Study of Capital Reserve Limits in Minnesota

Minnesota Department of Health

March 2014

Prepared with the assistance of DeWeese Consulting, Inc.

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MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, maintaining and improving the health of all Minnesotans

March 7, 2013

The Honorable Kathy Sheran
Chair, Health, Human Services and Housing Committee
Minnesota Senate
Room 120, State Capitol
75 Rev. Dr. Martin Luther King Jr. Blvd.
Saint Paul, MN 55155-1606

The Honorable Tony Lourey
Chair, Health Care and Human Services Finance Committee
Minnesota Senate
Room 120, State Capitol
75 Rev. Dr. Martin Luther King Jr. Blvd.
Saint Paul, MN 55155

The Honorable Tina Liebling
Chair, Health and Human Services Policy Committee
Minnesota House of Representatives
Room 367, State Office Building
100 Rev. Dr. Martin Luther King Jr. Blvd.
Saint Paul, MN 55155-1606

The Honorable Thomas Huntley
Chair, Health and Human Services Finance Finance Committee
Minnesota House of Representatives
Room 585, State Office Building
100 Rev. Dr. Martin Luther King Jr. Blvd.
Saint Paul, MN 55155

Dear Senator Sheran, Senator Lourey, Representative Liebling and Representative Huntley:

The 2013 Minnesota Legislature directed the Minnesota Department of Health (MDH), in consultation with the Departments of Commerce and Human Services, to conduct a study to identify:

- Methods to determine appropriate levels of capital reserves for Health Maintenance Organizations (HMOs), and
- Mechanisms to consider for implementing upper thresholds for capital reserves.

In conducting the study, MDH was directed to consult with HMOs, stakeholder, consumers, as well as perspectives from other states' regulators.

The enclosed report presents findings from our financial analyses; review of the regulatory history of Minnesota insurance markets; study the relevant literature, including any evidence about regulation in other states; and interviews with a range of stakeholders. The report includes a presentation of policy considerations the legislature may wish to consider about whether to establish capital reserve limits, how to implement them, and other possible tools available to the Legislature.

Please feel free to contact Stefan Gildemeister, the Director of the Health Economics Program with any questions. Mr. Gildemeister can be reached at 651.201.3554 or Stefan.Gildemeister@state.mn.us.

Sincerely,

Edward P. Ehlinger, MD, MSPH
Commissioner
P.O. Box 64975
St. Paul, MN 55164-0975

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Capital Reserves Summary Report

The 2013 Minnesota Legislature directed the Minnesota Department of Health (MDH), in consultation with the Departments of Commerce and Human Services, to conduct a study to identify:

- Methods to determine appropriate levels of capital reserves for Health Maintenance Organizations (HMOs), and
- Mechanisms to consider for implementing upper thresholds for capital reserves.

In conducting the study, MDH was directed to consult with HMOs, stakeholder, consumers, as well as perspectives from other states' regulators.

To conduct the study within the available timeline, MDH retained DeWeese Consulting Inc. (DeWeese), an actuarial team with diverse experience in conducting health plan financial analyses, review the history of Minnesota insurance regulation concerning capital reserve requirements; study the relevant literature, including any evidence about regulation in other states; conduct interviews with a range of stakeholders; perform broad financial analysis, and summarize the analysis for the report to the Minnesota Legislature.

As required, MDH and DeWeese conducted interviews with a number of experts and stakeholders:

- At the outset of the study, the team consulted experts at the Departments of Commerce and Human Services.
- Interviews were also conducted with current and former insurance regulators in nine other states.
- Stakeholder feedback was gained through interviews with representatives of six Health Maintenance Organizations, or HMOs (and affiliated insurance companies), three County-Based Purchasers (CBPs), and three consumer representatives. MDH also requested written feedback from representatives from the remaining three HMOs.
- Finally, the research team consulted economics faculty at the University of Minnesota School of Public Health Division of Health Policy and Management (a full list of participants in interviews is included in Appendix F to this report).

The consultants who contributed to this report on behalf of DeWeese Consulting, Inc. were:

Charles C. DeWeese, FSA, MAAA
Bela Gorman, FSA, MAAA
Don Gorman
Elinor Socholitzky, MBA
Steven Tringale
Anthony J. van Werkhooven, PhD, FSA, MAAA

Health Care Market Overview

In Minnesota, the four main types of domiciled health plan carriers are HMOs, County-Based Purchasers (CBPs), Nonprofit Health Service Plan Corporations (NHSPCs, of which Blue Cross Blue Shield of MN is the only one), and insurance companies. All but insurance companies maintain a nonprofit status.[1] HMOs, NHSPCs, insurance companies, and CBPs all offer multiple lines of business; however, state health care programs may only be offered by HMOs and CBPs. The majority of carriers in Minnesota have multiple companies in their organizational structure. Historically, HMOs were distinguished from insurance companies in that they provided comprehensive health maintenance services or arranged for the provisions of these services, often through a limited panel of providers, to enrollees on the basis of a fixed prepaid sum. Today, health care product design and health management is more uniform in the state, independent of organizational form. There remain regulatory differences in Minnesota concerning HMOs, including the requirement to deliver certain required services (mandated benefits) and maintain adequate provider networks.[2]

In researching the study questions, the contractor conducted financial analyses of data reported in Annual Financial Statements and in reports submitted annually to MDH by domiciled Health Maintenance Organizations (HMOs), affiliated insurance companies or non-profit health service corporations. The analyses extended beyond HMOs because of the substantial dependencies between some companies and interlocking business relationships, and to assess the need for parity in regulation of health insurance carriers in Minnesota's market. The report and appendices include findings from trend analyses of total revenue and revenue by product line; net underwriting gain and gain from investments; and capital reserves and surplus as measured through a number of standard assessment tools including number of months in claims and expenses, Surplus As a Percent of Revenue (SAPOR), and percent of the Authorized Control Level (ACL) in the National Association of Insurance Commissioner's Risk Based Capital Framework (RBC).

Some of the primary findings from the financial analysis are as follows:

- In 2012, Minnesota's combined fully-insured health insurance market generated $13.0 billion in health insurance premium revenue.[3]
- Of this, non-profit health plans, including HMOs and Blue Cross Blue Shield of Minnesota (BCBSMN), accounted for $9,825 million, or 75.6 percent.
- HMOs' share of the fully insured market has been declining steadily, reaching just 52.1 percent in 2012.

[1] Additional detail about health plan companies, their organizational structures and product lines can be found in Section II of the report and in appendices A, B, and D.
[2] HMOs in Minnesota are licensed under Minnesota Statutes, Chapter 62D; Blue Cross Blue Shield of MN, as a nonprofit health service corporation is licensed under Chapter 62C; County-Based Purchasers are licensed under Chapters 62D or 62N; and insurance companies are licensed under Chapter 62A.
[3] Insurance companies in the fully-insured health care market in Minnesota also generate revenue from serving employers with about 2 million Minnesota employees in self-insured arrangements. That revenue is not included in this estimate.

- County-Based Purchasers, organizations that exclusively serve public program enrollees[4] within their political boundaries, earned $406 million in premium revenue in 2012, or 3.1 percent of the health insurance total market revenue.
- For-profit insurance companies, including those affiliated with Minnesota domiciled non-profit health plans and HMOs, and indemnity insurance carriers accounted for the remainder of the health insurance market.
- In 2012, four Minnesota domiciled carriers and their affiliated companies – Blue Cross Blue Shield of Minnesota, HealthPartners, Medica, and UCare – accounted for 91.5 percent of the fully insured market, or about $11.9 billion.
- As commercial product lines have, for most HMOs, been transitioning to their for profit insurance affiliates, serving public program client has become an increasingly important line of business for HMOs. In 2012, HMOs generated $3.9 billion in public program revenue across the managed care Medicaid Program (Prepaid Medical Assistance Program, or PMAP), MinnesotaCare, Minnesota Senior Health Option, and Special Needs Medical Care), accounting for 53.1 percent of HMO total revenue.
- The net underwriting gain – earned premium revenue less expenses – from public programs for the period of 2003 to 2012 ranged from a low of 0.5 percent for Metropolitan Health Plan to a high of 3.1 percent for UCare.[5]

Definition of Capital Reserves & Health Insurer Surplus

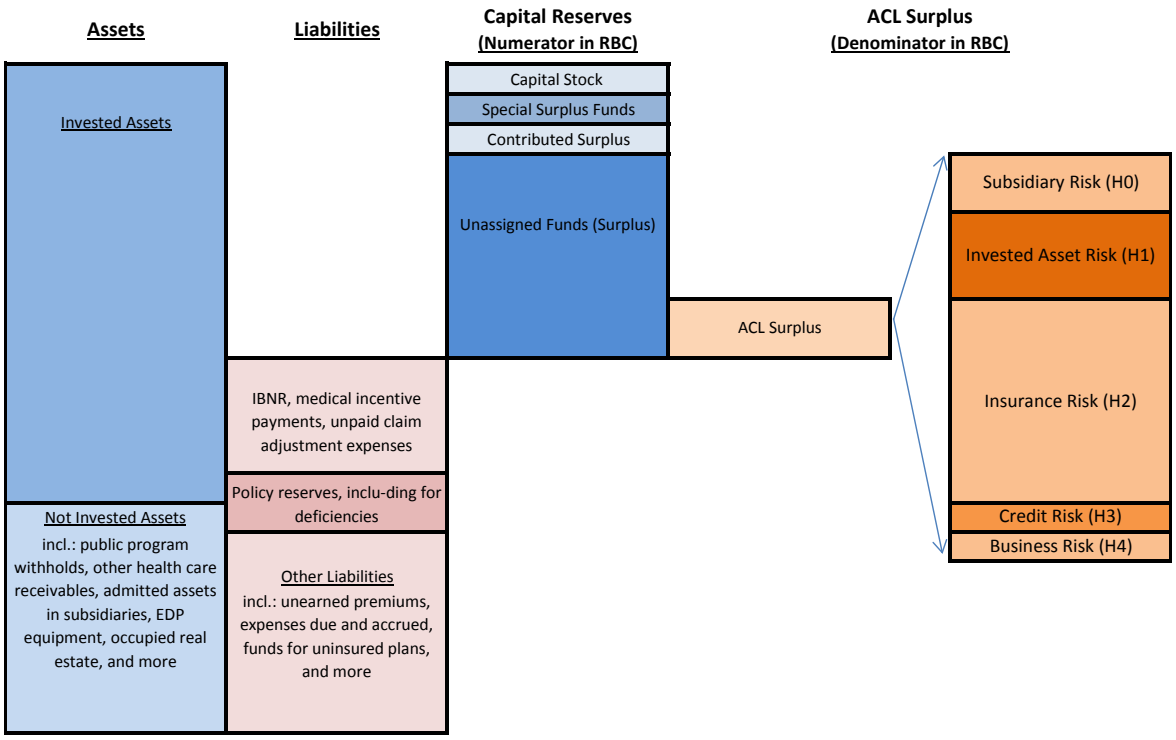
As noted, the financial analysis conducted for this report included analysis of data related to accumulated financial resources held by insurers for a variety of reasons. These resources are often termed capital reserves or surplus. For the purpose of this study, capital reserves refer to financial assets for which there is no corresponding liability. As shown in Figure 1 below, capital reserves are made up of varying types of surplus depending on the source of that funding. Assets with a corresponding liability, some of which are commonly known as reserves, are termed in this study as liabilities in order to distinguish them from capital reserves.

The primary purpose of requiring a minimal level of capital reserves is to ensure that health plans are appropriately prepared to financially withstand unanticipated losses associated with health care utilization trends or changes in the health care market or regulatory environment, or other kinds of risk, like losses on investments. Capital reserves are also used to make health plan investments in infrastructure or business intelligence, or to support health care access programs and other business goals of insurance carriers. Most generally, capital reserves are generated through net income (profits) investments gains over time. The issuance of capital stock or investments by affiliated business or holding companies can also be sources of capital reserves for those entities, although non-profits do not

[4] Both Medicare and state public health insurance programs
[5] Financial data for the report, unless noted otherwise, originated with publicly available health plan company Annual Statements and data from supplement reports delivered annually by HMOs to the Minnesota Department of Health.

themselves issue capital stock. Some of the HMOs and all of the CBPs also have contributed surplus from sponsoring organizations.

Figure 1: Composition of Assets, Liabilities and Capital Reserves



IBNR: costs for claims that are incurred but not reported

The analysis of 2012 capital reserves for Minnesota health insurance carriers and CBPs studied for this report showed that:

- HMOs held a combined volume of $1.785 billion in capital reserves, more than 95 percent of which were in the form of unassigned funds, or surplus.[6]
- Minnesota domiciled insurance companies and the Minnesota nonprofit health service corporation, all of which are affiliates of HMOs, held an additional $1.262 billion in capital reserves. Unassigned funds or surplus accounted for approximately 91 percent of the total capital.
- CBPs total capital reserves amounted to $64 million in 2012. Given the volume of contributed (rather than earned) surplus, unassigned funds amounted to $49 million or 76 percent.
- Our analysis shows that a number of Minnesota-domiciled HMOs and insurance companies calculate, by industry standards, sizable conservative margins in their liabilities for unpaid claims

[6] This estimate excludes a reported volume of $248 million in capital reserves for HealthPartners, Inc., because it represents surplus held by the affiliated HealthPartners Insurance Company. Including it would mean double-counting those resources.

(incurred but not recorded, IBNR). Had carriers employed more typical IBNR margins, another $56 million in 2011 would have been recorded in capital reserves.[7]

- Because of the range of sources that contribute to surplus, and the generally uncertain portion of investment income that is attributable to individual product lines, it is difficult to estimate the portion of reserves due to Minnesota public program product lines. Considering primarily net income, $482 million or 24.9 percent of 2012 HMO reserves is estimated to have originated over the past 10 years from underwriting gains on Minnesota public insurance programs.[8]

Risk-Based Capital Framework as One Tool for Assessing Capital Reserve Volumes

Insurance regulators, who among other responsibilities are tasked with assessing the adequacy of insurer reserves, generally for the purpose of meeting *minimum* solvency requirements, use a variety of tools to analyze capital reserves, including: (1) absolute volumes, (2) surplus as a percent of revenue (SAPOR), (3) months of expenses covered by capital reserves, and (4) surplus in the context of risk-based capital.

