, WellPoint Inc. of Indianapolis, reported a margin of 4.7 percent for 2004.

The profitable year allowed CareFirst to add to its surplus, which is comfortably larger than required by regulators. CareFirst recorded $1.1 billion in surplus at year's end, not counting its Delaware plan - up 18 percent from a year earlier.

Legislators and advocates have complained over the past few years - since CareFirst tried to convert to for-profit operation and sell itself for $1.3 billion, a deal that was blocked by regulators - that CareFirst, the largest health insurer in the state, was making too much money and not fulfilling its mission as a nonprofit.

Full Text (520 words)

CORRECTION: An article yesterday in the Business section misstated the number of CareFirst BlueCross BlueShield members. There were 3.3 million at the end of last year, up from 3.2 million at the end of 2003.

CareFirst BlueCross BlueShield - which has already promised to become less profitable to boost its nonprofit mission - posted $178.8 million in net income in 2004, according to filings with insurance regulators.

The number isn't a surprise. CareFirst officials told legislators at a January briefing that the bottom line would be about $175 million. It's slightly higher (4.4 percent) than the $171.3 million in net income CareFirst recorded in 2003.

Revenue, almost all from premiums and administrative fees, was $4.7 billion, up about 8 percent from the previous year. The insurer paid out about $4 billion in medical bills, up about 9 percent from the previous year.

Despite the higher earnings, CareFirst's margin - earnings as a percentage of revenue - is lower than that of its for-profit competitors. CareFirst's margin was 3.8 percent for the year. The average for commercial plans is 6.9 percent, according to Sherlock Co., a financial advisory company that publishes newsletters on industry performance. The largest for-profit Blue Cross plan, WellPoint Inc. of Indianapolis, reported a margin of 4.7 percent for 2004.

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In response to the criticism, the Owings Mills-based company unveiled what it said was a $90 million plan called CareFirst Commitment. As part of the plan, it cut its profit target for 2005 by $60 million so it could hold down premium increases. It said it would spend $8.7 million this year to improve patient safety and reduce health disparities among ethnic groups.

"We will not be driven by the bottom line to the extent the company was previously," Michael R. Merson, chairman of CareFirst's board, told lawmakers in January.

Then, in February, CareFirst said it would not pass along to consumers a new HMO tax, passed in January to help doctors pay for malpractice insurance. Instead, CareFirst will absorb the cost, estimated at $13.7 million after taxes.

The company also has commissioned an actuarial study of whether it has more surplus than it needs.

Membership at the end of the year was 3.3 billion, up slightly from 3.2 billion a year earlier. CareFirst operates Blue Cross and Blue Shield plans serving Maryland, the District of Columbia and Delaware.

The $178.8 million in earnings for 2004 did not include a noncash loss of $82 million associated with CareFirst's divestiture of Patuxent Medical Group, a 47-doctor group based in Howard County.

Credit: SUN STAFF

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Friday, June 17, 2005

Blues told to give up surplus

Lawmaker demands part of nonprofit's $2.2 billion cushion to help pay for health care for poor.

By Mark Hornbeck / Detroit News Lansing Bureau

LANSING -- Lawmakers are looking at a $2.2 billion surplus at nonprofit health insurer Blue Cross Blue Shield of Michigan to help bail out state health care programs for the poor that are in jeopardy because of the state's budget crisis.

If Blues officials don't voluntarily contribute some of that cash, says Senate Appropriations Chairwoman Shirley Johnson, R-Troy, she'll consider introducing legislation to revoke the tax-exempt and nonprofit status of Michigan's largest health insurer.

"The Blues' own financial statements say the cash surplus belongs to the residents of Michigan. Well, now we want it," said Johnson, whose chairmanship of the committee that helps determine spending priorities makes her one of the most powerful legislators in the capital.

The money could go toward saving Medicaid payments to young adults and caretaker relatives; staving off proposed cuts in the Wayne County mental health program; or restoring vision and hearing screening for children and dental care for Medicaid-eligible adults and other programs and services that have been cut in recent years or are threatened by the budget ax this year, Johnson said. The money also

Cash reserves

Blue Cross Blue Shield of Michigan has added about $1 billion to its cash reserves over the past five years.

Total	Surplus
2000	$1.24 billion
2001	$1.30 billion
2002	$1.53 billion
2003	$1.89 billion
2004	$2.24 billion

Source: Blue Cross Blue Shield of Michigan

CyberSurvey

Squeezing the Blues

Non-profit health insurer Blue Cross Blue Shield of Michigan has a $2.2 billion surplus. The state Legislature may revoke the insurer's tax-exempt status if it doesn't volunteer to help bail out state health care programs for the poor, which are facing severe cuts or elimination. Is this a reasonable request?

◯ Yes

◯ No

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Pistons Blog
Tigers Blog
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could be used to help cover the uninsured working poor.

Blues officials say the company already invests in health care and other programs in communities, including $1 million paid to 20 clinics across the state that serve the uninsured and an additional amount to supplement federal Medicare coverage for 200,000 seniors.

Johnson

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"We spend tens of millions of dollars already reinvesting in communities," said Helen Stojic, spokeswoman for Blue Cross. "Maybe Sen. Johnson wasn't aware of that."

Blue Cross serves 4.7 million Michigan customers.

Johnson's idea is patterned after a similar effort in Pennsylvania, where four Blue Cross companies agreed earlier this year to pay $150 million a year over six years to cover the uninsured working poor and help fund community health.

Pennsylvania uses reserves

Officials at Academy Health, a Washington, D.C., consulting group for health services researchers and policy-makers, said Pennsylvania is the only state tapping Blues cash reserves for state programs.

The agreement was struck between the Blues and Gov. Ed Rendell as state insurance regulators were investigating whether the Blues in Pennsylvania had piled up excessive surpluses. The cash reserves for the four health insurers there amount to $3.9 billion.

Last year's annual report for Blue Cross Blue Shield of Michigan shows it had a strong year, adding $422 million in net income to its cash reserves. That brought the total surplus to $2.24 billion.

"We had a good financial year, but things are very cyclical in health care," Stojic said. "That is not an unusual reserve for a health plan of our size."

State law requires the Blues to keep a reserve at 200 percent of the level of a certain category of invested capital, which the annual report pegs at $282 million. The Blues' national association requires 375 percent. At $2.24 billion, the Blues of Michigan is at nearly 800 percent.

"The reserves are there because of the risks you take," Stojic said. "We're well under the ... maximum."

Lawmaker: No dollar figure

Johnson said she hasn't arrived at an annual dollar figure she wants the Blues to contribute. That number would be determined during negotiations, she said.

"We have a crisis when it comes to health care in this state," Johnson said. "This is a nonprofit company sitting on this amount of surplus. If they want to continue sitting on their nonprofit status, now is the time for

them to become part of the solution."

Stojic said taxing the Blues would be counterproductive. "A similar idea was brought up years ago, and in 2002, Sen. Johnson and the Legislature reaffirmed our nonprofit, tax-exempt status because they realized the value to the state," she said.