As noted in the full report, in 2004 Minnesota adopted the Risk-Based Capital (RBC) framework developed by the National Association of Insurance Commissioners (NAIC) to assess and regulate solvency of companies selling health insurance policies in the state. This statutory approach, which has also been adopted by virtually all states in the country, replaced a capital reserve corridor in Minnesota that was used to assess reserves by the number of months of expenses they could cover. This earlier approach was in existence in Minnesota between 1993 and 2004 for HMOs; it functioned through a minimum and maximum reserve threshold.[9]

Underlying the RBC framework is a sophisticated mathematical formula that assesses capital reserve volume in the context of five types of financial risks that may be present to different degrees in various health plan companies. A ratio of capital reserves (total adjusted capital, or TAC) to the calculated volume of reserves at which the regulator has the authority to place the insurer under regulatory control (authorized control level, or ACL), expressed in percent, establishes the degree to which capital reserves are above minimum required levels. The RBC level at which, according to the NAIC, no regulatory action is required, is 200 percent of the ACL.

[7] Seven HMOs and insurance companies had "revealed" reconciled IBNR margins above 15 percent in 2011, the latest year for which this analysis is possible.
[8] Investment income allocated to public programs and reported by HMOs as part of plans annual filings to the state for the preceding 10 years, amount to $223 million, or another 11.5 percent of 2012 reserves. Not considered in this volume are underwriting gains and investment incomes related to public programs in prior years that contributed to current reserve levels.
[9] Prior to that, a minimum only was used for HMOs from 1988 through 1992. For non-profit health service corporations, a minimum and a maximum was used from 1971 through 2004. The level of maximum varied over time.

Part of the strength of the RBC is that it is a standardized tool for ensuring that comparable risks across the industry are calculated in similar ways for purposes of solvency assessment; companies are using NAIC supplied software, somewhat limiting the potential for variability in assumptions underlying the calculation. A weakness of the RBC is that it is relatively formulaic, and does not distinguish well between businesses with different risk characteristics, something that the NAIC is pursuing to correct through the development of an additional layer to the solvency monitoring process, currently termed Own Risk and Solvency Assessment (ORSA).

The report provides substantial analysis of capital reserve volumes over time and is based on health plan submitted data covering RBC calculation, as well as replication of that calculation by the contractor. Our analysis of 10 years of capital reserves for HMOs, affiliated insurance companies, and CBPs showed:

HMOs

- With the exception of 2008, when investment losses affected capital reserves growth for Minnesota health plan companies, reserves have been steadily increasing. Since 2003, reserves for HMOs, insurance companies, and Blue Cross Blue Shield rose 112 percent.
- Capital reserves for HMOs in total amounted to $1,785 billion.[10]
- Expressed in the RBC framework, HMO capital reserves ranged from a low of 357 percent of ACL for PreferredOne Health Plan to a high of 942 percent for Blue Plus.[11]
- In 2012, three HMOs would have been above the upper capital reserve threshold that was in place prior to the adoption of the RBC framework. HealthPartners, Blue Plus, and Medica Health Plan exceeded that historical ceiling by a combined $198 million.[12]
- Overall, capital reserves covered between 1.9 months to 4.3 months of HMO expenses.

Insurance companies

- Minnesota-domiciled Insurance companies, including BCBSM, a non-profit health service plan corporation, held a combined $1.262 billion in capital reserves in 2012.
- Expressed in the RBC framework, capital reserves for insurance companies and non-profit health service corporations ranged from a low of 472 percent of ACL for PreferredOne Insurance Company to a high of 703 percent of capital reserves for BCBSM.
- No insurance company exceeded the historical upper threshold in 2012 (insurance companies were not subject to the historical corridor).
- Capital reserves covered between 2.1 and 3.3 months in expenses for insurance companies and non-profit health service corporations.

[10] This includes HealthPartners on a net basis, removing the reserves of its non-HMO subsidiary HPIC which are included in its consolidated reserves, and counting the reserves of its HMO subsidiary Group Health only once.
[11] Sanford was excluded from the analysis because of the small number of Minnesota enrollees covered.
[12] This analysis excludes capital reserves associated with all HealthPartners subsidiaries, recognizing that otherwise certain reserves would be double-counted or assets, that are not liquid for the purposes of covering insurance obligations, would be included.

County-Based Purchasers

- CBPs held $64 million in capital reserves in 2012. This represented 216 percent of ACL for Itasca Medical Center, 269 percent for South Country Health Alliance, and 614 percent for PrimeWest Health.
- These reserves covered between 1.2 and 2.7 months in expenses for CBPs.

Policy Considerations

Based on our financial analysis; research of the literature, including studies conducted in other states (see Appendix C); discussions with agency partners, a range of experts and stakeholders (see Appendix F), MDH and its contractor concluded that there are important considerations that both support the establishment of an upper limit on capital reserves and that favor, at least for the time being, a regulatory framework that ensures minimum levels of capital reserves to assure solvency but does not include an upper limit. This section presents both perspectives and follows-up, as directed by the legislature, with considerations concerning the determination of levels of upper thresholds and their implementation.

1. Considerations that Favor an Upper Limit on Capital Reserves

Reserves in HMOs have been substantially funded through tax-payer resources: As shown earlier, an estimated 24.9 percent of the $1.785 billion in 2012 HMO reserves were accumulated through earnings from Minnesota public health insurance programs; investment income allocated to public program product lines accounted for another 11.5 percent. These earnings were generated from valid contracts between the State and HMOs. However, accumulation of these funds originally intended for health care access, in capital reserves may not be an efficient use of public resources. This is particularly the case as further increases in capital reserves will only marginally add to financial solvency. While the policy rationale appears particularly strong with regard to tax-payer funded capital reserves, efficiency concerns also extend to commercial policies funded through private premium payments.

Historically, oversight of and contracting with an industry that is substantially motivated by non-profit principles has not constrained net income growth: Mechanisms such as rate filing, rate review, and contract negotiations have not meaningfully constrained growth in capital reserves over the past 10 years. Profits appear to have exceeded assumptions built into health plan pricing models for HMOs and affiliated insurance companies.

Lack of upper limits on capital reserves reduces pricing transparency for HMOs and affiliated insurance companies and provider organizations: Interdependencies and formal business relationships through service agreements and risk contracts between HMOs and affiliated insurance companies and

provider organizations currently provide legal mechanisms to financially subsidize lines of businesses, creating the potential for opaqueness in pricing of health insurance products.

Some levels of insurance uncertainties have been moderated in the Minnesota insurance market over the past ten years, reducing the need for high reserves: Historically, the health insurance business was associated with substantial uncertainties such that pricing estimates were low for some periods, relative to costs, followed by periods of "catching-up" where premiums were high compared to claims costs. This phenomenon, labeled the business cycle, has been moderated in Minnesota over the past decade, presumably indicating that the exposure to some kinds of unanticipated risks has been declining in this market.

After a period of adjustment, changes in the health insurance market will likely further reduce the need for high levels of capital in the health insurance market: Changes in the health insurance market, accelerated by private sector delivery system reforms and provisions of the Affordable Care Act, have the potential to reduce administrative and transaction costs in the health insurance market by reducing the need for underwriting and marketing, as well as risk management (in the individual market). Provided that payment reform in Minnesota continues to mature from performance contracts to risk-sharing contracts, a greater portion of insurance risk will be borne by medical providers.

High and increasing reserves may act as a disincentive to share/transfer risk with medical providers: Many policy makers view payment reform through financial risk sharing between providers and health plans as a critical tool to managing health care cost growth. High and growing reserves can reduce health plan incentives to pursue meaningful risk (and profit) sharing with providers.

Concentrated markets may require lower reserves. The market for health insurance coverage in Minnesota is moderately concentrated, with certain sub-markets (individual or public program coverage) being characterized by higher concentration. In comparison with highly competitive markets, in which many sellers hold smaller shares of the market, moderately concentrated may require lower capital reserves.

2. Considerations that Do Not Favor an Upper Limit on Capital Reserves

Health plan solvency is a critical public policy concern for regulators, health plan enrollees and policy makers. Financial solvency and the confidence in it are important factors for health care market stability, guaranteed access to services for enrollees and financial predictability for providers. Restricting reserves paired with cycles of adverse health experience could challenge a carrier's solvency.

Ordinarily, competitive markets will act as tools to restrain excessive capital reserve growth: Health plans and health plan products that produce greater than normal returns will fall in their level of competitiveness in the market over time, thereby reducing the ability for further reserve accumulation.

Changes to the state's Medicaid program are reducing the potential for consistently high returns from the program: The Medicaid competitive bid process, paired with the movement to establish Medicaid

Accountable Care Organizations (Health Care Delivery System Demonstration, or HCDS) have reduced the margins from public programs and thereby the potential for further reserve build-up. In addition, the program has the potential to move a large number of lives from one carrier to another as a result of the competitive bid process, creating new uncertainties and potentially requiring nimbleness in risk management.

Medical Loss Ratio (MLR) limitations of the Affordable Care Act (ACA) will constrain capital reserve growth: The MLR provisions of the ACA, which penalize carriers for not meeting requirements for spending a minimum amount of premium revenue on medical costs (claims expenses), cost containment activities, and quality improvement initiatives are likely to limit the pace of capital reserve aggregation going forward. These provisions potentially also function to constrain the ability of health plans to recover from a reduction in reserves due to health care market or business risk.

For not-for profit companies capital reserves are important to their credit rating. Unlike for profit insurance companies, non-profit HMOs cannot access capital markets to raise capital. Instead, they rely on borrowing in the bond market to finance parts of their operations and investments. Maintaining capital reserve levels consistent with bond covenants and lender expectations will help maintain lower cost of borrowing.

As a result of the ACA, there are significant changes occurring over the next few years in the Minnesota health insurance market that are associated with considerable financial uncertainties: In particular, the Medicaid expansion, enrollment of high-risk individuals into non-group insurance products, the evolution of the Minnesota's health insurance exchange with unknown risk profiles, and shifts in enrollment in response to premium rate competition come with uncertainties against which high reserves provide a margin of protection. The unknown degree of effectiveness of risk adjustment and reinsurance mechanisms, particularly for smaller health plans and in the early years, may require financing of operational losses through capital reserves.

Capital reserves represent a source of funding for infrastructure investments: Given numerous changes underway resulting from delivery system reform in Minnesota and implementation of the ACA in the state, health plan companies are in the process of making sizable IT infrastructure investments that are funded from reserves. For the major companies, efforts related to implementing significant changes to the medical classification system that underlies all health care payment transactions (ICD-10), strengthening analytic capabilities to adapt to the changing health care market environment and meeting new federal reporting requirements under the ACA reportedly add up to nearly $100 million in investments, roughly equivalent to 100 RBC points.

New solvency criteria under development by the NAIC may require higher capital reserves of plans subject to the changes. The NAIC is in the process of modernizing its solvency criteria, including by assessing risks that are currently not fully incorporated in the RBC framework, such as market, credit, operational and liquidity risks. Beginning in 2015, certain large health plan companies (including the four largest Minnesota HMOs and affiliated insurers) will be required to annually complete the Own Risk and Solvency Assessment (ORSA). This is likely to demonstrate capital reserve needs higher than current

regulatory floors. While not intended as a framework to assess upper threshold of capital reserves, a comprehensive assessment of risks and the corresponding development of standards for reserves, may implicitly define levels of reserves that are adequate for solvency, so that there may be a better basis for identifying amounts that could be considered unnecessary or excessive. There may be value in assessing the impact of these changes before establishing Minnesota-specific upper thresholds for capital reserves.

3. Considerations for Establishing Upper Thresholds on Capital Reserves

Should policy makers wish to move forward with the establishment of upper thresholds for capital reserves in Minnesota's health plan market, there are a number of key questions that are necessary to consider. Drawing on our analysis and discussion with stakeholders, we present the key questions and relevant considerations.

(1) What entities should capital reserve limits apply to? The Legislature, in directing MDH to conduct the study, asked the agency to focus its analysis on HMOs. But thresholds just on HMOs have the potential to affect the market overall:

a. Our analysis and discussions with stakeholders suggest that establishing capital reserve limits just on HMOs might imbalance the market by resulting in changes to organizational structures of HMOs and further movement of commercial business from non-profit HMOs to affiliated for-profit insurance companies.

b. Further, upper thresholds on capital reserves have the potential to disproportionately affect HMOs ability to make financial investments in infrastructure and market share in Minnesota and beyond, given that, unlike insurance companies, they are not able to raise resources in capital markets.

c. On the other hand, because of the significant tax advantages enjoyed by HMOs (and not by insurance companies), HMOs might be better positioned to work under a lower capital reserve limit than other insurance carriers in the state.

d. While in the interest of a balanced playing field there may be value in instituting a threshold across the whole health plan market, there are practical and legal challenges related to applying a threshold to non-domestic companies that also underwrite non-health policies. Because capital reserves are maintained for an entire company to cover all product lines across business operations in all markets, reserve thresholds would potentially apply to companies that generate business outside of Minnesota. At the same time, establishing upper limits just on Minnesota-domiciled companies may put them at a disadvantage to non-domestic carriers.

(2) How should capital reserve thresholds be expressed? Because strong empirical evidence does not exist to suggest the advantage of one method over another, the Legislature may wish to consider the tradeoffs between analytic simplicity and relative sophistication.

a. The ratio of capital reserves to the number of months of expenses is a measure that is easily understood by experts and laymen. It is also one that Minnesota carriers are

familiar with, given that it was used in the state's previously existing capital reserve corridor, and some carriers continue to monitor their reserves using this measure.

b. On the other hand, there seems to be broad agreement that the RBC framework is a better measure of capital reserve adequacy, because it is more successful at taking into account the broad set of risks a health plan company carries, including those posed by affiliated insurers, fee-based income from serving self-insured businesses, and provider affiliation in vertically-integrated organizations. Also, there may be value in further alignment with the RBC framework given the NAIC continuously updates the model to more fully capture financial risk.
c. At the same time, for most companies there is a relatively stable relationship between the RBC framework, and months of expenses or SAPOR, the measure considered by some of the other states in the context of reserve regulation, suggesting that the impact of choosing a particular method for expressing capital reserves may be somewhat marginal, as long as structural differences among companies are considered.