Tom Clay of the Citizens Research Council of Michigan, a public policy think tank, said of tapping the Blues reserves: "That sounds like a creative plan. These are the kinds of ideas brought on by the pressure policy-makers find themselves under because of the budget problems."

Clay said Blues subscribers also might feel they have a claim to that surplus in the form of lower rates.

"You could make the argument that if the Blues are building up a reserve, they're probably charging more for insurance than they need to."

Company officials say their financial gains in recent years have enabled the Blues to temper increases in rates. Rates will go up less than 10 percent this year while other companies are assessing larger increases, officials said.

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Blue Cross critic: Surplus excessive

Allison Farrell. **The Billings Gazette**. Billings, Mont.: Oct 17, 2004. pg. C1

Subjects:	Health insurance, Disputes, Budget surplus, Donations, Childrens health insurance programs
Classification Codes	2410, 9190, 8210
Locations:	Helena Montana
Companies:	Blue Cross Blue Shield of Montana (Sic:6324, 524114, Duns:01-037-0237)
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Full Text (429 words)

HELENA - The recent $1.9 million donation Blue Cross Blue Shield of Montana made to the state Children's Health Insurance Program is not enough, and the company should give back some more of the $90 million it's holding in reserves, one critic says.

The state insurance commissioner requires Blue Cross Blue Shield to carry a minimum of $28 million in reserves. Helena nurse practitioner Beth Sirr called the company's $90 million surplus "excessive."

On the very day the state and Blue Cross Blue Shield completed its annual CHIP contract, Sirr also blasted the company for giving its top executive a half-million dollar compensation package, while 200 lowincome children wait for slots in the CHIP program to open up.

"The way we, as the public, need to see this is that children are going without health care," Sirr said in a telephone interview. "When you don't get the money to patients, then real people suffer."

Blue Cross Blue Shield's Chief Executive Officer Peter Babin earns more than $500,000 a year as head of the Montana company, according to documents filed with the state insurance commissioner. But he said his salary, and the company's reserves, are appropriate.

"You have to pay salaries commensurate with national levels," Babin said. "We have to compete nationally. It's the only way we can get the appropriate talent."

And Babin went on to say that the company's $90 million reserve is at an average level when compared with the reserves of other Blue Cross Blue Shield companies across the nation.

"We're at the average of the pack," Babin said. "That's a good place to be."

But Sirr said some of those reserves should be used to enroll more children in CHIP, and to reduce the cost of insurance premiums. Blue Cross Blue Shield, she said, is a not-for-profit corporation.

"It makes me feel sick to think I have to explain this to people," Sirr said before she headed off for her morning shift at the hospital. "But the people don't have the money. We have given the money to Blue Cross Blue Shield."

Blue Cross Blue Shield has administered the state CHIP contract for five years now.

The program supplies free health insurance to 10,900 Montana children who live at or below 150 percent of the poverty level, or on an annual income no more than $22,890 for a family of three.

Nearly 200 children are sitting on the waiting list for the program. CHIP is a joint state federal program, where the federal government puts in $4 for every $1 the state spends on the program.

Washington State
Office of the Insurance Commissioner

OIC News Release

Mike Kreidler
Washington Insurance Commissioner

News Release

For More Information, Contact:
Public Affairs: (360) 725-7055
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11/22/2005

Public hearing Dec. 8 on regulating health carrier surplus

Olympia, Wash. —

Insurance Commissioner Mike Kreidler will hold a public hearing on Dec. 8 to consider if health insurer surplus should be regulated, given the rising health insurance rates and recent record profits of health carriers.

Public Hearing

Date: Thursday, Dec. 8, 2005

Time: 1 p.m.

Place: State Capitol Legislative (domed) Building, Columbia room (bottom floor), Olympia

"Regulators look at carriers' surplus to be certain it's sufficient to protect policyholders and the market," said Kreidler. "There currently is no standard that determines how much surplus is excessive. Given today's climate where carriers are experiencing record profits, yet health insurance premiums continue to rise faster than the rate of inflation, we need to ask, how much is too much?"

While Washington insurance law sets minimum financial requirements to ensure companies are financially solvent, it does not set a limit on the maximum a carrier can hold in surplus, nor does it stipulate how surplus should be considered when regulating insurance rates.

A number of states are studying the surplus issue and currently two states (Michigan and Hawaii) regulate the maximum surplus held by companies.

The purpose of next month's hearing is to gather facts and examine the pros and cons of regulating the amount of surplus. The hearing will also look at, if surplus is regulated, what should happen to the excess and how regulation would impact the marketplace.

Health and disability carriers have been invited to participate and will receive prepared questions in

advance. Agents, brokers, consumer groups and other interested parties also are invited to testify.

"In Washington, we've had four companies in receivership because they failed to meet the minimum financial requirements," said Kreidler. "Excess surplus is an emerging issue which I believe deserves a closer look and is one of my top policy priorities for 2006."

Viewpoint

THE CONSUMERS UNION PERSPECTIVE

Make 'nonprofit' health insurers do their duty

As the cost of health insurance has risen, the number of employers offering health care to their workers has fallen. As of 2003, nearly 45 million Americans under age 65 were uninsured, more than 5 million more than in 2000. Yet at some health-insurance companies, consumer dollars are fueling excessive cash surpluses, well in excess of what the organizations need to pay claims.

The situation is particularly alarming when the health-insurance companies in question are nonprofit organizations. Unlike for-profit corporations, nonprofit health insurers are legally bound to fulfill a public-benefit obligation, such as meeting the needs of people without health insurance, in exchange for significant tax advantages and other benefits.

But while consumers are getting squeezed by higher premiums and copays, some nonprofit health insurers are quietly abandoning their social-mission obligations. Some are stockpiling cash and spinning off for-profit subsidiaries.

As of December 2003, the 38 nonprofit Blue Cross and Blue Shield plans across the country retained approximately $20 billion in surplus, an increase of 30 percent since 2002. Concerns about "excess surplus" in nonprofit "Blues" plans have recently arisen in several states, including Delaware, Maryland, New Jersey, Pennsylvania, Rhode Island, and in Washington, D.C.

In Pennsylvania, for example, the state's four nonprofit Blues plans and their for-profit subsidiaries hold more than $6 billion in surplus, by one estimate. At the same time, 1.4 million Pennsylvanians are uninsured. Local unions have joined with community advocates for the unemployed and for low-wage earners to challenge the Pennsylvania Blues plans' surplus levels and to question expenditures made on behalf of their mission. Consumers Union, the nonprofit publisher of CONSUMER REPORTS, provided technical assistance for those efforts.

In 2004 the Pennsylvania Insurance Department ordered the insurers to submit detailed information on their surplus levels and a proposal for equitable distribution of excess surplus to benefit policyholders, the uninsured, and the underinsured. The state insurance commissioner subsequently decided that the Blues plans' surplus levels were acceptable. Advocates are appealing that decision.