(3) Can one standard be applied across all companies or should certain differences between carriers be considered? The establishment of a single standard would establish simplicity and transparency in regulation and be administratively simple to implement. At the same time, a single standard may effectively be unfair to a diverse set of health plan companies and it may be imprudent to assume that very complex entities in the market that express with substantial organizational differences,[13] may be reduced to a single quantifiable number and approach for the purpose of regulating capital reserves. Where states have implemented maximum reserve limits, they have generally been set on a company-specific basis.

a. Smaller companies may experience greater financial volatility and might therefore require higher reserve limits.
b. Companies' product mix may also affect the need for differential reserve limits. For example, carriers who only serve public program enrollees in what was historically an actuarially approved "cost plus" environment may require lower capital reserves than carriers who bear underwriting risk in the commercial market or participate in the Department of Human Services' competitive bidding process.
c. Health plan companies with a diversity of affiliated businesses on their balance sheets would have to be treated consistently by regulators – for instance the practice of admitted assets would have to be applied more consistently – or more complex firms would require higher reserve limits to protect against more complex risks.
d. While segregation of capital reserves -- tracking reserves by distinct product lines separately -- may appear desirable from a policy perspective, because of the additional transparency of the use of public resources, doing so would undermine the actuarial standards related to protecting a company's overall business. In addition, if would be an

[13] Appendix A includes detailed information about each of Minnesota-domiciled health plan companies that illustrates differences in organizational structures, including treatment of admitted and non-admitted assets; the degree to which organizations earn revenue from other sources, make investments in subsidiaries, or make payments to parent companies; and variation in product mix.

inefficient use of capital to establish separate surplus lines and likely result in raising overall capital reserve needs.

(4) What level of capital reserve limits would be appropriate to institute in Minnesota? Again, there are currently no objective, empirically based standards in place that describe appropriate reserve thresholds for health plan companies. Guidelines in other states for maximum capital reserves range between 750 percent and 1,000 percent of RBC or higher. In very few states is an upper threshold currently being used in the rate review or approval process – although a number of states, including Minnesota, have committed to considering capital reserves as a condition of accepting federal ACA implementation funds to strengthen their rate review programs – and no state currently has an active program in place to recover surplus already built up. In the course of developing this report, a diversity of opinions with regard to specific upper levels came to the fore.

a. In general, consumer representatives thought that upper thresholds between 200 percent and 400% RBC would be appropriate, and that excess surplus should be returned to the customers, or used to promote access to health care.
b. Insurers and HMOs generally thought that a limit was not necessary, but that if there was a limit, it should be at least three to four months expenses, which might translate to a range of about 650 percent to 850 percent RBC.
c. Representatives of County Based Purchasers appeared generally comfortable with a limit in the range of 600 percent RBC.
d. Given the changes introduced by the ACA and the considerable uncertainties that are associated with them, the actuarial team contracting with MDH for this study felt that implementation of RBC levels of less than 800 percent may be short-sighted at this time. Nevertheless, close monitoring of capital reserve trends, including through probabilistic modeling of the likelihood of insolvencies, may help assess the appropriateness of upper threshold levels over time.[14]

4. Considerations for Implementing Upper Thresholds

Should the Legislature wish to implement upper thresholds of capital reserves in Minnesota's health plan market place, the following considerations should be taken into account:

Time periods: Compliance with upper thresholds should likely be managed over a period of two years to account for potential short-term volatility in financial performance and capital reserve trends introduced by changes to the health plan market place

[14] For this report we conducted some preliminary modeling of various probabilities that companies would stay above certain ratios of the RBC Company Action Levels. This analysis would be valuable if it could incorporate levels of volatility in reserves introduced by the ACA.

Oversight: In the interest of fairness between health plan companies, implementation of upper thresholds must be coupled with appropriate oversight over factors potentially affecting capital reserve levels, including IBNR practices, pricing of administrative services arrangements across affiliated businesses, allocation practices of investment income and administrative expenses across affiliated organizations, provider payment policies, and major capital and investment expenses, including investments in affiliated businesses. Finding a balance between appropriate levels of oversight and reasonable levels of administrative burden associated with the policy change will be an important challenge in the implementation.

Methods of expending excess capital reserves: At this point, health plans and their boards decide how to manage their reserves, including by determining how to spend down earnings not intended as surplus. In interviews, representatives from HMOs and CBPs spoke of strategies currently in place including making community benefit decisions and varying provider payments based on financial performance of the health plan business. In order to prevent unintended consequences resulting from expending excess capital reserves, such as shifts in market share, implementation of upper thresholds will benefit from discussions between regulators, health plan members and health plans, as well as from broad criteria established by the Legislature about permissible uses of capital reserve funding.

Conclusions

As directed by the Minnesota Legislature, MDH, in consultation with the Minnesota Department of Commerce and Human Services, and with assistance of a team of actuarial consultants, researched a set of questions concerning the implementation of upper thresholds for capital reserves for Minnesota HMOs.

The research, which encompassed analysis of health plan financial data, a study of insurance regulation in Minnesota and in other states, an analysis of available literature on the topic, and interviews with a wide range of stakeholders, concluded that there are numerous considerations in favor of as well as against implementing at this time upper thresholds of capital reserves for Minnesota HMOs.

One of the most significant considerations in favor of implementing an upper threshold for capital reserves is that HMO reserves of $1.785 billion in 2012, which equated between 2.1 months and 3.3 months of expenses, were substantially funded by underwriting earnings (24.9 percent) and investment gains (11.5 percent) from public health care programs. Accumulation of these resources, which were initially intended for health care access, in health plan capital reserves may not represent an effective use of tax-payer funded resources. This appears particularly the case, as these resources as for many HMOs only add marginally to stronger financial solvency.

Most prominent among the considerations that would favor not implementing reserve thresholds at this time are the significant health care market uncertainties over the next few years that are associated with implementation of state and federal reforms in Minnesota and the development of new and expanded solvency criteria (ORSA) by the NAIC. Factors including the Medicaid expansion; the transition

of high-risk individuals into the non-group insurance market; the evolution of a Minnesota's health insurance exchange, MNsure; the implementation of risk adjustment mechanisms, re-insurance and risk corridors; the substantial investments in information technology necessitated by health reform provisions; and the payment reform efforts targeted at creating greater shared accountability between providers and payers, have the potential to result in significant financial uncertainties.

Should the Legislature choose to move forward with implementation of upper reserve thresholds at this time, our research indicate that the Legislature may wish to consider the following:

- **Whether to establish limits only for HMOs:** There are tradeoffs between a more narrowly applied limit and a wider one, in that the former would potentially create a competitive disadvantage for HMOs and continue regulatory differences between health insurance providers of different organizational form. The latter option, to apply limits consistently to health plan companies, will be met with considerable practical challenges, related to applying the limit to non-domiciled insurance companies, who hold reserves for books of business exceeding Minnesota.
- **The range of options available to express capital reserve thresholds:** Other than familiarity with the RBC framework, there do not appear to be strong arguments in favor of a single method of expressing capital reserves. When adjusting for organizational dependencies between carriers, there appear to be relatively stable relationships between all commonly used methods, including months of expenses, RBC, and SAPOR. The advantage of the RBC approach resulting from its relative sophistication in assessing a broad set of risks might be offset by the complexity of the approach, which would not be present by a "month of expenses" framework.
- **Whether more than one standard may be required:** While a single standard would establish simplicity and transparency in regulation, it would at the same time treat companies of different sizes, with substantial organizational variation and diversity in insurance risk alike, possibly resulting in an uneven playing field.
- **Various perspectives on appropriate levels of thresholds:** While there are a number of tools and modeling approaches available and in use to determine appropriate levels of reserves, there is not a single "right" approach. The analysis team received recommendations reaching from establishing reserve levels as low as between 200 percent and 400 percent of RBC to highs of 650 percent to 850 percent of RBC. Given the near-term uncertainties, establishing immediate reserve thresholds below 800 percent of RBC may be not prudent.

Finally, should the Legislature move forward with establishing reserve thresholds at this time, it may wish to consider establishing parameters concerning appropriate oversight, the compliance window, and the process for expending excess reserves.

In the interest of preventing unintended consequences resulting from rapid spend-down of existing reserves and implementing upper thresholds on a level playing field, the Legislature may wish to establish mechanisms to monitor factors that can affect change in reserves, including IBNR practices, pricing of administrative services arrangements between affiliated companies, allocation practices of investment income, provider payment policies, investments in affiliated businesses and major capital

expenditure. To avoid volatility in financial reserves and limit administrative burdens in the implementation, compliance with upper thresholds should likely be implemented over at minimum a period of two years, and with clear definitions concerning permissible uses for expending excess capital reserves. The establishment of such permissible uses would likely benefit from further discussions between Legislators, regulators and, importantly, rate payers, including the Department of Human Services and the State Employee Group Insurance Programs.

Should the Legislature conclude that at this time establishing upper thresholds to capital reserves in the health care market are not in the public interest, it still has available a set of tools with which to manage the policy goal of balancing affordable health care premiums with sufficient financial solvency and efficient use of tax-payer funded resources:

- The Department of Human Services under the Dayton Administration has used a number of tools to limit HMO and CBP net income from Minnesota public health care programs, including competitive bidding and the establishment of caps on profits. These tools hold promises for constraining the pace of HMO capital reserve growth.
- Some states authorize health plan regulators to consider capital reserves as one factor when approving premium rate growth. Even in an environment, where the MLR provisions of the ACA are somewhat likely to constrain health plan premium growth through penalty payments for years where minimum loss ratios (premiums volume spent on claims) targets are not met, considering existing volumes of reserves could help moderate future premium growth. As a grantee of the federal Department of Health and Human Services Rate Review program, the state of Minnesota may have resources available to assess what processes and expertise would need to be developed.
- Minnesota health plans already submit a substantial volume of information to regulators and the Department of Human Services. There may nevertheless be a benefit in greater transparency concerning consistency in allocation mechanisms of administrative expenses and investment income, the uniform allocation of Medicare and Medicaid revenue and expenses to reporting categories, the pricing of business service arrangements with affiliated companies, and changes in provider payment policies.
- Legislative deliberations on future considerations to establish capital reserve thresholds may benefit from periodic reports on IBNR reserve assumptions and statistical (Monte Carlo) modeling of the likelihood of health plan insolvency. Such analysis would be more powerful than the preliminary work conducted for this report, because it would likely capture more volatile periods in 2014 and 2015 associated with health insurance market reforms.
- Future deliberations may also benefit from better understanding how the move of Minnesota's health care market towards greater financial risk sharing between health plan companies and health care providers may result in a shift of health insurance risk that could solvency requirements.
- Finally, the Legislature may wish to require that health plan companies engage rate payers, including plan enrollees and the Department of Human Services, in structured discussions outside of a regulatory framework about appropriate uses of existing capital reserves, including

through investments in population health, health and health insurance literacy, and other measurable community benefit activities.

Glossary

Acronym	Meaning
ACA	Affordable Care Act
ACL	Authorized Control Level
ACO	Accountable Care Organization
APPM	NAIC Accounting Practices and Procedures Manual
ASC	Administrative Services Contract
ASO	Administrative Services Only
BCBSM	BCBSM, Inc. D/B/A Blue Cross Blue Shield of Minnesota
BCBSMI	Blue Cross and Blue Shield of Michigan
BCBSRI	Blue Cross & Blue Shield of Rhode Island
CA	Certificate of Authority
CAL	Company Action Level
CareFirst	CareFirst BlueCross BlueShield
CBC	Capital Blue Cross
CBP	County-Based Purchasers
CFMI	CareFirst of Maryland, Inc.
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare and Medicaid Services
COMM	Minnesota Department of Commerce
DeWeese	DeWeese Consulting Inc.
DHS	Minnesota Department of Human Services
DOI	Division of Insurance
DORA	Department of Regulatory Agencies
EDP	Electronic Data Processing
FEHBP	Federal Employees Health Benefit Plan
FFS	Fee For Service
GAMC	General Assistance Medical Care
GHMSI	Group Hospitalization and Medical Services, Inc.
HCDS	Health Care Delivery System
HMO	Health Maintenance Organization
HPAI	HealthPartners Administrators, Inc.
HPIC	HealthPartners Insurance Company
IBC	Independence Blue Cross
IBNR	Incurred But Not Reported
IMCare	Itasca Medical Care
LOB	Line of Business
MCHA	Minnesota Comprehensive Health Association
MDH	Minnesota Department of Health
Medica	Medica Health Plans

MHC	Medica Holding Company
MHP	Metropolitan Health Plan
MIC	Medica Insurance Company
MLR	Medical Loss Ratio
MNcare	Minnesota Care
MSC+	Minnesota Senior Care Plus
MSHO	Minnesota Senior Health Options
NAIC	National Association of Insurance Commissioners
NEPA	Blue Cross of Northeastern Pennsylvania
NHP	Neighborhood Health Plan of Rhode Island
OHIC	Office of the Health Insurance Commissioner
ORSA	Own Risk and Solvency Assessment
PAS	PreferredOne Administrative Services, Inc.
PBM	Pharmacy Benefit Manager
PCHP	PreferredOne Community Health Plan
PDR	Premium Deficiency Reserves
PIC	PreferredOne Insurance Company
PID	Pennsylvania Insurance Department
PMAP	Prepaid Medical Assistance Program
PMPM	Per Member Per Month
PrefOne Ins.	PreferredOne Insurance Company
QHP	Qualified Health Plan
RBC	Risk Based Capital
SAPOR	Surplus as a percentage of revenue
SCHA	South Country Health Alliance
SNBC	Special Needs BasicCare
SSAP	Statements of Statutory Accounting Principles
TAC	Total Adjusted Capital
TPA	Third Party Administrator
UCare	UCare Minnesota

I. Overview of Capital Reserves Limits Study

The 2013 Minnesota Legislature in HHS Omnibus Finance Bill--HF1233, Article 12, Sec. 104 directed the Minnesota Department of Health (MDH), in consultation with the Departments of Commerce and Human Services, to conduct a study to identify:

- Methods to determine appropriate levels of capital reserves for Health Maintenance Organizations (HMOs), and
- Mechanisms to consider for implementing upper thresholds for capital reserves.

In conducting the study, MDH was directed to consult with HMOs, stakeholder, consumers, as well as perspectives from other states' regulators.

To conduct the study within the available timeline, MDH retained DeWeese Consulting Inc. (DeWeese), an actuarial team with diverse experience in conducting health plan financial analyses, review the history of Minnesota insurance regulation concerning capital reserve requirements; study the relevant literature, including any evidence about regulation in other states; conduct interviews with a range of stakeholders; perform broad financial analysis, and summarize the analysis for the report to the Minnesota Legislature.

As required, MDH and DeWeese conducted interviews with a number of experts and stakeholders:

- At the outset of the study, the team consulted experts at the Departments of Commerce and Human Services.
- Interviews were also conducted with current and former insurance regulators in nine other states.
- Stakeholder feedback was gained through interviews with representatives of six Health Maintenance Organizations, or HMOs (and affiliated insurance companies), three County-Based Purchasers (CBPs), and three consumer representatives. MDH also requested written feedback from representatives from the remaining three HMOs.
- Finally, the research team consulted economics faculty at the University of Minnesota School of Public Health Division of Health Policy and Management (a full list of participants in interviews is included in Appendix F to this report).

The consultants who contributed to this report on behalf of DeWeese Consulting, Inc. were:
Charles C. DeWeese, FSA, MAAA
Bela Gorman, FSA, MAAA
Don Gorman
Elinor Socholitzky, MBA
Steven Tringale
Anthony J. van Werkhooven, PhD, FSA, MAAA

A. Study Methodology

In order to conduct this study, we reviewed the Minnesota statutory authority and history regarding capital reserves, and we gathered information on the regulation of capital reserves in other states. We conducted interviews with representatives of Minnesota health plans, consumer representatives, provider representatives, Minnesota regulators, and regulators in other states to determine perspectives on the appropriate level of capital reserves and on appropriate uses for those reserves, including advantages and disadvantages of any particular method. It is important to note:

- Interviewees were promised that the report would not attribute specific comments to specific individuals. Thus, comments have been grouped together. In certain categories, only one individual was interviewed. In these cases, categories of stakeholders were grouped together for this summary.
- Minnesota Department of Health (MDH) representatives were involved in all of these interviews. (One carrier submitted written comments only.)
- Not everyone the MDH requested to participate did so.

A summary of the discussions we had or the comments we received is contained in Appendix F.
The Minnesota health insurance organizations which participated in interviews or otherwise provided comments included representatives of: (1) BCBSM, Inc. (BCBSM, D/B/A Blue Cross Blue Shield of Minnesota) and Blue Plus; (2) HealthPartners, Inc. and affiliated companies; (3) Medica Health Plans (Medica) and affiliated companies; (4) PreferredOne Community Health Plan (PCHP) and affiliated companies; (5) UCare Minnesota (UCare); (6) PrimeWest Health Plan; (7) Itasca Medical Care (IMCare); and (8) South Country Health Alliance (SCHA).

We also interviewed representatives of a Minnesota Provider group, Minnesota consumer groups, and a University of Minnesota expert in health insurance economics, as well as Commissions or other representatives in several states, including Colorado, Maryland, Pennsylvania, Massachusetts, Oregon, Rhode Island, Washington (state), and Washington, D.C.

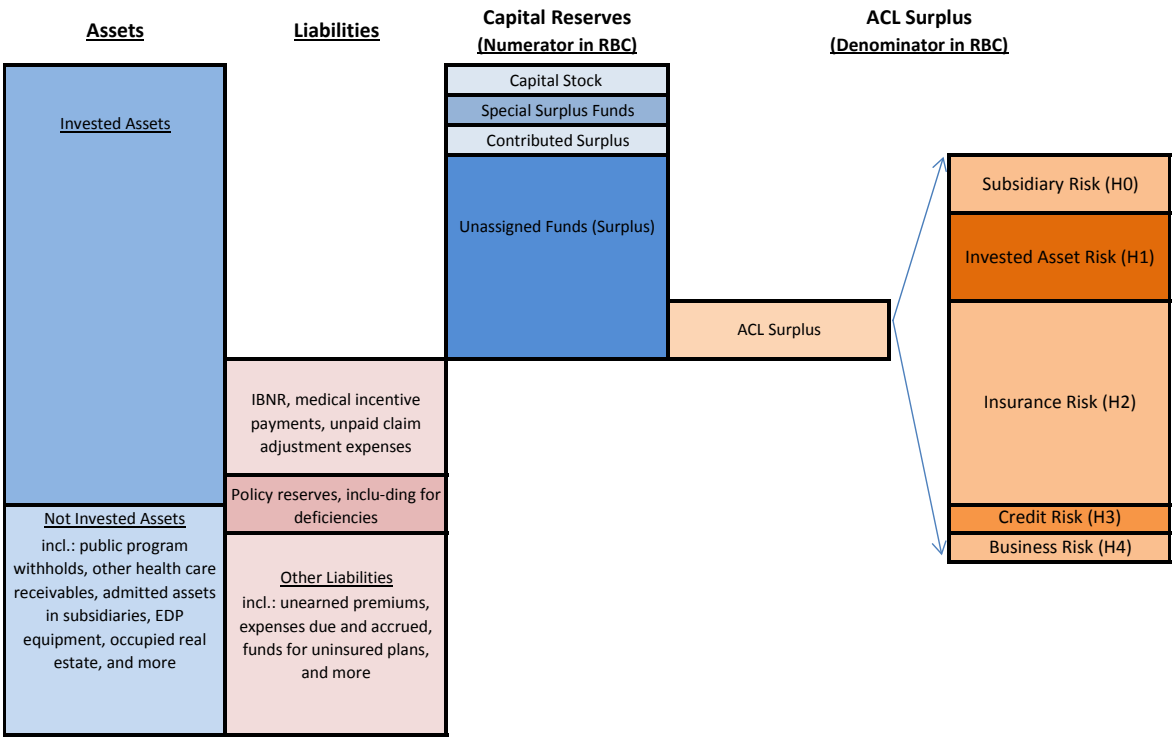
We analyzed ten years of financial history of the Minnesota health plans and their affiliate insurance companies, including analysis of trends in enrollment, revenue, operating income and capital reserves, looking separately at experience by lines of business as well as operations of affiliated companies. We modeled the Risk Based Capital (RBC) of each company to determine the risk factors of each company's business and how those factors affect the level of each company's capital reserves. In addition, we validated the modeling of the Authorized Control Level surplus with the amounts reported in the National Association of Insurance Commissioners (NAIC) annual statements.

We synthesized this information and collected it in this summary report.

B. Definition of reserves and surplus

For the purpose of this study, capital reserves refer to financial assets for which there is no corresponding liability. As shown in Figure 1 below, capital reserves are made up of varying types of surplus depending on the source of that funding. Assets with a corresponding liability, some of which are commonly known as reserves, are termed in this study as liabilities in order to distinguish them from capital reserves. They exist for the overall benefit of the health plan and its customers, but are not allocated to any specific liability or line of business. Capital reserves may increase over time because of the accumulation of profits – underwriting gains and investment income. They may decrease if a company experiences underwriting or investment losses, or if it spends on capital improvement projects. The part of capital reserves that is accumulated from profits is listed in annual financial statements as unassigned funds (surplus).

Figure 1: Composition of Assets, Liabilities and Capital Reserves



IBNR: costs for claims that are incurred but not reported

In addition to unassigned funds (surplus), capital reserves can be built up in other ways. Some of the Minnesota health plans have contributed surplus, amounts that have been paid in by investors or other responsible entities. This is particularly true of Minnesota County-Based Purchasers (CBPs) who have contributed surplus from the county governments. For-profit insurance companies can issue capital stock, the value of which is part of capital reserves. Companies with reserves below regulatory benchmarks may also issue surplus notes, under which an investor would provide surplus in exchange

for notes with limited repayment provisions. Surplus notes do not apply to any of the Minnesota health plans.

In addition to capital reserves, health plans have certain kinds of liabilities that are also called reserves, but these liabilities are dedicated to specific obligations of the company and do not function as capital reserves. They include incurred but not reported claims (IBNR), policy reserves including premium deficiency reserves (PDR), provider incentive liabilities, and unpaid claims adjustment expense.

Adequacy of capital reserves is monitored by regulators in all states, by the Minnesota Department of Commerce (COMM) in Minnesota. Capital reserves are monitored with regard to a methodology called Risk Based Capital (RBC), which is described in Minnesota law. This represents minimum standards for an adequate level of surplus, but does not address an appropriate maximum level. The history and nature of Minnesota capital reserves regulation is discussed later in this report.

C. Purpose of capital reserves

Before assessing capital reserve regulatory options, it is first necessary to understand why reserves are kept by health plans. Under Minnesota law, health plans must maintain minimum capital reserves to be considered solvent. Under *Minnesota Statutes Chapter 60A.50, et seq.*, first enacted in 2004, health plans must meet certain standards related to their RBC ratio. The Minnesota statute is based on the NAIC model, and is similar to statutes in most other states. The statute develops four different levels of RBC ratio that result in regulatory action, ranging from the Company Action Level (200% RBC ratio) to the Regulatory Action Level (150%) to the Authorized Control Level (100%) to the Mandatory Control Level (70%). The statute does not set any upper limit for the RBC ratio. In addition, *Minnesota Statutes Chapter 60A.57, Subd. 2* prohibits the use of RBC reports for rate making or deriving elements of an appropriate rate level.

Beyond regulatory requirements and assurances of solvency to guarantee plans have adequate resources to pay claims, as well as protection against catastrophic claims or adverse investment circumstances, health plans hold reserves for a number of additional reasons. Health plans need to be financially solvent in order to maintain their credit rating in the event they need to raise additional capital. A reduction in credit rating would make borrowing much more expensive. They also hold reserves to support business expansion - if an insurer's premiums and the associated obligations increase because of writing additional business, because of medical care inflation, or because of changes in business resulting in greater exposure, additional surplus is required. Some examples might include:

- changing over from Medicare Cost to Medicare Advantage coverage, as insurers with Medicare Cost contracts do not have responsibility for Part A costs;
- Bidding on and gaining additional Medicaid lives;
- Expanding into a new geographic area; or

- Writing additional business because of the Affordable Care Act (ACA).

Capital reserves are helpful for maintaining premium stability and providing competitive rates. A marginally capitalized plan may have to react more quickly and with higher rate increases to a cyclical experience downturn than a more adequately capitalized plan. A plan with lower capitalization may need to build more contribution to reserves into its rates in order to re-build capital reserves.

Capital reserves are also a source of capital for investment in infrastructure. During our interviews, insurers mentioned a number of capital infrastructure improvement projects that they expect to be funding out of reserves in the coming years. In particular many of them have major efforts underway to adopt and implement ICD10 coding and several discussed enhanced IT systems for claims and administration. We were told that some of these large projects can run into $50 or $100 million or more. In addition, several of the plans may be entering into agreements and joint ventures with provider organizations to improve care management capabilities.

Adequate capital reserves permit community benefit investment. Several companies mentioned using capital reserves to support health care infrastructure in their local communities. Another project mentioned was a multicultural program designed to communicate and work with substantial populations for whom English is not a first language. This benefits the covered members with improved access to care, and also can help make administration more efficient and therefore lower long term cost. Capital reserves can support innovative approaches to care management and joint ventures with other health related companies.

In Minnesota, health plans active in state programs also are subject to state mandated withholds. Medicaid premiums are subject to a 9.5% annual withhold, 5% of the amount withheld is guaranteed to be paid after July 1 of the following year and 4.5% is based on performance criteria. In addition, approximately 2.5 months of premiums are withheld from mid-April through June, and paid in July. While plans cover these premiums in the interim they may not deduct the amount from surplus, because the amount of the premium withhold is an admitted asset despite the money not actually being available. The existence of these withholds requires companies to select short term investments that are easily sold so that claims can continue to be paid on time during these periods.

Generally, there has been a preference on the part of regulators responsible for monitoring insurer solvency to allow and on the part of companies to establish and maintain reserves without limitation. This provides the greatest safety against insolvency and the greatest flexibility for the insurer in making investments in infrastructure, supporting community benefit programs, and pricing its products competitively. The capital reserves of HMOs ultimately are held for the benefit of the members. However, it has been questioned whether capital reserves levels greater than reasonably needed for solvency or than can reasonably be deployed for beneficial projects could be returned to the community that developed the reserves through premiums that are lower than they would be otherwise or through benefits in access and quality of health care.

II. Overview of MN Health Plan Marketplace

An understanding of the marketplace is important, as each company respond differently to regulatory changes depending upon their lines of business. Additionally each health plan that participates in state programs has a unique corporate structure that impacts calculation of capital reserves. This section looks first at the types of health business in Minnesota, followed by an examination of the corporate structure and other lines of business HMO parent companies have as part of their total reserve calculation.

A. Overview of carriers, state programs, and lines of business

Minnesota has a large number of domestic health insurance carriers; that is, carriers that are domiciled in the state and authorized to do business in Minnesota. Many of these companies have not historically written business outside the state, although that is changing. Some of the HMOs have affiliates that market in adjacent states. At the same time, many national carriers do not have a large presence in the Minnesota marketplace, with the exception of certain large national carriers who primarily administer health plans of self-insured customers. The four main types of MN domiciled carriers are Health Maintenance Organizations (HMOs), County-Based Purchasers (CBPs), Nonprofit Health Service Plan Corporations (BCBSM is the only one), and insurance companies. Historically, HMOs were distinguished from insurance companies in that they provided comprehensive health maintenance services or arranged for the provisions of these services, often through a limited panel of providers, to enrollees on the basis of a fixed prepaid sum. Today, health care product design and health management is more uniform in the state, independent of organizational form. There remain regulatory differences in Minnesota concerning HMOs, including the requirement to deliver certain required services (mandated benefits) and maintain adequate provider networks. In addition, many large group customers are self-insured – they work with either an insurance company or a Third Party Administrator (TPA) to provide coverage.

HMOs, Insurance companies, and CBPs all offer multiple lines of business. The major lines are as follows: commercial comprehensive, Medicare Advantage, Medicare Cost, Minnesota Senior Health Options (MSHO), Prepaid Medical Assistance Program (PMAP), PMAP Plus, MinnesotaCare (MNCare), Special Needs BasicCare (SNBC). Until the program ended in 2011, the HMOs and CBPs also offered General Assistance Medical Care (GMAC). When that program ended the enrollees were transferred into PMAP. Please refer to Appendix B for a description of each product. State programs are offered only by the HMOs and CBPs and not by the insurance companies, whether for profit or nonprofit.