The good news is that in February 2005, the governor of Pennsylvania and the Blue Cross plans reached an agreement under which the four insurers promised to devote almost $1 billion over nearly six years to charitable community health activities. That includes the provision of basic health-care coverage for thousands of the state's low-income and uninsured residents.

Consumers can demand that nonprofit health insurers meet much higher standards of accountability to their communities. State policymakers should consider enacting standards for appropriate ceilings on nonprofit surplus accumulation. Policymakers can establish guidelines for the use of existing "excess surplus." The National Association of Insurance Commissioners, which advises state insurance regulators, should amend its model legislation to ensure that health insurers do not stockpile excessive surpluses. And regulators should exercise their existing authority to oversee nonprofit health plans' activities to ensure accountability.

what you can do

For more information on efforts to address nonprofit insurers' public accountability, go to *www.ConsumersUnion.org/cony*.

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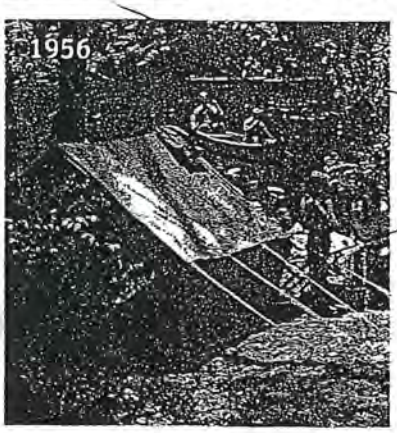
then & now into the woods



Camping took off in the 1950s. We touted its virtues in 1956: campsites abounding with nature's beauty, pure drinking water, good fishing and swimming, and forest rangers who check in to offer help. Camping, we said, was one of the most inexpensive and pleasant holidays a family could have, assuming the family members liked one another.

There were other caveats: Be ready for anything. Dig a drainage ditch around the tent, because not every model had a "sewed-in" floor, unlike today's tents. Made of nylon or polyester, many are now also rain-resistant and easier to set up (see report on page 48). The Eureka Titan, at right, has doors and windows that provide extra ventilation. To keep peace in the family, a second tent might be in order.

Blues Plans in the New Competitive Landscape:

Products, Partnerships and Patient Programs

AIS

Blues Plans' Financial Performance

Blues Plans Likely to See Improved Earnings Results for Full-Year '04, Ratings Firms Say

Many Blue Cross and Blue Shield plans are on track to report financial results that meet expectations for earnings and membership growth results for full-year 2004, say financial ratings companies. In fact, several Blues plans, including Blue Shield of California and Highmark, Inc., met projections for full-year results at the close of the third quarter.

Like the rest of the health insurance industry, Blues plans are benefiting from more predictable network-based products and administrative efficiencies, says ratings company Standard & Poor's (S&P). In addition, moderating medical cost trends and strong premium increases helped boost financial results, Fitch Ratings says.

But 2005 may be more challenging, the ratings companies warn. Operating margins are likely to decline modestly, Fitch says, driven by growing price competition and lower investment yields. In addition, Blues plans in several states, including Pennsylvania, North Carolina and Rhode Island, are facing regulatory pressure to limit profits and reserves to a moderate level. Legislative or regulatory reforms could further pressure these companies to reduce reserve levels.

For Blues plans that are not-for-profit or mutual companies, financial results are not publicly available except via state regulators and ratings companies, and are delayed well beyond the 15- to 60-day lag on quarterly financial results from most publicly traded firms. S&P in December 2004 issued a summary of how several Blues plans are likely to fare compared with expectations for full-year 2004 financial results.

Here's a look at the estimates:

◆ ***Blue Cross and Blue Shield of Florida,*** which has an A rating from S&P, is expected to report full-year 2004 pretax earnings of up to $325 million, the ratings company said. For the first nine months of 2004, the insurer had pretax earnings of $305 million. For the same period, membership rose about 5% from the year-end 2003 level of 6.5 million.

◆ ***Blue Cross and Blue Shield of Nebraska*** is likely to report that medical membership remained flat or even declined in 2004 because of a strategic decision not to accept unprofitable business to grow market share, S&P said. The insurer has 560,000 members, serving about one-quarter of Nebraska's population. The ratings company had expected the Nebraska Blues plan to report $50 million in pretax net income, but the insurer has already reached $48.5 million for the first nine months of the year. The insurer has an A+ rating from S&P.

◆ ***Blue Cross and Blue Shield of North Carolina*** is likely to see "some form of negative legislation" aimed at reducing premium or reserve levels introduced in the state legislature in early 2005, S&P predicted (see story, p. 5). S&P expects the company to report full-year 2004 pretax net income of $230 million to $240 million. For the first nine months of 2004, the insurer had $218.4 million in pretax net income.

◆ ***Blue Cross Blue Shield of Michigan*** is likely to continue an upward trend in earnings, S&P says. The insurer reported $343 million in pretax net income for the first nine months of 2004, compared with $367.7 million for the same period in 2003. The insurer has almost 4.8 million members, a 54% share of Michigan's market.

◆ ***Blue Shield of California*** already beat S&P's full-year 2004 earnings expectations after nine months of operations, reporting $385.4 million in pretax net income. The ratings company had projected full-year pretax net income of $375 million to $385 million.

◆ ***Empire Blue Cross and Blue Shield*** is in line to report full-year financial results that meet projections of more than $350 million in pretax net income, S&P says. The insurer posted $291.2 million in pretax net income for the first nine months of 2004. Empire's managed care membership growth (excluding the New York City and New York State accounts) also exceeded expectations, rising 11.5% to 2.5 million on Sept. 30, 2004, compared with an expected increase of 9% to 11%.

◆ ***Excellus Health Plan, Inc.*** is likely to report full-year 2004 pretax net income of $130 million to $140 million, S&P says. The parent of Blues plans in Rochester, central New York and the Utica-Watertown regions of New York reported $119.2 million in pretax net income for the first nine months of 2004.

◆ ***Hawaii Medical Service Assn.*** is expected to report $50 million to $60 million in 2004 pretax net income, S&P said. The insurer reported $41 million in pretax net income for the first nine months of 2004. For 2005, S&P forecasts, pretax net income will decline to a range of $45 million to $55 million. The insurer should report 695,000 members as of Dec. 31, 2004, up from 690,000 as of Sept. 30, 2004, and then remain flat through 2005. S&P has a negative outlook on the insurer, in part because of Hawaii legislation that grants the state insurance department authority to review and approve the Hawaii Blues plan's rates for all underwritten products.

◆ ***HealthNow New York, Inc.*** was expected to boost membership by 3% in 2004 from 771,000 as of Dec. 31, 2003. The insurer had reported $65 million in pretax earnings for the first nine months of 2004, and should meet the full-year 2004 earnings goal of $75 million.

◆ ***Highmark, Inc.*** already has exceeded full-year 2004 pretax earnings expectations of $260 million to $265 million, S&P said. The company posted $291.4 million in pretax earnings for the first nine months of 2004.

◆ ***Blue Cross and Blue Shield of Louisiana*** is expected to report $80 million to $85 million in pretax net income for full-year 2004, S&P estimates. For the first nine months, the insurer reported $72.8 million in pretax net income.

Call S&P analyst Timothy Clark at (212) 438-7182. ✧

Blues Plans Remain Under Fire in States For What Some Call 'Excessive' Reserves

It may seem more likely for health insurers to find themselves on the hot seat for inadequate reserves — but Blue Cross and Blue Shield plans in several states find themselves under fire for what some consumer groups, legislators and regulators are calling excessive reserve levels.

In September 2004, the Hawaii insurance commissioner started an evaluation of that state Blues plan's reserve levels to determine whether the insurer is keeping too much money aside rather than using it to reduce premiums or increase services. Blues plans in Rhode Island, Pennsylvania and North Carolina are facing similar probes.

The insurers insist their reserves are justified and point out that the levels fall well within the parameters established by the BlueCross BlueShield Assn. The reserves help them remain competitive and absorb cost increases and, they assert, would be needed to cover claims if an epidemic were to strike.

The critics aren't buying it. Several years of rising premiums, combined with growing uninsured populations, have prompted them to demand that the insurers spend down their reserves, issue rebates or use surpluses to help cover the uninsured.

The idea that an epidemic would whittle away reserves is an unfounded claim, says Dennis Olmstead, chief economist at the Pennsylvania Medical Society. "If there were an epidemic, the government would step in to help. The government would not allow [Blues plans] to go bankrupt."

Here's a look at Blues plans in states where surplus levels have recently been called into question:

Reporter Prompts Inquiry in Hawaii

Hawaii Medical Service Assn. (HMSA), parent of the Hawaii Blues plan, says the topic of excessive reserve levels had never been an issue prior to an Aug. 26, 2004, article in a Honolulu newspaper.

"We had a reporter who had looked into reserve levels in other states and asked our insurance commissioner if our [reserve levels] were excessive," Cisco says.

Now, the state's insurance commissioner is reviewing reserves to determine how they compare with levels held by other not-for-profit Blues plans. The Hawaii Blues plan has $508 million in reserves, which would cover about three months worth of claims, according to HMSA spokesperson Cliff Cisco. "We don't think there is any reason for concern here," he says. "Three months in reserves is not excessive — it's right about where it should be."

Under state law, a percentage of the Blues plan's investment income has to be used to offset rate increases. That has helped hold rate increases to the single digits for the past three years, Cisco says, adding that this year's rate increase is between 5% and 6%.

Hawaii Insurance Commissioner J.P. Schmidt, however, says he has received letters from consumer groups that contend even small rate increases shouldn't be approved for an insurer that has "so much revenue" in reserve.

"I'm looking at [HMSA's reserve levels] to see if action is appropriate, and what that action might be," he says.

Schmidt admits that his powers to limit reserve levels are limited, and would need to be addressed by state legislators. If he determines reserve levels are too high, he intends to submit a bill to the legislature asking it to develop appropriate standards.

HMSA, with 680,000 enrollees or about 60% of the market, is the dominant insurer in Hawaii. More than half of its enrollees are in PPO products. Kaiser Foundation Health Plan is a distant second with 25% of the market (about 270,000 lives).

Pennsylvania Blues Plans Defend Reserves

In January 2004, each of Pennsylvania's four Blues plans was ordered by the state's insurance department to justify its surplus and reserve levels through written applications. The applications also included a business plan that explained how reserves would be distributed if they were deemed excessive by the state.

The request for applications was prompted by what the insurance department perceived as excessively high cash reserves among all four plans. Regulators found that as of the end of 2002, the four Blues plans collectively held more than $2.4 billion in reserves and about $3.5 billion in surpluses. As of Dec. 31, 2003, Highmark, Inc. reported $2.2 billion in total capital and surplus, Independence Blue Cross posted a $1.3 billion surplus, Capital Blue Cross reported a $515 million surplus and Blue Cross of Northeastern Pennsylvania had a $470 million surplus.

"The [insurance department] has told us that their goal is not to try and reduce surpluses, but to have a process that will determine if surpluses are excessive," explains Butch Ward, a spokesperson for Independence Blue Cross. "We pay about $620 million a month in claims, so our surplus is about 41 days. Once they see our thoughts on how we calculate reserves, there is no way it will be seen as excessive." At the end of January 2004, Independence had a risk-based capital (RBC) level of 391%, according to Ward.

RBC measures how much capital an insurer has relative to the requirements from underwriting, insurance, credit and other risks. The average for Blues plans is about 600%, and the BlueCross BlueShield Assn.'s "early warning level" is 375%.

In separate applications, the four Blues plans detailed reserves and surplus levels and presented arguments for why existing surplus levels shouldn't be deemed excessive.

The insurance department has indicated that an RBC ratio range of between 350% and 650% would be an appropriate range for surplus levels. The Blues plans, however, have complained that setting such surplus limits exceeds the department's authority. Other states that have established surplus maximums have done so through hearings and state legislation, they say.

"It's really sad that $4 billion is sitting there in reserve [the combined reserve level among all four Blues plans], especially when we have 1.3 million people without health insurance," says Alisa Simon, health director for Philadelphia Citizens for Children & Youth.

Rhode Island Pledges to Freeze Reserves

In response to regulators in Rhode Island, that state's Blues plan in August 2004 announced that it would voluntarily freeze the growth of its reserves for one year. Blue Cross & Blue Shield of Rhode Island says it has about $277 million in reserves — about 17% of its annual premium revenue. That level will have dropped to about 15% by the end of the 12-month freeze, says spokesman Scott Fraser. In spring 2004, the insurer said it would increase provider reimbursements, but noted the freeze would not increase premiums paid by its customers. Fraser calls the move a "good-faith effort."

But Fraser insists the current reserve levels already are below where they should be. A consultant hired by the insurer determined that between 22% and 30% of its annual premium revenue should be held in reserve.

"This freeze will delay our plan to reach 22%," Fraser says. "Reserve levels are always an issue because people compare it to their own personal checkbooks. But we paid about $2 billion in claims in 2003."

North Carolina Lawmakers May Consider Action

A bill proposed in May 2004 by the North Carolina Department of Insurance — which sought to limit reserve levels held by the state's Blues plan — failed to find a sponsor among state legislators. Department spokesperson Chrissy Pearson says the bill was proposed during the state's "short session" in summer 2004, which deals primarily with budget issues. Pearson says the department stands behind the merits of the bill and hopes the issue will be resurrected in the state legislative session that began in January 2005.

The North Carolina Blues plan said 2003 net income more than doubled, from $76.1 million in 2002 to $196.3 million in 2003. Not-for-profit Blues plans in other states also posted strong financial results for 2003. For example, Blue Cross Blue Shield of Massachusetts said it had after-tax net income of $232.3 million for 2003, more than double the $85.7 million it had for 2002; CareFirst, Inc. reported 2003 net income of $171.3 million, a 64.1% increase over $104.4 million in net income from operations for 2002.