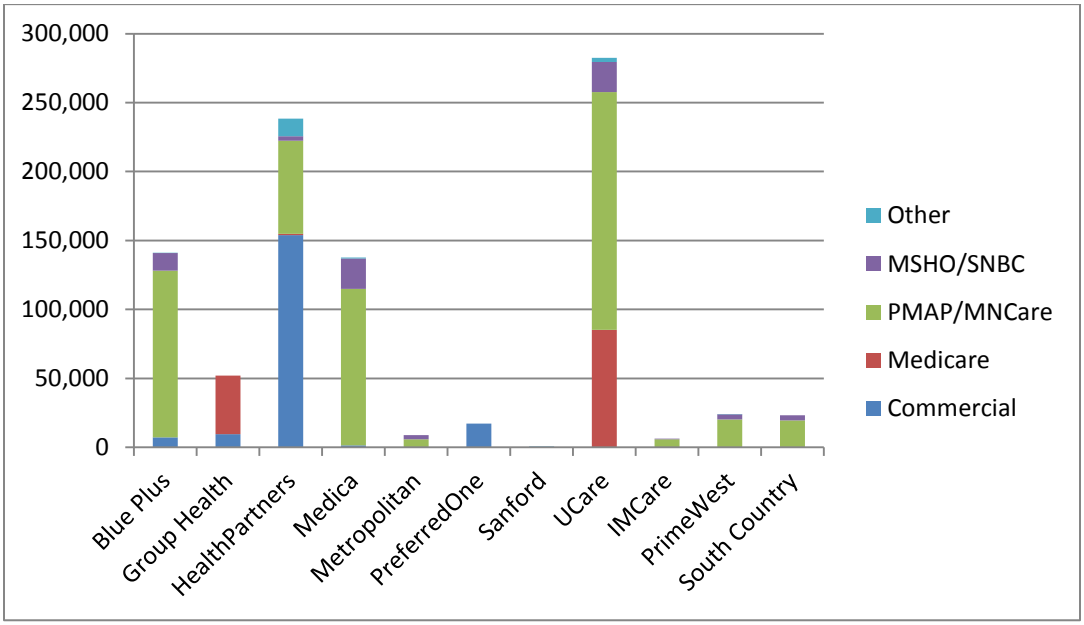
Minnesota has nine HMOs and three CBPs that cover approximately 930,000 Minnesota residents[15]. Of these, approximately 190,000 have commercial comprehensive coverage, 130,000 have Medicare Cost or Medicare Advantage coverage, and a total of 610,000 are insured under the state programs. Those

[15] Source – 2012 Minnesota Supplement Forms

programs are: PMAP – 400,000 members; MNCare – 120,000 members; MSHO – 40,000 members; and SNBC – 30,000 members. For the purposes of this report we refer to these programs collectively as state programs, but they are funded to varying degrees by Medicare (for the dual-eligible MSHO and SNBC populations) and Medicaid (PMAP), that involve Federal dollars as well. There are also almost 20,000 members under other types of coverage.

The following chart shows the members reported by Minnesota HMOs and CBPs as of 2012 by type of coverage. In this chart, "Medicare" refers to the Medicare Cost and Medicare Advantage business only. Additional detail is available in the individual company profiles contained in Appendix D.

Chart 1. 2012 Covered Members by Market Segment – HMOs and CBPs[16]



Member data for the insurance companies is a mixture of direct insurance and stop loss coverage on self-insured plans, so it may not be directly comparable.

The majority of carriers in Minnesota have multiple companies in their organizational structure. For some, a non-profit HMO is the parent; for others, a non- insurance holding company may be the parent. Many of the large Minnesota insurers have both an HMO and an insurance company within their corporate structure. Multiple companies discussed the fact that products – with the exception of the state programs – may move from one company within the affiliated group to another based on market conditions. Carriers may have, in addition to an HMO and an insurance company, a third-party administrator, a Pharmacy Benefit Manager (PBM), a provider system, etc. The structure may be formalized by ownership or control through overlapping Boards of Directors. The corporate structure of

[16] Source – 2012 Minnesota Supplement Forms

each of the insurers is described in Schedule Y, Parts 1 and 1A of companies' annual statements. These pages from the 2012 company Annual Statements can be found in Appendix A.

The fact that HMOs have had limits on their product design flexibility has meant that over time much of Minnesota's commercial comprehensive health insurance business has moved out of HMOs and into insurance companies. According to the carriers interviewed, customers have been interested in pursuing plans with higher deductibles and more cost sharing features than HMOs have been permitted to provide. Annual and out of pocket maximums had also been an issue, although the Affordable Care Act has somewhat resolved this difference in product design capability between HMOs and insurance companies. As a result, many of Minnesota's HMOs have a relatively small percentage of commercial business – membership is primarily Medicare and/or Medicaid. Carriers interviewed felt that, absent any other change that might influence this, the move from HMOs to insurance companies had run its course.

Because many of the corporate entities providing health care coverage have both an HMO and an insurance company within their corporate organization, there is a potential that, in addition to moving products due to marketplace circumstances, products could be moved for regulatory reasons as well. In addition, carriers mentioned in stakeholder interviews that corporate structure could be changed should that prove beneficial to the organization.

1. Health Maintenance Organizations (HMOs) and Nonprofit Health Service Plans

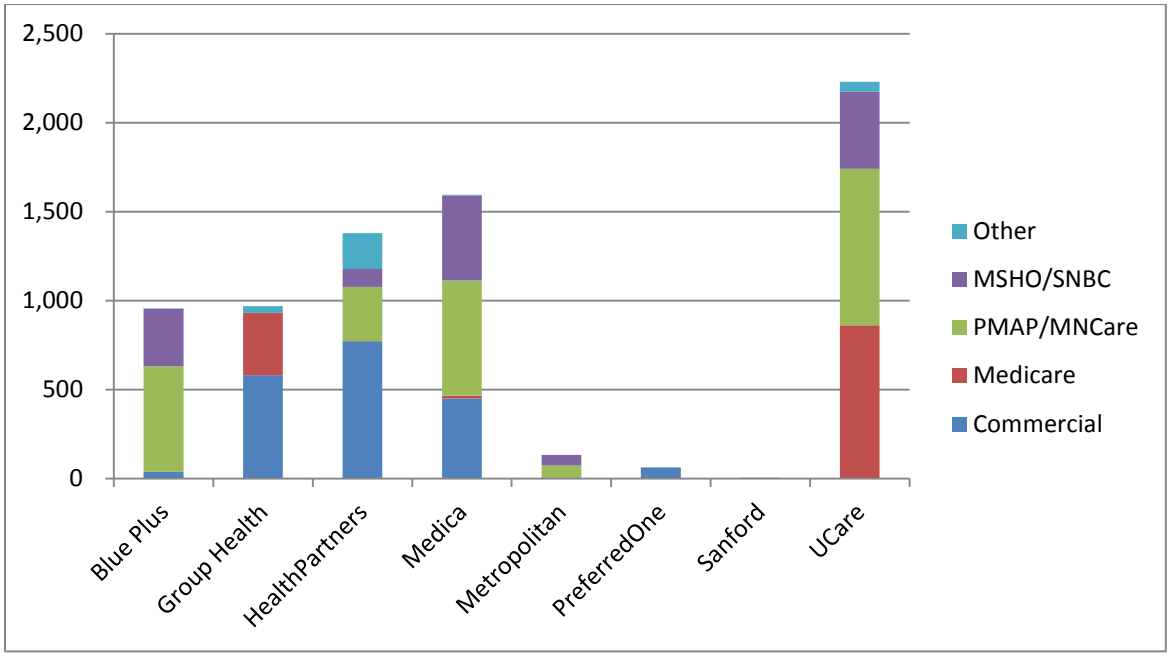
Minnesota HMOs are licensed under Minnesota Statutes Ch. 62D. HMOs are required to be non-profit organizations. There are also requirements with respect to product design, particularly deductible levels and out of pocket maximums. All HMO products are insured – that is, the health plan collects a flat premium amount from members or employers and the health plan is responsible for paying all provider claims, subject to allowable co-pays. BCBSM is licensed as a Nonprofit Health Service Company under Minnesota Statutes Ch. 62C, and it is the only Minnesota company so licensed. While there are similarities to the regulations that govern HMOs, there are also, differences.

With the exception of PreferredOne, Sanford, and Gunderson, Minnesota HMOs have offered the PMAP and MNCare programs that Minnesota provides for those unable to afford coverage on their own. Several of the HMOs also offer the dual eligible programs MSHO and SNBC. All these together we have referred to as the state programs. PMAP is a Medicaid program, MNcare is a state funded program with subsidized premiums for low income people not eligible for Medicaid. MSHO and SNBC are dual eligible programs with funding from Medicare and Medicaid (see Appendix B, lines of business). Many HMOs also contract with the Federal government to offer a Medicare Advantage plan, or operate a Medicare Cost contract. Under Federal law, a company cannot offer both Medicare Advantage and Medicare Cost.

By statute HMO rates are regulated by the Department of Health (MDH); the Department subcontracts this effort to COMM. Individual and small group rates must be approved by the state.

Chart 2 Shows the 2012 revenue of the HMOs by type of business. Three of the HMOs, Group Health, HealthPartners and Medica, have large blocks of commercial comprehensive business. Group Health and UCare have large Medicare blocks. Blue Plus, Medica and UCare have large blocks of the public programs PMAP, MNCare, MSHO and SNBC, while HealthPartners has a smaller but still significant block.

Chart 2. 2012 HMO Revenue by Market Segment ($000,000)[17]



2. County –Based Purchasers (CBPs)

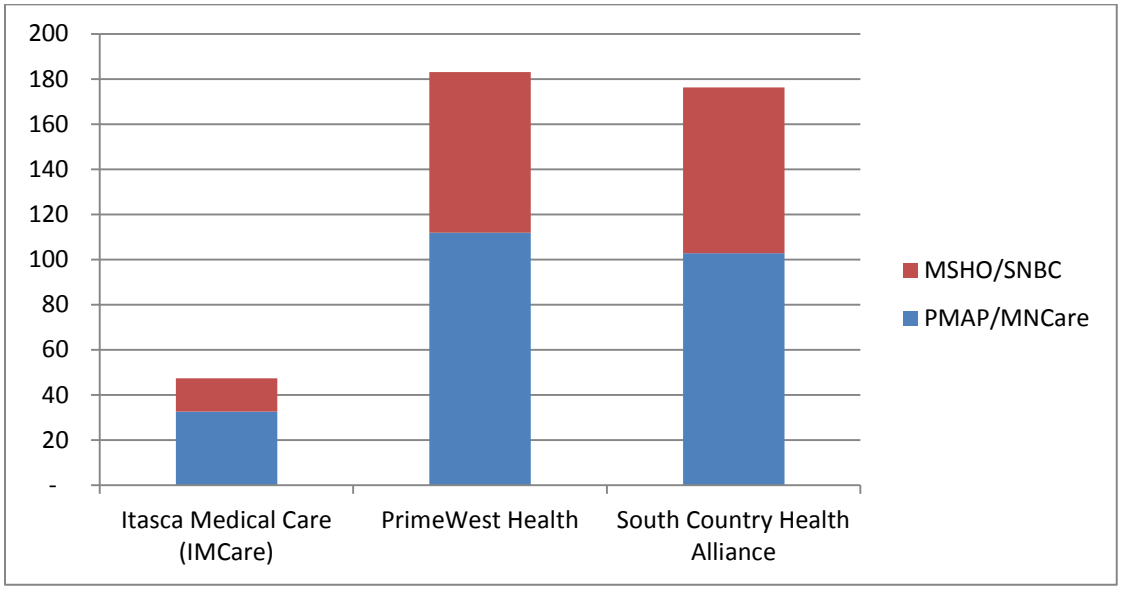
There are three County-Based Purchasers in Minnesota -- IMCare, PrimeWest, and South Country Health Alliance. They were authorized by the Legislature in 1997 in order to cover local Medicaid members. While not HMOs, they are subject to all the regulatory requirements of HMOs, including reserve requirements. However, the CBPs are joint provider/county endeavors. The government of the county or counties involved guarantees the claims payments and the solvency of the entity. Also, as a component of county government, the CBPs are subject to open meeting laws and other government transparency rules.

All products offered by CBPs are Medicaid, dual-eligible MSHO, or Minnesota-based, non-Medicaid programs for designated low income, elderly, or disabled populations, although PrimeWest reported a small amount of Administrative Services Only (ASO) business in its MN supplement filing.

Chart 3 shows the 2012 Revenue of the County Based Purchasers. This business is virtually all public programs, PMAP, MNCare, MSHO and SNBC.

[17] Source – 2012 Minnesota Supplement Forms

Chart 3. 2012 CBP Revenue by Market Segment ($000,000)[18]



3. Insurance companies

Health insurance companies in Minnesota are licensed as are all other (e.g., property and casualty, disability) insurance companies, under chapter 60A. Insurance companies are not required to be non-profit, and there are no statutory-prescribed limits on product design. However, under the Affordable Care Act, much of the difference in benefits permitted to be sold by HMOs and Insurance Companies will disappear due to the Essential Health Benefits requirements.

Insurance carriers may sell multiple health care product lines – some products may have limited networks, or different benefits in or out of network, such as a Preferred Provider Organization. Products may have large, up front deductibles, and may be paired with a Health Savings Account, a Health Reimbursement Arrangement, or a Flexible Spending Arrangement. Insurance companies might also sell Medicare Supplement coverage.

Insurance company products may be insured or not. Non-insured products provided to some large employers are classified as ASO or Administrative Services Contract (ASC). Under ASO agreements, the employer sets up a fund out of which the administrator pays provider claims incurred by the employer's own employees, dependents and/or retirees plus an administrative fee. The insurer is not at risk for provider claims. Under ASC agreements, the insurer pays the claims, but the employer is required to reimburse the insurer for the amount of the claims. Several of the Minnesota insurance companies and BCBSM also sell stop loss insurance to self-insured customers. Such coverage protects those customers

[18] Source – 2012 Minnesota Supplement Forms

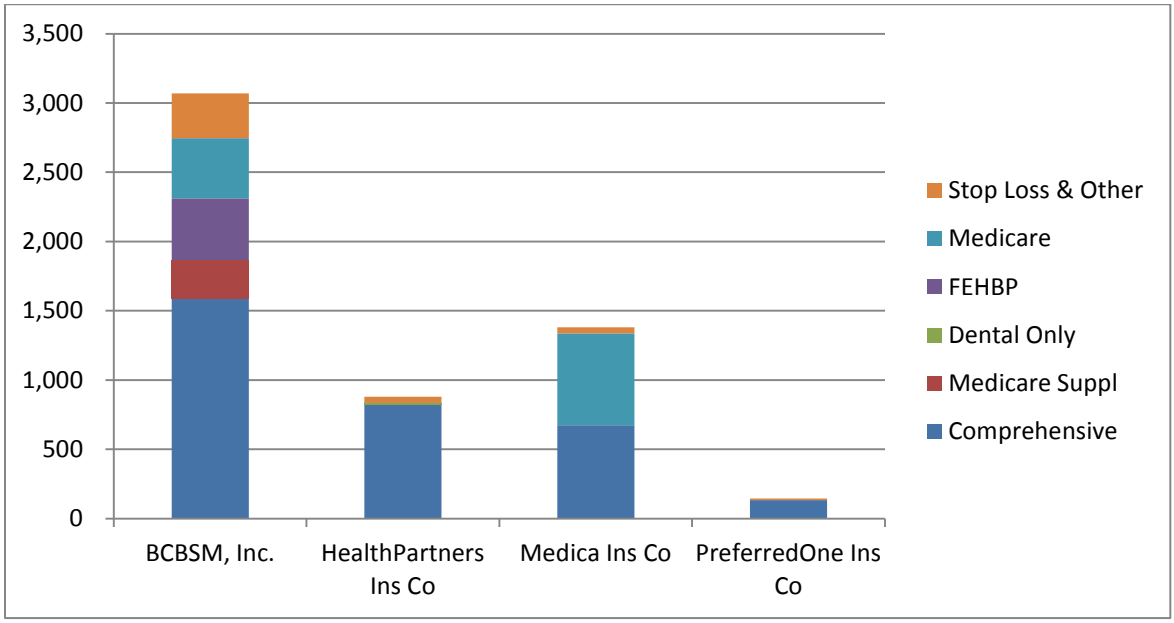
from large claims incurred by their employees or dependents. HMOs are not permitted to sell stop loss coverage.