What's more, Pearson says, "Their latest financials reflect a smaller profit margin, and we see that as a positive sign....But we still have some worries about their reserve level, which remains about the same."

As of the end of the second quarter of 2003, the Blues plan had $272.1 million in reserves and a surplus (which includes the required reserve level) of $608.2 million. On the same date in 2004, the insurer had $299.6 million in reserves and a surplus of $853.6 million, according to the insurance department.

The insurer's reserves appear higher than they actually are, says North Carolina Blues plan spokesperson Mark Stinneford. "The company has grown significantly in the last few years, but the reserves we maintain only cover less than four months of expenses," he says.

For more information, contact Fraser at fraser.s@BCBSRI.org, Cisco at cliff_cisco@hmsa.com, Schmidt at (808) 586-2799 and Olmstead at (717) 558-7750.

Not-for-Profit Blues' Strong 2003 Financial Results Could Invite Regulatory Scrutiny

Several not-for-profit Blue Cross and Blue Shield plans have reported unusually strong financial performance for 2003. The higher profits represent a welcome opportunity for plans to reduce premiums, shore up reserves and invest in new technologies. But they also may bring increased scrutiny from regulators.

Case in point: After Blue Cross and Blue Shield of North Carolina in July 2003 abandoned its 19-month campaign to convert to for-profit status, the insurer kept acting like a for-profit company, say some critics. In fact, after the Blues plan reported record profits for the 2003 calendar year, the North Carolina Department of Insurance in June 2004 called for strict controls over the state's largest insurer.

After several years of double-digit rate hikes, the North Carolina Blues plan's numbers raised eyebrows among employers, state lawmakers and the insurance department. In response, the department proposed legislation that seeks to cap the insurer's reserve levels and mandate premium rebates when reserve levels get too high.

Blues plans in New Jersey, Tennessee and Rhode Island already have said they will refund some 2003 premiums to customers. In other states, such as Pennsylvania, legislators and regulators have targeted what they perceive as unnecessarily high reserves.

In the past, the North Carolina Blues plan has returned premiums to members when surpluses rose too high, as measured by the number of months of operating expenses and medical claims the company could pay with cash on hand. In 1985, the North Carolina Blues plan adjusted the premium structure to ratchet down reserves that had swelled to 6.2 months.

But members shouldn't hold their breath for another payout. North Carolina Blues plan spokesperson Mark Stinneford ruled out another premium refund, since the company's surplus is well below the 6.2-month mark. As of Dec. 31, 2003, the health plan's surplus was 3.7 months, just above the 3.6-month target established by state law, he says. The insurer used some of its 2003 profits to boost the surplus from 2.8 months, where it stood at the end of 2002.

"We're confident that we're maintaining reserves in a manner that's both prudent and fully in accordance with the law," Stinneford says. "We welcome any guidance they [i.e., the insurance department] might have."

The North Carolina Blues plan argues that legislation isn't needed, especially in light of its first-quarter 2004 profits, which were 14% lower than those for the same period a year earlier. And the robust 2003 profit will help the insurer hold future rate increases to a minimum, says Blues spokesperson Mark Stinneford.

"2003 was certainly a remarkable year for us, but it probably won't be repeated," he says. "Medical costs last year were substantially lower than we expected, but we've since adjusted for that. We expect the trend toward lower profits to continue."

The North Carolina Blues plan's record profitability shouldn't have come as a surprise to the insurance department, asserts Dave Garbrick, president of Garbrick & Associates, Inc., a health care consulting firm in Charlotte, N.C. The insurer spent 19 months working on the

Blue Cross and Blue Shield

Some Blues' Premium Givebacks Generate Sales, Goodwill, While Others Get Criticized

Reprinted from the February 2004 issue of The AIS Report on Blue Cross and Blue Shield Plans, a hard-hitting independent monthly newsletter on business strategies, products and markets, mergers and alliances, and financing of BC/BS plans.

As more not-for-profit Blue Cross and Blue Shield companies close the books on a very profitable 2003, the use of premium givebacks and holidays is growing more common. Some Blues plans are returning a portion of 2003 premium payments to enrollees to address an unusual problem -- what to do with surpluses that have risen well beyond the insurer's expectations and above what is required for conservative financial management.

But the refunds themselves could create new trouble for Blues plans. The refund checks could expose some self-funded employer clients to legal risks, one employee benefits attorney warns.

In addition, the Blues plan could open itself to criticism because of how it chooses to allocate funds. For instance, Horizon Blue Cross Blue Shield of New Jersey, which this month said it would distribute $55 million to employers, seniors, individuals and providers, came under fire because of the mechanism it used to allocate the funds.

Specialty Pharmacy
Health Plan Strategies
Drug Mgmt. Products

E-Health
Today in E-Health Bus.
E-Health Terms
Executive Compensation
Company Profiles

Consumer-Directed Care
Articles on CDH
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Still, premium refunds can be a huge public relations and marketing coup for Blues plans. For example, BlueCross BlueShield of Tennessee said this month that it has logged record-breaking enrollment gains in 2003, in part because of the decision first to slow premium rate increases, then to give back some premium payments altogether, because of higher surpluses. In addition, by voluntarily returning excess surplus to members, insurers can avoid having such a move forced on them by regulators -- as is happening to Blues plans in Pennsylvania.

Blues plans have used a variety of strategies to spend down surpluses, including offering a premium holiday to enrollees, tying givebacks to pending legislation, directing them to information technology upgrades and repaying funds to self-funded employers.

Among the options used by Blues plans:

- Blue Cross and Blue Shield of Rhode Island said in October 2003 that it would distribute $21 million to customers, hospitals and other providers via premium rebates and increased reimbursements. The insurer decided to use a "rate holiday" to return $7 million to employers. Each employer group would get a 5% discount on one month's premium payment. Another $7 million would be used to increase physician reimbursement, and the last $7 million was distributed to hospitals in Rhode Island.
- BlueCross BlueShield of Tennessee said in October 2003 that it would refund $67 million in premium payments to fully insured group and individual members starting in December 2003. Any enrollees or businesses that had fully insured Tennessee Blues coverage for at least one month during 2003 were eligible to receive about 4.5% of premiums back, in the form of a check mailed in December 2003 or a credit on their statement for January 2004. The Tennessee Blues plan did not include providers in the giveback program.
- Horizon Blue Cross Blue Shield of New Jersey said it would distribute $33.8 million to small businesses, $7.9 million to senior Medigap members and $8.3 million to individual enrollees under age 65. In addition, the insurer said it would commit $5 million to provide computer hardware and software to a number of New Jersey hospitals and physicians.

A few years ago, the suggestion that several Blue Cross and Blue Shield plans across the country might have such generous surpluses that they would return millions to enrollees in rebates seemed unthinkable. At that time, medical costs were rising 10% to 15% per year. But a slowdown in the rate of increase in health care spending left many not-for-profit Blues plans with unexpectedly high reserves, while for-profit Blues plans reported robust earnings.