The Department of Commerce has been delegated the responsibility for approving individual and small group rates for all insured products offered by insurance companies.

While people typically think of HMOs in terms of care management, many insurance companies have significant care management components that are an integral part of their products.

Chart 4 shows the2012 revenue by type of business of BCBSM, the non-profit service company affiliated with Blue Plus, and of the for-profit insurance companies that are affiliated with other Minnesota HMOs. Commercial Comprehensive is generally the largest line of business for these companies, but BCBSM, Inc. has a large block of Medicare Supplement, and a large block of Federal Employees Health Benefit Plan (FEHBP) insurance. BCBSM and Medica Insurance Company (MIC) have substantial blocks of Medicare business. All of these companies write stop loss coverage on self-insured customers or customers of affiliate insurance administrators.

Chart 4. 2012 BCBSM and MN Insurance Company Revenue by Market Segment ($000,000)[19]



4. Self-insured business

In addition to self-insured business being offered by Insurance companies, either directly or through an affiliated Third Party Administrator (TPA) that is part of their overall corporate structure, self-insured business can be purchased through an independent TPA. What all self-insured business has in common

[19] Source – 2012 Annual Financial Statements.

is that the purchaser – typically the employer – is at risk for provider claims. Rather than pooling the risk of the claims that are incurred of multiple employers and individuals, a TPA or an insurance company with a self-insured account keeps separate track of each employer's claims and that employer pays only for the claims incurred by its own covered members. The TPA or insurer charges an administrative fee – a fee that covers enrollment, claims processing, billing, marketing, and other costs of doing business.

Several of the Minnesota HMOs have affiliated companies that provide administrative services to self-insured customers, and those affiliated companies generally have subsidiary insurance companies that may offer commercial comprehensive health insurance as well as providing stop loss coverage to self-insured customers of the administrative services affiliate or parent company.

While there may be a contribution to reserves in the administrative fee for a self-insured account to cover credit and/or administrative expense risk, it is generally much smaller than the contribution to reserves for an insured product.

5. Other operational characteristics of the marketplace

In the 1990s, a number of HMOs paid providers on a capitated basis – that is, they paid providers a flat dollar amount per member per month, regardless of the medical costs incurred by that member. Providers were financially responsible for meeting the total costs of care for all their patients out of that medical budget. Most health plans and providers greatly reduced this practice in the late 1990s, and moved to fee for service (FFS) contracting. In this model, providers are paid a flat amount for each specific procedure, visit, or other type of service they provide to members. Providers bear no risk of meeting a medical budget.

Partly as a result of the ACA – see below – health plans, carriers and providers are now starting to change the way providers receive payment. While most financial relationships are not "full (or global) risk" – (that is, similar to capitation, providers receive a flat amount per member per month (PMPM) for medical services) – providers in Minnesota are starting to share risk with carriers.

Not all providers are similarly situated with respect to their ability to accept risk. We have heard in stakeholder interviews that most providers are at risk, at most, for about 5% of the medical budget, and only for some of a carrier's products. Of course, some providers accept more risk than this, others none at all. However, the trend is clear – providers are accepting more and more financial responsibility for the care of their patients.

Accepting such responsibility means that providers now are becoming financially responsible not just for the care they themselves provide but also for care provided outside their own organization – e.g., home health care or rehabilitation services. In order to properly manage this risk, providers need to, among other things, (a) implement data systems so that they know where their patients are and can better understand the care that is being provided to patients, (b) offer care coordination and quality

monitoring to their members; and (c) develop reporting systems so that they fully understand all the care that is being provided and the financial risk involved.

Such efforts require capital, and not all provider systems have sufficient capital available to implement these changes. This is one of the reasons that provider groups are consolidating, combining, and merging into larger entities. Some are also affiliating either for specific product lines or for all business with carriers as well.

B. Health plans in study

Our study analysis is focused on nine insurers that are organized as HMOs, on BCBSM and on three CBPs. Each of the HMOs is organized in accordance with Minnesota Statutes Ch. 62D. The CBPs are organized under the authority of Minnesota Statutes Ch. 256B.692 and they are also subject to various provisions of Minnesota Statutes Ch. 62D. BCBSM is a Nonprofit Health Service Plan Corporation organized in accordance with Minnesota Statutes Ch. 62C.

We identified nine active Minnesota HMOs:

Blue Plus
Group Health Plan, Inc.
Gunderson Lutheran Health Plan Minnesota
HealthPartners, Inc.
Medica Health Plans
Metropolitan Health Plan
PreferredOne Community Health Plan
Sanford Health Plan of Minnesota
UCare Minnesota

We also identified one Nonprofit Service Company and three Insurance Companies that are affiliated companies of the Minnesota HMOs.

BCBSM, Inc. D/B/A Blue Cross Blue Shield of Minnesota
HealthPartners Insurance Company
Medica Insurance Company
PreferredOne Insurance Company

Data from the three County Based Purchasing organizations was also analyzed:

IM Care
PrimeWest Health
South Country Health Alliance

We gathered and analyzed available public data for all of these companies over the period 2003-2012, with the exception of Gunderson, which first began operations in 2013. We supplemented the public data analysis with interviews with representatives of the five largest HMOs and their affiliated insurance companies.

Detailed profiles of each company are contained in Appendix D.

1. Organizational structure

Brief overviews of the structure of each of the individual organizations are provided below. Organizational charts for each company are included in Appendix A and detailed profiles provided in Appendix D.

BCBSM and Blue Plus: BCBSM and Blue Plus are part of a holding company system. BCBSM is a taxable nonprofit Health Service Plan Corporation, which allows it to operate similarly to an insurance company. Blue Plus is a not-for-profit tax-exempt Minnesota HMO that is 100% owned by BCBSM. BCBSM is in turn 100% owned by Aware Integrated, Inc., which is the holding company for an array of health service related entities. BCBSM holds Blue Plus as a non-admitted asset, a permitted practice required by COMM since 1993. This means that BCBSM and Blue Plus are completely separate from each other in terms of the development of RBC. (Please refer to Section III. 4 and Appendix E for a description of RBC – a measure of insurance company solvency.)

Group Health and HealthPartners: HealthPartners, Inc. (HealthPartners) is a not-for-profit tax-exempt Minnesota network model HMO, and it is also the holding company for an organization which includes insurers, administrators and hospital and provider groups. HealthPartners, Inc. is the parent company for Group Health Plan, Inc., (Group Health), a not-for-profit tax-exempt Minnesota staff model HMO, which itself has subsidiaries that operate as clinics and hospitals.

HealthPartners also has a subsidiary, HealthPartners Administrators, Inc. (HPAI), a third party administrator licensed in 14 states. HPAI has five subsidiaries, including organizations that provide support staff for medical and dental clinics, and HealthPartners Insurance Company (HPIC). HPIC provides commercial indemnity health insurance plans as well as stop loss reinsurance for self-insured plans administered by HPAI. Analysis of reserves of HealthPartners includes the reserves and the RBC authorized control level surplus requirements of its subsidiary health insurers Group Health and HPIC. (Again, please refer to Section5for a description of authorized control level.) It also includes the asset value of HealthPartners' non-insurance subsidiaries.

Gunderson Lutheran Health Plan of Minnesota: Gunderson Lutheran did not file a 2012 financial statement, because it is new to Minnesota in 2013. We did not obtain or analyze any information about its ownership structure or affiliated companies.

Medica Health Plans: Medica is a not-for-profit tax-exempt Minnesota HMO. Medica Holding Company (MHC) directly controls Medica Health Plans and indirectly (through Medica Affiliated Services) controls MIC. Medica and MIC are ultimately controlled by MHC through their common Boards of Directors. Medica Health Plan of Wisconsin and several other affiliates are also part of the MHC group.

Metropolitan Health Plan (Metropolitan, or MHP): Metropolitan's financial statements do not include a holding company organizational chart.

PreferredOne Community Health Plan: PCHP is a not-for-profit tax-exempt Minnesota HMO controlled by two hospital systems (Fairview Health Services and North Memorial Health Care) and a physician group, PreferredOne Physician Associates. Administrative services are provided to PCHP by PreferredOne Administrative Services, Inc. (PAS). PAS is 50% owned by Fairview Health Services and 25% each by North Memorial Health Services and PreferredOne Physician Health Services. PAS in turn owns 100% of PreferredOne Insurance Company (PrefOne Ins or PIC). PAS and PIC are for-profit entities.

Sanford Health Plan of Minnesota: Sanford Health Plan of Minnesota is a Minnesota HMO controlled by Sanford Health. Sanford Health is a wholly owned subsidiary of Sanford, which provides clinical care and health care coverage. Sanford Health Plan (South Dakota) is also controlled by Sanford.

UCare Minnesota (UCare): UCare is a not-for-profit tax-exempt Minnesota HMO. It has a wholly-owned subsidiary company UCare Health, Inc., which is a nonprofit service insurance corporation domiciled in Wisconsin and licensed as a foreign insurer in the State of Minnesota. No other affiliated companies are shown in its organization chart.

Itasca Medical Care (IMCare): IMCare is a CBP that serves approximately 6,000 members in Itasca County. It participates in MSHO, PMAP and MNCare, with about 31% of its revenue from MSHO, 57% from PMAP and 11% from MNCare. Providers share in the revenue-sharing decisions with the county. IMCare has been a fully integrated ACO (Accountable Care Organization) with 100% of capitation risk flowing to a network provider pool for the past three decades.

PrimeWest Health: PrimeWest is a CBP that serves approximately 24,000 members in 13 rural counties of Minnesota. It also participates in MSHO, PMAP and MNCare, with about 39% of its revenue from MSHO, 56% from PMAP and 5% from MNCare.

South Country Health Alliance(South Country or SCHA): South Country is a CBP that serves approximately 24,000 members in 12 rural counties. It also participates in MSHO, PMAP and MNCare, with about 42% of its revenue from MSHO, 55% from PMAP and 3% from MNCare.

2. Overview of health plans financials

HMOs are organized in accordance with Chapter 62D. An HMO is required to obtain a Certificate of Authority (CA). The application for the CA must be made to the Commissioner of Health in accordance with the requirements stated in Chapter 62D.03 Subd. 4 and meet the requirement of an initial net worth of the larger of (i) 8-1/3% of first year expenses or (ii) $1.5 Million. Various sections of Chapter 62D specify requirements for coverage, renewal and submission of reports.

In addition to the reporting required by Chapter 62D, HMOs are required to annually submit an RBC report on or before April 1 to the NAIC and the Commissioner of COMM in Minnesota. This requirement is detailed in Minnesota Chapter 60A.50. Annual Statements submitted by Minnesota insurers conform to Minnesota statutory accounting rules.

HMOs operating in Minnesota are required to be non-profit organizations. Chapter 62D.12 Subd. 9 requires that all earnings by an HMO be devoted to providing comprehensive health care. This section specifically prohibits the payment of any dividend or rebate (excluding any provider payments as incentives for quality care).

Chapter 62D.04 Subd. 5 requires that an HMO, as a condition of receiving and retaining its certificate of authority, "participate in the medical assistance, general assistance medical care, and MinnesotaCare programs." The Minnesota Department of Human Services (DHS) has not required PCHP to submit proposals for the provision of health care services to Medical Assistance and MinnesotaCare enrollees in various counties, in exchange for PCHP's willingness to make its network available to other entities participating in the procurement process.

CBPs are organized in accordance with Chapter 256B.692. County boards or groups of county boards are allowed to provide health care services on behalf of individuals who are eligible for medical assistance who would otherwise be required to participate in a prepaid medical assistance plan. CBPs are subject to regulatory supervision by the Commissioner of Health. The county board of supervisors is the governing body of a single county CBP and in the case of a multi-county CBP, the governing body is established in accordance with Chapter 471.59. The CBPs are subject to various provisions of Chapter 62D. Prior to the adoption of the RBC framework, CBPs would have been subject to the net worth requirements of Chapter 62N described earlier, if they were licensed according to that statute. The Commissioner of Health is authorized to develop, in consultation with county government, the necessary administrative and financial reporting requirements. CBP revenue is derived from the Department of Human Services for providing public program health insurance benefits to their enrollees CBPs are subject to a special solvency requirement schedule, in lieu of that specified for HMOs in Chapter 62D that is stated in Chapter 256B.692 Subd. 2(b).

The following discussion presents an overview of revenue, membership, expenses, surplus, RBC ratio, participation in public programs, and net income as a percent of revenue. Detailed information on these items, and other health plan financial indicators, can be found in the company profiles in Appendix D.

Revenue

Table 1 below indicates the annual statement lines of business that the various insurers participated in during 2012 and the level of revenue received. Revenue for the companies listed in the table totaled $12.8 Billion. This includes premiums of $12.6 billion and additional revenue of approximately $570 million, the largest part of which is non-risk fee-based revenue of hospital subsidiaries of Group Health.