N.J. Governor Critical of Rebate

When Horizon unveiled its plans for a premium repayment, it said that although small employer groups and Medigap members would start receiving checks in March, individuals would not see refunds until "after meaningful reform of the individual insurance market is enacted." The insurer explained, "The dividend will aid those who may face higher costs during the transition to a reformed system."

New Jersey Gov. James McGreevey (D) criticized the New Jersey Blues plan, asking whether the refunds were being used to advance the insurer's political agenda. One of the proposed legislative changes would allow the insurer to charge different rates for individuals based on their health.

"The notion that you would hold hard-working citizens hostage in order to advance your political agenda is, quite simply, unacceptable," McGreevey wrote in a Feb. 5 letter to Horizon President and CEO William Marino. The letter also criticized Marino's $2.65 million in annual compensation.

In a strongly worded response, Horizon Chairman Vincent Giblin defended the decision to hold onto dividends for individual policyholders. The strategy, he wrote, is intended to provide "some type of subsidy to those of our members that might experience an increase in their premiums" as a result of the proposed reforms.

Standard & Poor's estimates Horizon's 2003 year-end statutory surplus at between $865 million and $875 million. The planned dividend represents about 6% of the insurer's surplus. The insurer's surplus growth, according to S&P, will likely slow moderately in 2004.

Pennsylvania Blues Plans Face Regulation

Issuing a rebate also could help nonprofit Blues plans stay a step ahead of state regulators, says Joseph Marinucci, a credit analyst with Standard & Poor's in New York City. "I think a lot of [Blues plans] are concerned with what's happening in Pennsylvania."

State regulators in Pennsylvania last month issued a notice directing the state's four Blues plans to submit detailed information about their surplus levels. If the state determines surpluses are excessive, the insurers will be required to come up with a plan to give rebates to members or subsidize the uninsured.

"This is an election year, and health care is a huge issue. By issuing a rebate, [Blues plans] acknowledge that there is a problem," Marinucci says. "It's a great [public relations] move." But Bill Steverson, spokesperson for the Tennessee Blues plan, and Tom Rubino, Horizon spokesperson, say the rebates were never seen as a way to curry favorable press or advance a political agenda.

Although rebates aren't yet widespread, Marinucci says they could become more common this year. Nonprofits with strong market positions, he says, are probably contemplating the idea. Such rebates, he says, could have some "collateral impact" on for-profit competitors. "You're not going to see Aetna give money back," he says. "In my view, this could strengthen their [i.e., Blues plans'] market position."

Some Employers Could Face Legal Risk

While most employers welcome premium repayments, those companies that sponsor self-insured employee benefit plans could run into problems once they cash their checks, warns David Joffe, an employee benefits attorney in Nashville, Tenn.

Self-insured health plans, he explains, are subject to the requirements of the Employee Retirement Income Security Act (ERISA). If employees contribute to their health coverage using pretax dollars, a portion of the refund could be considered a "plan asset" under ERISA, and that limits what can be done with the funds. Any money refunded to the employee directly could be considered taxable income.

Although the U.S. Department of Labor, which has authority over ERISA plans, doesn't specifically address insurance rebates, ERISA generally requires such assets

to be held in a trust, says Joffe. In New Jersey, Horizon says the employers eligible to receive rebates provide health coverage to about 250,000 people.

"The best thing [Blues plans] can do is give employers a lot of advance notice so they can decide what to do with the refunds," Joffe says. "I would tell employers to apply the check to future premiums if it contains plan assets."

Some employer clients of BlueCross BlueShield of Tennessee were concerned about ERISA compliance related to that insurer's premium repayment, says Steverson. A note included with the refunds urged employers to consult ERISA rules before cashing the checks, he says. Although Blues plans aren't responsible for explaining ERISA to employers, Horizon likely will include a similar note, says Rubino.

BlueCross BlueShield of Minnesota

P.O. Box 64560 • St. Paul, Minnesota 55164-0560

December 16, 1993

Mr. Patrick Nelson
Deputy Commissioner
State of Minnesota
Department of Commerce
133 East 7th Street
St. Paul, MN 55101

Dear Mr. Nelson:

I'm writing in response to your letters dated November 2, 1993, and November 16, 1993, addressed to Andrew Czajkowski, regarding your concerns that the surplus reserve position for BCBSM is currently exceeding the statutory corridor.

We do have a detailed plan of action that provides for BCBSM to be within the statutory reserve corridor by December 31, 1993. The enclosed Schedule A lists the planned calculations and adjustments that result in BCBSM's surplus reserves being at 3.88 months by December 31, 1993. The following provides more detailed explanations for the item numbers presented on the enclosed Schedule A:

Item 1.

The addition of $53,200,000 to reserves for fourth quarter operations includes anticipated net gains for BCBSM and its affiliates and subsidiaries partially offset by a $2 million increase in non-admitted assets due to routine equipment purchases.

Item 2.

In general, a gross premium valuation projects the future financial experience of business to determine the present value of future profits or losses. Thus, a gross premium reserve is the present value of the excess of future outflows (claims and expenses) over future income (premium and investment income).

We have identified two such gross premium reserve items which will negatively impact our surplus reserve balance. They are (1) a $55.3 million individual business reserve (recognition of future premiums allowed by MinnesotaCare being less than future projected claims costs for our individual lines of business), and (2) a $15.0 million gross premium reserve to accommodate the

transfer of five closed blocks of BCBSM individual business to our in-force block of business (this would result in lower rates and in some cases a richer benefit package for these subscribers).

Another identified reserve item is a $1.0 million rate stabilization reserve to meet the new MinnesotaCare law requiring for the first time a minimum anticipated loss ratio for small group insurance of 75% starting in July, 1993. BCBSM believes there is an intent that the loss ratios actually be attained.

BCBSM projects the total of these two gross premium reserve liabilities and the rate stabilization reserve liability to be $71,300,000.

Item 3.

We are planning to non-admit the portion of equity in our affiliates and subsidiaries (including Blue Plus, HMO Midwest and MII Life) that represents the mandatory minimum reserve requirements for those organizations which we project at year-end 1993 will equal $9,200,000. It is our position that since these portions of equity are already used to meet the minimum reserve requirements of the affiliates and subsidiaries, they should not be used again in meeting reserve requirements for BCBSM.

Item 4.

In the summer of 1993, Affiliated Medical Centers (AMC), P.A., Willmar, and BCBSM jointly organized a general business corporation under the name of Pioneer Health Systems, Inc. BCBSM and AMC plan to enter into a number of 30-year covenant agreements for which BCBSM will agree to pay AMC the sum of approximately $10 million. As you are aware, similar information regarding this subject has been previously shared with you. We will be reflecting this item as a non-admitted intangible asset on the books of Blue Plus, a BCBSM affiliate. Since this will likewise reduce the asset value of the affiliate on BCBSM's books, BCBSM's reserves will also be reduced by the same amount.

Item 5.

To lend support to our EDI operations, we transacted a MedCom stock purchase in the amount of $500,000. Since this stock has an insupportable market value, we will be treating this as a non-admitted asset.

Item 6.

Since the 30-year treasury bond interest rate has fallen to a level of 6.3%, we are reducing the discount rate assumption used for our pension and retiree health benefit plans to 6.5%. This will increase CY 1993 after-tax costs and thus, reduce reserves by $3,200,000.

From the enclosed schedule you will note that the net impact of the above-discussed items will take our surplus reserves from $215,652,000 at September 30, 1993, to a projected amount of $174,652,000 at December 31, 1993. Dividing this reduced reserve level by $44,956,000 (the projected CY 1993 estimate of one month of incurred health service claims and associated administrative expenses), the projected months in reserve at December 31, 1993, is calculated to be 3.88 months, within the statutory reserve corridor.

Please advise if you have any questions or if you would like us to provide any further clarifications regarding this plan of action.

Sincerely,

Norman C. Storbakken
Group Vice President and
Chief Financial Officer

NCS/br

Enclosures

Schedule A

BCBSM
PROJECTED MONTHS IN RESERVE
AS OF DECEMBER 31, 1993

Free Reserves Balance, 9/30/93		$215,652,000
1.	Projected Net Additions to BCBSM Reserves for 4th Quarter, 1993 Operations	+53,200,000
		$268,852,000
2.	Less: Duration Reserves Liab. (Before Taxes)	(71,300,000)
3.	Less: Duplicative Reserves for Blue Plus, HMOMW, and MII Life Minimum Reserve Requirements (Non-admitted Equity)	(9,200,000)
4.	Less: Non-admitted Intangible Asset - Right of First Purchase from Affiliated Medical (Recorded on Blue Plus)	(10,000,000)
5.	Less: Non-admitted MedCom Stock Purchase Due to No Supportable Market Value	(500,000)
6.	Less: Change in the Discount Rate Used to Calculate Pension/Retiree Health Benefits from 8.5% to 6.5% (Net of Taxes)	(3,200,000)
Net Projected Free Reserves, 12/31/93		$174,652,000
Projected CY 1993 1 Mo. of Claims and Admin. Expense =		$44,956,000
Projected Months in Reserve, 12/31/93		3.88 Mos.

BlueCross BlueShield of Minnesota

5555 Blue Cross Road • P.O. Box 64560 • St. Paul, MN 55164-0560 • (612) 456-8000 • 1-800-382-2000

JUDY BUSSE

MAY 21 1998

May 19, 1998

Ms. Julia T. Philips, F.S.A.
Minnesota Department of Commerce
Health and Life Section
133 East Seventh Street
St. Paul, MN 55101

SENT VIA FAX

Dear Julia:

This letter provides background on the reserves Blue Cross Blue Shield of Minnesota (BCBSM) intends to establish for its closed block of Medicare Supplement products.

Medicare Supplement blocks in Minnesota are especially difficult to manage, due to the community rating requirement. In this context, community rating means everyone pays the same rate regardless of age. Claims costs still increase with age, making the rating difficult. On open blocks, younger new entrants have lower claims costs and therefore help support older, existing members. In other words, the aging of the members, which gives rise to increasing costs (and hence premium rates), is suppressed to an extent. The extent depends on how much new business is written versus how much existing business persists.

On closed blocks, this effect does not happen at all. Therefore rates must increase, not just due to normal trend (i.e. trend that has no aging component), but also due to the aging of the members. In addition, some people in closed blocks can go through health screening and move into an open block with lower rates. Thus, the average cost on closed blocks increases still more.

As this continues over time, rate increases needed on some closed blocks have been higher than we have been willing to file and/or higher than the Department of Commerce has been willing to approve. As a result, rates on some of the closed blocks have become deficient, and in some cases, will remain that way throughout the future life of the block.

In this situation, we should hold a deficiency reserve equal to the present value of future premium deficiencies. This would be calculated assuming the premium rates are deficient by the same percentage in the future as they are now. Additionally, we think it is also appropriate to hold a reserve for that portion of future rate increases that relates to increased costs due to the aging of the members. If future increases are capped at levels comparable to those applied to the open blocks, then future aging will not be entirely provided for, and the percentage deficiency in the rates will grow larger each year. The sum of these two reserves is essentially a gross premium reserve: the present value of future costs less the present value of future revenues.

If we were allowed to hold such reserves on our closed Medicare Supplement blocks, the benefit to these members would be enormous as future rate increases would be much more modest.

We have not finalized the calculation of these reserves yet, but this outlines the issue and approach. My estimate at this point is that the reserve for aging will be between $5 million and $10 million, and the

reserve for deficiency in the range of $6 million to $11 million, for a total reserve between $11 million and $21 million.

You asked me to comment on discussions and correspondence BCBSM has had with the Department of Commerce in the past regarding intent to establish a gross premium reserve for the closed block Medicare Supplement business. We have reviewed our correspondence files and acknowlege that we indicated intent to establish such a reserve during 1995. My understanding of the events causing our inaction is that the key executive involved in the discussions with the Department on the reserve left BCBSM in early 1995.

Our interest in establishing the reserve at this point stems in large part from the problems in obtaining approval for our requested 1998 rate increases for the Medicare Supplement closed block products as noted above. The reserve would help us to manage future rate increases.

Finally, in the event that we were to close additional blocks of business in the future, our intent would be to establish appropriate deficiency and/or aging reserve. We note that, depending on our financial position at such time, we might present a plan to the Department to build such a reserve over a multi-year period.

The commitment that had been made to the Department was not communicated to the successor leadership through the transition. All of our correspondence indicates limited involvement by staff on the issue; we acknowledge that the lack of continuity on this issue through a leadership transition is unfortunate. Certainly, there were not financial reasons that limited our ability to establish the reserve.

Please call me at 456-8553 to discuss your comments. Thank you.

Sincerely,

Nancy F. Nelson/jc

Nancy F. Nelson

Vice President and Chief Actuary

NFN:jc

bcc: Dick Niemiec
Judy Busse
Jim Vanvig

This Exhibit Contains Confidential Information

Notes to Financial Statement

1. Summary of significant accounting policies.

A. Accounting Practices.

The financial statements of BCBSM are presented on the basis of accounting practices prescribed or permitted by the Minnesota Department of Commerce.

The Minnesota Department of Commerce recognizes only statutory accounting practices prescribed or permitted by the State of Minnesota for determining and reporting the financial condition and results of operations and for determining solvency under state law. The National Association of Insurance Commissioners' (NAIC) Accounting Practices and Procedures manual, (NAIC SAP) has been adopted as a component of prescribed or permitted practices by the State of Minnesota.

BCBSM, with permission from the Minnesota Department of Commerce, reports its investments in affiliated HMOs as a nonadmitted asset instead of admitting those investments pursuant to NAIC SAP. These affiliated HMOs include: Blue Plus, Atrium Health Plan and First Plan of Minnesota. If these investments were to be admitted, statutory surplus at December 31, 2005 would be increased by $190,784,000 with no impact on the 2005 income statement.