Table 1. 2012 Revenue by Line of Business ($000,000)

Company	Comprehensive	Medicare Suppl	Dental Only	FEHBP	Medicare	Medicaid	Other Health	Total
BCBS	1,588	277	-	446	434	-	324	3,069
Blue Plus	38	1	-	-	324	593	1	957
Group Health	533	-	37	48	350	-	-	968
HealthPartners, Inc	771	1	51	-	2	556	-	1,379
HPIC	822	-	13	0	0	-	45	881
Medica	445	1	4	1	324	821	-	1,595
Medica Ins Co	674	-	-	-	663	-	45	1,381
MHP	-	-	-	-	60	72	(0)	132
PrefOne	63	-	-	-	-	-	-	63
PrefOne Ins	135	-	-	-	-	-	10	145
Sanford	3	1	-	-	-	-	-	3
UCare	-	0	-	-	861	1,368	-	2,230
Total	5,070	280	105	494	3,018	3,410	426	12,803

BCBSM reported $1.6 Billion of comprehensive revenue, approximately 50% of its total revenue, while its sister company Blue Plus reported a minimal amount of comprehensive medical business. Blue Plus participates in the PMAP, and MNCare programs and the MSHO program, which Blue Plus reports in the Medicare column of the annual statement. (Some companies report MSHO revenue as Medicare and some include it in Medicaid.) BCBSM is a multi-line company with over half of its business in commercial Comprehensive, and significant blocks of Medicare Supplement, Medicare, FEHBP, and Stop Loss. 96% of 2012 Blue Plus revenue is derived from state subsidized programs (MSHO, PMAP and MNCare). The combination of BCBSM and Blue Plus earned approximately 31% of the revenue of the insurers included in our analysis.

In the HealthPartners group, Group Health does not participate in any of the state program business.

HealthPartners participates in MSHO, PMAP and MNCare. HealthPartners reports its MSHO business as part of the Medicaid line. Approximately 40% of HealthPartners revenue is state subsidized programs (MSHO, PMAP and MNCare) business. HPIC business is 95% commercial Comprehensive and Dental insurance and 5% stop loss written on customers of HPAI.

Approximately 70% of Medica's business is state programs business (MSHO, SNBC, PMAP, and MNcare). In its annual statement, Medica Health Plans includes MSHO in the Medicaid Line and SNBC in the Medicare line. Medica Health Plans also reported a small amount of revenue adjustment in the Medicare line in 2012, but it has no current Medicare business. MIC writes stop loss on self-insured business administered by Medica Self Insured (about 3% of total revenue). The balance of its business is approximately evenly split between MedicareCost and commercial comprehensive business.

Metropolitan's business consists entirely of MSHO, SNBC and PMAP business. Metropolitan reports its MSHO and SNBC business in the Medicare line. MHP operates with a guarantee from Hennepin County to ensure that funds will be available to meet operating costs during a fiscal year.

PCHP and PIC write commercial comprehensive business, although PIC also writes stop loss coverage for self-insured customers of its parent, PAS.

UCare's Medicare revenue consists entirely of Medicare Advantage revenue. Approximately 61% of UCare's revenue is derived from the MSHO, SNBC, PMAP and MNCare programs. It reports all of them in the Medicaid line of business. UCare has not written any commercial comprehensive insurance to date, but it has entered the market for MNsure.

The CBPs-- IMCare, PrimeWest and South Country --all write only public program business. Unlike the HMOs, they appear to have split their MSHO and SNBC revenue into Medicaid and Medicare portions for reporting in their annual financial statements.

We noted some differences in how the companies reported their public program business. The following table summarizes the reporting conventions by Annual Statement line of business (LOB) for the public programs business of each of the HMOs in 2012. In earlier years, other categorizations were used by at least some of the companies.

Table 2. Company Reporting of Public Program Business by Line of Business

Carrier	Medicaid LOB	Medicare LOB
Blue Plus	PMAP, MNCare	MSHO
Health Partners	PMAP, MNCare, MSHO	
Medica	PMAP, MNCare,MSHO	
Metropolitan	PMAP	MSHO, SNBC
UCare	PMAP, MNCare, MSHO, SNBC	
IMCare	PMSP, MNCare, MSHO (in part)	MSHO (in part)
PrimeWest	PMSP, MNCare, MSHO/SNBC (in part)	MSHO/SNBC (in part)
South Country	PMSP, MNCare, MSHO/SNBC (in part)	MSHO/SNBC (in part)

Table 3 indicates the total revenue collected by the insurers included in the analysis. The combined revenue for the companies increased for each year. The smallest increase occurred in 2007, when there

was a 2.8% increase over the prior year. The largest increase was 11.7%, which occurred in 2009. The average increase was 7.9%. The total revenue for 2012 was approximately 200% of the 2003 revenue.

Table 3. Total Revenue ($000,000)

Company	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
BCBS	1,780	1,958	2,177	2,498	2,689	2,819	2,795	2,819	2,920	3,069
Blue Plus	628	586	608	772	816	878	967	1,034	1,090	957
Group Health	486	543	559	583	578	687	841	825	931	968
HealthPartners, Inc	1,130	1,139	1,285	1,460	1,584	1,640	1,591	1,519	1,352	1,379
HPIC	43	55	82	156	202	320	447	664	861	881
Medica	1,485	1,375	1,220	1,027	1,042	1,053	1,368	1,706	1,587	1,595
Medica Ins Co	307	661	936	1,253	932	1,022	1,065	1,117	1,230	1,381
MHP	-	-	-	-	-	-	140	142	164	132
PrefOne	101	121	125	135	153	157	136	138	104	63
PrefOne Ins	-	0	1	2	6	18	80	104	119	145
Sanford	7	3	2	2	2	2	3	3	3	3
UCare	540	609	706	890	1,016	1,152	1,461	1,604	1,743	2,230

i. Membership

Table 4 shows the number of member months reported by each company in its annual statement. For all the companies combined, the 2012 member months were approximately 3% higher than those for 2003, with small year to year changes. Significant changes occurred for certain individual companies.
Blue Plus experienced a significant decline over the 10 year period while BCBSM gained members. This can largely be explained by a decrease in commercial comprehensive business in Blue Plus and a gain in comprehensive business at BCBSM. Similarly, Medica and HealthPartners also saw commercial comprehensive business volume move to their affiliated insurance companies. With all the variation, total member months has remained fairly constant over the last ten years at about 30 million member months per year, or about 2.5 million members. It should be noted that there may be double counting of members who have dental insurance and medical insurance for example, or who have products with both HMOs and insurance companies. Therefore numbers may not be strictly comparable from company to company, or from year to year. One of the large multi-company groups states that the reported numbers overstate total membership by approximately 3.6 million member months each year. The same may be true in other company groups. These kinds of reporting differences add to the complexity of comparing companies to each other and over time.

Table 4. Member Months ('000)

Company	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
BCBS	7,865	8,228	8,757	9,559	9,595	9,277	8,705	8,220	8,083	8,152
Blue Plus	2,340	2,069	2,015	1,944	1,767	1,701	1,681	1,778	1,887	1,693
Group Health	536	493	444	341	310	276	629	596	619	624
HealthPartners, Inc	4,243	4,006	4,057	4,157	3,997	4,050	3,621	3,355	2,906	2,860
HPIC	3,627	3,822	4,115	4,379	4,530	5,034	5,704	6,031	6,200	6,159
Medica	5,832	4,816	3,831	2,485	2,262	1,984	2,092	2,379	2,156	1,654
Medica Ins Co	3,828	5,180	5,269	4,935	4,827	4,716	4,419	4,181	4,375	4,984
MHP	-	-	222	208	210	106	229	217	215	250
PrefOne	491	562	567	590	635	610	491	476	337	205
PrefOne Ins	-	16	67	90	138	221	566	674	893	967
Sanford	28	13	8	6	6	8	11	11	11	10
UCare	1,286	1,346	1,417	1,471	1,486	1,636	1,975	2,284	2,570	3,389
IMCare	-	-	-	-	-	68	70	72	75	76
PrimeWest	-	-	-	-	-	186	237	254	268	287
South Country	-	-	-	-	-	322	362	387	302	280
Total	30,077	30,549	30,768	30,165	29,762	29,619	30,121	30,202	30,252	30,947

ii. Expenses

Insurance related expenses include those expenses that are included in the annual statement as claim adjudication expenses and administrative expenses. Expenses related to investment activities are not included, but rather investment earnings are reported net of investment expenses. Insurance related expenses vary by product and in a given year may reflect the expense of a major investment (such as a data processing investment). One would anticipate that, without a change in the mix of business, expense growth would reflect (i) general inflation which would tend to increase expenses over time and (ii) improvements in productivity which would tend to reduce expenses over time. PMPM expense increased by 103% over the 10-year period, an average 8.2% compound growth rate.

The PMPM expense level varies significantly by company and in part reflects the mix of business that is underwritten. Certain products cost less than others to administer. In the following table, it may be that certain carriers appear relatively low because they write a lot of low premium stop loss coverage, resulting in lower average PMPM premium and expenses. The change over time is also misleading because taxes and assessments have increased over the ten-year period, including assessments to fund Minnesota Comprehensive Health Association (MCHA) and the premium tax, which only was applied beginning in 2004. In addition, some kinds of administrative expense are related to improvements in health care quality. These kinds of expenses are now treated differently in loss ratio calculations, but are all included in the following exhibit. These kinds of changes add to the complexity of comparing expenses from company to company or from year to year.

Table 5. Expenses per Member per Month ($)

Company	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
BCBS	27	32	32	33	38	41	47	50	49	57
Blue Plus	19	27	30	33	38	44	46	44	48	46
Group Health	43	52	58	64	88	146	72	73	88	89
HealthPartners, Inc	24	29	31	29	35	34	38	39	42	42
HPIC	2	2	3	5	6	9	11	15	19	19
Medica	29	34	33	33	36	40	48	55	54	71
Medica Ins Co	12	17	24	31	32	35	39	39	43	42
MHP	-	-	-	-	-	308	109	100	106	80
PrefOne	29	35	35	32	37	39	40	40	40	40
PrefOne Ins	-	2	3	4	9	14	20	23	20	22
Sanford	29	34	54	51	56	58	51	55	51	51
UCare	28	33	41	49	59	47	51	52	58	46
Average (weighted by membership)	22	26	27	29	33	36	38	40	43	44

iii. Capital Reserves

Table 6 indicates the capital reserves or surplus reported by each of the companies that are the subject of our analysis. The primary sources of insurer capital reserves (surplus) are underwriting gains and investment gains (realized and unrealized). In addition, an insurer's surplus can be increased by a capital contribution. A capital contribution can be a significant factor for an individual company but is a minor factor when considering the combined surplus for the companies listed in Table 6.

The combined surplus for the listed companies grew 128% over nine years, which is a compound growth rate of 9.6%, somewhat higher than the compound PMPM revenue growth rate of 7.5%.
There are significant differences in the growth of surplus for individual companies. The combined surplus experienced a decrease of approximately 6% in 2008, which is primarily attributable to the investment results of BCBS and Blue Plus.

It is reasonable to ask whether capital reserves growth should track revenue growth, or whether some absolute level of reserves should be considered adequate even if revenue increases. All the traditional measures of reserve adequacy monitor capital reserves by comparison to the associated volume of business measured in terms of revenue (SAPOR or Surplus As Percent Of Revenue), assets (for investment risk under RBC), volume and type of claims (for underwriting risk under RBC) or volume of claims and expenses(months of expenses). We did not encounter any precedent in regulation or in scholarship that would say it should be proportional to members, or that some absolute level would be adequate to cover all risk. RBC does make some provision for lessening the requirement for a large company with diverse risks, on the theory that not all adverse risks will occur at once and that the law of large numbers makes large companies less volatile. However, all of the large Minnesota HMOs are large enough that this is not an issue – they are at or near the maximum size band for underwriting risk factors in RBC analysis. Reserve analysis under Own Risk and Solvency Analysis (ORSA - discussed more

fully later in this report) will be more sophisticated, but risk analysis will still follow the volume of business under ORSA analysis.

Table 6. Surplus ($000,000)

Company	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
BCBS	608	692	693	713	646	518	629	763	794	827
Blue Plus	96	130	162	210	235	201	251	318	357	360
Group Health	76	58	44	60	61	76	79	86	99	99
HealthPartners, Inc	167	265	275	297	345	335	387	497	617	709
HPIC	11	18	24	30	39	50	64	84	113	149
Medica	317	330	321	282	319	318	361	399	416	442
Medica Ins Co	60	71	119	142	160	174	197	191	249	255
MHP	-	-	-	-	-	5	8	11	19	25
PrefOne	25	26	27	22	19	15	11	12	11	10
PrefOne Ins	3	3	5	5	5	12	20	22	26	30
Sanford	1	2	2	2	2	2	2	1	1	1
UCare	75	119	138	170	199	204	246	308	322	388
Total*	1,353	1,637	1,741	1,843	1,930	1,784	2,111	2,522	2,812	3,047

***Adjusted to remove Group Health and HPIC, which are already included in HealthPartners, Inc**

In Table 7 below is the compound growth rate of surplus for the major insurers for the 10 year period 2003 through 2012. It should be noted that this is somewhat misleading with regard to HealthPartners because of changes in reporting requirements in 2004 that caused the subsidiaries to be included in the surplus whereas they had not been included before. Adjusting for that in Table 7 below would reduce the compound growth rate from 17.4% to 12.0%. Also, a large element of the HealthPartners growth in surplus relates to the value of its non-insurance subsidiaries. These circumstances add to the complexity of analyzing variations in surplus from company to company and from year to year.

Table 7. Surplus Compound Growth Rate

Company	Growth Rate
BCBS	3.5%
Blue Plus	15.8%
HealthPartners, Inc	17.4%
Medica	3.8%
UCare	20.1%

iv. Risk Based Capital (RBC) Ratio

The absolute value of an insurer's surplus needs to be evaluated in the context of the level of risks that it is intended to mitigate. The RBC ratio reflects the insurers surplus position relative to a risk based capital formula established by the National Association of Insurance Commissioners. Regulatory action may occur when the RBC ratio drops below 200%.

The RBC ratio for each company has shown variability by year. Most notably, the RBC ratios declined in 2008 for BCBS and Blue Plus largely due to realized and unrealized investment losses. The Blue Plus RBC ratio has shown significant increase over the past three years in part due to a decline in its comprehensive medical business and its Medicaid enrollment and in part to investment gains tied to overall market performance. PCHP's RBC ratio has declined by 45% as compared to its 2003 level. It is interesting to note that the revenue weighted average RBC ratio of all the companies has been relatively stable over the 2003 through 2012 timeframe, more stable than the results for any one company.