B. Use of Estimates in the Preparation of the Financial Statements.

The preparation of financial statements of insurance companies requires management to make estimates and assumptions that affect amounts reported in the financial statements and accompanying notes. Such estimates and assumptions could change in the future as more information becomes known, which could impact the amounts reported and disclosed herein.

C. Accounting Policies

Fixed Assets

Land is reported at cost. Real estate occupied by BCBSM and real estate held for the production of income are reported at depreciated cost net of related obligations. Real estate that BCBSM has the intent to sell is reported at the lower of depreciated cost or fair value, net of related obligations.

Depreciation is calculated on a straight-line basis over the estimated useful lives of the properties.

Realized Capital Gains and Losses

Realized capital gains and losses are determined using the specific identification basis. Declines in the fair value of any investments below cost that are deemed other than temporary, are recorded as realized losses resulting in a new cost basis for the investment. Changes in admitted asset carrying amounts of bonds, common and nonredeemable preferred stocks are credited or charged directly to unassigned surplus.

Equipment

The admitted value of BCBSM's electronic data processing equipment and operating software is limited to three percent of capital and surplus. The admitted portion is reported at cost, less accumulated depreciation of $35,574,000 and $31,246,000 at December 31, 2005 and 2004, respectively. Electronic data processing equipment and operating software is depreciated using the straight line method over the lesser of its useful life or three years. Nonoperating software is depreciated using the straight line method over the lesser of its useful life or five years. Other furniture and equipment is depreciated using the straight line method over its estimated useful life.

STATEMENT OF ACTUARIAL OPINION

Statutory Annual Statement of Blue Cross Blue Shield of Minnesota as of and For the Year Ended December 31, 2005

I, Nancy F. Nelson, am an officer of Blue Cross Blue Shield of Minnesota and a member of the American Academy of Actuaries. I have been appointed by the Blue Cross Blue Shield of Minnesota Board of Directors to provide the Statement of Actuarial Opinion for the Plan. I meet the American Academy of Actuaries' qualification standards for rendering this statement of actuarial opinion.

I have examined the assumptions and methods used in determining loss reserves, actuarial liabilities and related actuarial items listed below, as shown in the annual statement of Blue Cross Blue Shield of Minnesota as prepared for filing with state regulatory officials, as of December 31, 2005.

(a) Claims Payable (Page 3, Line 1)	$314,682,889
(b) Accrued Medical Incentive Pool (Page 3, Line 2)	$0
(c) Unpaid Claims Adjustment Expenses (Page 3, Line 3)	$56,347,970
(d) Aggregate Policy Reserves (Page 3, Line 4)	$146,350,000
(e) Aggregate Claim Reserves (Page 3, Line 7)	$0
(f) Experience-Rated Refunds (included in Page 3, Line 4)	$9,450,000
(g) Other Actuarial Liabilities (Page 3, Line 21)	$0

I relied upon underlying records and/or summaries prepared by the responsible officers or employees of the organization. In other respects, my examination included such review of the assumptions and methods used and such tests of the calculations as I considered necessary.

My opinion rests on the assumption that the Company's December 31, 2005 statutory based unpaid claims liability is funded by valid assets that have suitably scheduled maturities and/or adequate liquidity to meet future cash flow requirements.

Part II Balance Sheets — Attached schedules and amounts in the description column should be for end-of-year amounts only. (See instructions.)

		Beginning of year	End of year	
		(a) Book Value	(b) Book Value	(c) Fair Market Value
Assets	1 Cash—non-interest-bearing	1,991,321	375,745	375,745
	2 Savings and temporary cash investments	0	0	0
	3 Accounts receivable ► 0			
	Less: allowance for doubtful accounts ► 0	0	0	0
	4 Pledges receivable ► 0			
	Less: allowance for doubtful accounts ► 0	11,202,092	0	0
	5 Grants receivable	0	0	0
	6 Receivables due from officers, directors, trustees, and other disqualified persons (attach schedule) (see page 15 of the instructions)	0	0	0
	7 Other notes and loans receivable (attach schedule) ► 0			
	Less: allowance for doubtful accounts ► 0	0	0	0
	8 Inventories for sale or use	0	0	0
	9 Prepaid expenses and deferred charges	0	0	0
	10 a Investments—U.S. and state government obligations (attach schedule)	12,448,160	18,229,948	18,229,948
	b Investments—corporate stock (attach schedule)	21,008,076	33,105,930	33,105,930
	c Investments—corporate bonds (attach schedule)	0	0	0
	11 Investments—land, buildings, and equipment: basis ► 0			
	Less: accumulated depreciation (attach schedule) ► 0	0	0	0
	12 Investments—mortgage loans	0	0	0
	13 Investments—other (attach schedule)	0	0	0
	14 Land, buildings, and equipment: basis ► 0			
	Less: accumulated depreciation (attach schedule) ► 0	0	0	0
	15 Other assets (describe ► See statement attached)	188,883	336,687	336,687
	16 **Total assets** (to be completed by all filers—see page 16 of the instructions. Also, see page 1, item I)	46,838,532	52,048,310	52,048,310
Liabilities	17 Accounts payable and accrued expenses	953,104	597,471	
	18 Grants payable	0	0	
	19 Deferred revenue	0	0	
	20 Loans from officers, directors, trustees, and other disqualified persons	0	0	
	21 Mortgages and other notes payable (attach schedule)	0	0	
	22 Other liabilities (describe ►Deferred tax liability)	19,500	55,200	
	23 **Total liabilities** (add lines 17 through 22)	972,604	652,671	
Net Assets or Fund Balances	**Organizations that follow SFAS 117, check here ►☐ and complete lines 24 through 26 and lines 30 and 31.**			
	24 Unrestricted	0	0	
	25 Temporarily restricted	0	0	
	26 Permanently restricted	0	0	
	Organizations that do not follow SFAS 117, check here ►☐ and complete lines 27 through 31.			
	27 Capital stock, trust principal, or current funds	0	0	
	28 Paid-in or capital surplus, or land, bldg., and equipment fund	0	0	
	29 Retained earnings, accumulated income, endowment, or other funds	45,865,928	51,395,639	
	30 **Total net assets or fund balances** (see page 17 of the instructions)	45,865,928	51,395,639	
	31 **Total liabilities and net assets/fund balances** (see page 17 of the instructions)	46,838,532	52,048,310	

Part III Analysis of Changes in Net Assets or Fund Balances

1 Total net assets or fund balances at beginning of year—Part II, column (a), line 30 (must agree with d-of-year figure reported on prior year's return)	1	45,865,928
ter amount from Part I, line 27a	2	3,477,744
3 Other increases not included in line 2 (itemize) ► Unrealized gain on investments	3	2,051,967
4 Add lines 1, 2, and 3	4	51,395,639
5 Decreases not included in line 2 (itemize) ► N/A	5	0
6 Total net assets or fund balances at end of year (line 4 minus line 5)—Part II, column (b), line 30	6	51,395,639