Table 8. Risk Based Capital Ratio

Company	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
BCBS	819%	811%	753%	666%	596%	489%	583%	718%	757%	703%
Blue Plus	418%	656%	758%	729%	751%	595%	703%	865%	924%	942%
Group Health	726%	507%	393%	601%	680%	812%	557%	573%	565%	527%
HealthPartners, Inc	499%	683%	623%	580%	628%	591%	446%	491%	561%	573%
HPIC	371%	542%	607%	473%	470%	403%	371%	365%	385%	468%
Medica	620%	689%	715%	706%	828%	881%	781%	668%	745%	773%
Medica Ins Co	498%	299%	348%	327%	498%	487%	543%	507%	608%	516%
MHP	-	-	313%	214%	232%	71%	136%	177%	284%	515%
PrefOne	643%	551%	528%	386%	311%	239%	213%	223%	252%	357%
PrefOne Ins	-	-	3092%	881%	540%	930%	493%	444%	472%	472%
Sanford	238%	725%	1020%	1019%	1133%	953%	670%	398%	446%	125%
UCare	405%	582%	553%	545%	564%	487%	462%	531%	524%	476%
Weighted Average (by revenue)	617%	656%	627%	589%	626%	575%	557%	603%	645%	620%

It should be noted that HealthPartners, Inc. is anomalous as compared to the other companies in that it is a holding company in addition to being an HMO. Under current statutory accounting rules, this means that the value of its subsidiaries is included in its financial statements. The investments in subsidiaries also affects the calculation of its RBC ratio, both by the value of subsidiaries included in the capital reserves (the numerator of the RBC calculation) and by the risk parameter associated with the investment subsidiaries in the calculation of its Authorized Control Level (ACL) surplus, the denominator of the RBC calculation. Because the effect of removing the subsidiaries from the ACL calculation is relatively greater than the effect of removing the surplus itself, removing the subsidiary investments to put HealthPartners on a similar footing to the other companies results in higher RBC. However, removing the subsidiary investments does not affect the claims and expenses of HealthPartners, but only the capital reserves, so the number of months of claims and expenses calculated decreases. The following table shows the effect on RBC and on months of claims and expenses of adjusting out the value of the subsidiaries. It is reasonable to make this adjustment to show HealthPartners on an equal footing basis with the other companies. The investments in subsidiaries are not available to pay HealthPartners claims. Furthermore, if a limit on capital reserves were instituted, HealthPartners might wish to modify its corporate structure, or to request a permitted reporting practice that would result in the investments in subsidiaries being reported as non-admitted.

Table 9. Effect on HealthPartners RBC and Months of Expenses if Subsidiary Investments Adjusted Out

	As Reported			Remove Investments in Subsidiaries		
	2010	2011	2012	2010	2011	2012
Total Capital Reserves ($000,000)	$ 497.4	$ 616.9	$ 709.1	$ 256.2	$ 318.8	$ 359.1
ACL Surplus ($000,000)	$ 101.4	$ 110.1	$ 123.7	$ 51.3	$ 45.1	$ 46.2
Ratio (Surplus/ACL)	491%	561%	573%	499%	707%	777%
Months of Claims and Expenses	4.12	5.87	6.67	2.12	3.04	3.38

v. Participation in Public Programs

The Minnesota HMOs (excepting PreferredOne and Sanford, and excepting Group Health which participates through its affiliate HealthPartners) and CBPs generally participate in the public programs PMAP, MNCare, SNBC and MSHO, the program for Medicare/Medicaid dual eligible individuals. The CBPs write no private or commercial business, and only cover PMAP, MNCare, SNBC and MSHO.

Analysis of public program business reported over the period 2003-2012 in the Minnesota Health Supplements shows total revenue of $30.1 billion for the public programs taken together, or almost 50% of total revenue for all business. Of the programs, PMAP has been the largest, with about $14.7 billion of revenue, while MNCare resulted in $5.1 billion and MSHO/SNBC resulted in $8.9 billion. The plans reported $1.4 billion in General Assistance Medical Care (GAMC) revenue, but that program has not been active after 2010.

vi. Net Income as a Percent of Revenue

For all the plans taken together, over the 2003-2012 period, net income as a percent of revenue was 3.7% for PMAP, -11.8% for GAMC, 0.3% for MNCare and 4.4% for MSHO/SNBC, for a total public program percent of 2.6%. By comparison, net income for commercial business was 1.6% of revenue over the 2003-2012 period.

Taking 2012 alone, however, commercial net income was higher as a percent of revenue than public program net income, with commercial at 4.1% and total public program net income at 1.8%.
Some stakeholders expressed concern that the growth in surplus of HMOs over time had been the result of profits from the public programs PMAP, GAMC, and MNCare, and the dual eligible programs MSHO and SNBC. In aggregate, underwriting gains from those programs in the last ten years have been approximately $482 million, equivalent to about 25% of the 2012 surplus level of the companies that insure those programs. There is considerable variation by company, and underwriting gain has also varied by program and by year for each of the companies.

The following table shows the Net Income for all lines of business together for each plan each year, including both underwriting gain and investment income, and pre-FIT for taxable companies. Over the ten year period, the net income of all plans taken together was approximately $1.9 billion.

Table 10. Net Income by Company and by Year 2003-2012 ($000,000)

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	10 Yr Tot
BCBSM	96.4	9.5	59.5	0.9	(3.9)	(2.1)	33.5	100.1	155.4	50.4	449.3
Blue Plus	13.7	44.5	31.9	17.3	27.8	(16.3)	28.7	70.9	50.6	(4.4)	269.1
Group Health	4.3	(4.7)	(5.0)	1.2	5.5	7.1	18.9	8.5	27.0	20.3	62.8
HealthPartners, Inc.	24.4	19.6	16.7	21.2	34.6	35.3	36.0	74.2	94.5	106.4	356.5
HPIC	1.1	6.1	5.9	5.7	8.1	10.6	11.6	16.7	32.7	14.0	98.5
Medica Health Plans	41.0	27.9	2.8	(27.0)	30.0	11.5	49.7	29.1	14.6	44.5	179.6
Medica Ins Co	8.7	11.3	(1.8)	24.4	14.9	15.3	17.4	44.1	50.9	(2.6)	185.2
Metropolitan	-	-	-	-	-	(8.4)	2.5	2.2	8.6	5.5	4.9
PreferredOne CHP	4.9	0.4	0.7	(4.2)	(2.1)	(4.3)	(2.1)	0.4	1.2	(0.8)	(5.1)
PreferredOne Ins Co	0.0	(0.1)	(0.1)	0.2	0.3	1.7	2.0	1.6	1.9	3.1	7.5
Sanford Health Plan	(0.1)	0.5	0.4	0.2	0.2	(0.4)	(0.3)	(0.4)	(0.0)	(1.2)	0.2
UCare	34.6	45.7	19.9	33.8	31.9	3.2	37.5	61.0	33.9	70.7	301.5
Total Net Income	228.9	160.6	130.8	73.7	147.3	53.3	235.3	408.6	471.2	306.0	1,909.8

Table 11. Comparison of 10-Year Underwriting Gain and 10-Year Investment Income from Public Programs to 2012 HMO Surplus[20]

		10 Yr Underwriting Gain		10 Yr Inv Income	
HMO	2012 Surplus	Public Programs	All Other	Public Programs	All Other
Blue Plus	$ 360	$ 112	$ (5)	$ 89	$ 69
HealthPartners, Inc.	$ 560	$ 19	$ 412	$ (3)	$ 118
Medica	$ 442	$ 125	$ (99)	$ 84	$ 127
Metropolitan	$ 25	$ 6	$ (13)	$ 5	$ 0
PreferredOne	$ 10	$ 0	($20)	$ 0	$ 14
Sanford	$ 1	$ 0	($1)	$ 0	$ 0
UCare	$ 388	$ 220	$ 54	$ 66	$ 32
Total	$ 1,785	$ 483	$ 327	$ 241	$ 361

vii. Investment policy

A question was raised as to whether investment in equities increases the surplus need of Minnesota HMOs because of the risk assigned to equity investments by the RBC calculation process. Of the companies we reviewed, only BCBSM, Blue Plus, Group Health, HealthPartners, Inc., PCHP, PIC, and UCare reported equity investments. The percentage of invested assets in equities as of year-end 2012 for those companies ranged from 6% (UCare) to 23% (BCBSM). For the other companies (HPIC, Medica HP, Medica Ins Co, Metropolitan and Sanford), the percentage was zero. In the RBC calculation, equity investments are assigned a risk factor of 15%. If those investments were held in Class 1 bonds instead, they would only have a risk factor of 0.3%. However, the RBC calculation is complex, and much of the effect of these investment choices is outweighed by the underwriting risk. The range of impact on reported RBC of the risk factors on these investments is from 0.1% (UCare) to 3.0% (Blue Cross) except

[20] Surplus here excludes the capital reserves of HealthPartners, Inc.'s non-HMO subsidiary HPIC, and includes the consolidated value of the combined business of HealthPartners, Inc. and its HMO subsidiary Group Health.

for Group Health, which does not have as much relative underwriting risk as the other carriers because most of its claims are non-risk fee based claims of their subsidiary hospitals. For Group Health, a bonds only investment strategy would result in 10% lower ACL, and therefore 10% higher reported RBC ratio.

Of course, these companies invest in equity investments for many factors, including the possibility of superior returns, and general diversification of their portfolios. The investment strategies of the companies do not have a material effect on surplus need as measured by RBC.

III. Health Plan Reserves

A. Sources of capital reserves

This section of the report discusses the sources of the capital reserves of health insurers, how we calculated and analyzed reserves from the health insurers' filed statutory financial statements, and the methods that are generally used for measuring the size and adequacy of health insurer capital reserves.

1. Retained earnings

One of the main ways that HMOs and other insurers can obtain capital reserves is by accumulating the margins in the premiums they charge over the claims and expenses they pay out. Health insurers generally build in a margin in the rates intended to provide a cushion against adverse experience and to help build the reserves. For a company to maintain its level of reserve adequacy, additional reserves would need to be accumulated to allow the company to write additional business, to increase membership in existing accounts, or to cover medical inflationary trend on its existing business. That margin is often called a contribution to reserves. The amount of contribution to reserves that can be added to the premiums can be limited by competitive pressure (another carrier charging lower premiums), by regulatory oversight (rate review), or by other regulatory restraint (for example, minimum medical loss ratio (MLR) regulation under the Affordable Care Act).

2. Investment performance

Health insurers invest existing capital reserves and other reserves. Many of these investments are in cash and short term investments and in long term bonds, although some invest in equity investments. The earnings and capital gains on these investments, if they are not needed to pay claims, add to the company's capital reserves.

3. Capital contributions

A health plan that needs capital can be supported by a parent or affiliate who makes a contribution of capital. Capital contributions are shown separately in the financial statement.

4. Additional contributions to capital reserves

Under certain circumstances, a company can borrow money that can be counted as surplus. Borrowed money does not usually result in additions to surplus because the money must be repaid, and therefore a corresponding liability is set up. However, interest and principal payments on surplus notes are payable on a conditional basis. Subject to review and acceptance by the regulator, surplus notes can be used to bring the level of surplus up.

B. Study methodology to calculate reserves from financial statements

The amounts we are discussing are reported in the annual statement as Total Capital and Surplus on page 3, line 33 of the 2012 annual statement, although the line number used has changed from year to year. The annual statement also includes Total Adjusted Capital, reported in the Five-Year Historical Data section of the annual statement at page 28. For most companies, Total Adjusted Capital and Capital and Surplus have been the same. However, we have noted a minor difference for one company in our study (less than one percent). We therefore have generally used these terms interchangeably.

Financial results for HMOs and health insurers generally are reported on the NAIC Health Annual Statement Blank. The rules for health insurance accounting are contained in the NAIC Accounting Practices and Procedures Manual (APPM), and are described in detail in the Statements of Statutory Accounting Principles (SSAP) contained in the APPM.

Capital Reserves are distinct from certain liabilities of a health plan that are also commonly referred to as reserves, but that exist as recognition of liabilities for amounts the insurer must pay. Common examples of liabilities that are not Capital Reserves, but that may be referred to as “reserves” include the following:

- Claims unpaid, or liabilities for incurred but not reported (IBNR) claims. These are sometimes called claim reserves. Technically, they are liabilities (amounts already owed) and not reserves (amounts held for future obligations). They appear on page 3, line 1 of the annual statement. The accounting treatment is described in SSAP No. 55.
- Unpaid claims adjustment expense, sometimes called loss adjustment expense reserves. These are reported on page 3, line 3 of the annual statement. The accounting treatment for unpaid claims adjustment expense is also described in SSAP No. 55, and it is also addressed in SSAP No. 85.
- Aggregate health policy reserves. This category of reserves is reported in detail in the Underwriting and Investment Exhibit Part 2D of the annual statement and summarized on page 3, line 4. It includes unearned premium reserves, premium deficiency reserves and reserves for experience rating refunds. The accounting rules are specified in SSAP No. 54.
- Aggregate health claim reserves. These are reserves for amounts that are not yet due, but that are expected to become due in a future period. A typical example would be reserves for future disability benefits on a currently disabled person. None of the Minnesota HMOs has any reserves of this type. The accounting rules are also specified in SSAP No. 54.

IV. Capital Reserve Regulation in Minnesota and Other States

A. Methods for measuring reserves

Before we can discuss Minnesota and other state methods of regulation reserves, first it is necessary to understand different regulatory methodologies for measuring levels of capital reserves. Insurance regulators, who among other responsibilities are tasked with assessing the adequacy of insurer reserves, generally for the purpose of meeting *minimum* solvency requirements, use a variety of tools to analyze capital reserves, including: (1) absolute volumes, (2) surplus as a percent of revenue (SAPOR), (3) months of expenses covered by capital reserves, and (4) surplus in the context of risk-based capital. In addition, they consider the overall risk profile of an insurer and any additional information needed to determine the adequacy of an insurer's capital reserves for solvency purposes.

1. Absolute value of reserves

The Minnesota HMOs we studied and the affiliated non-profit health service company and three affiliated health insurance companies reported a total of $3.2 billion of capital reserves at the end of 2012. This is a very large amount of money, but for perspective, health care insurance is an extremely large industry with large commitments to the covered members. Total health care revenues in 2012 for these companies were $12.8 billion, or four times as much. Just knowing the amount of capital reserves held by a health plan does not provide any information about whether the reserves are adequate, or about whether a limit would be appropriate without understanding the amount and kind of business the health plan manages and the characteristics of the risks the health plan has taken on.

The following charts show the 2012 Capital and Surplus of the Minnesota HMOs, of BCBSM and of the insurance companies affiliated with other HMOs, and of the CBPs.

Chart 5. 2012 HMO Capital and Surplus ($000,000)[21]

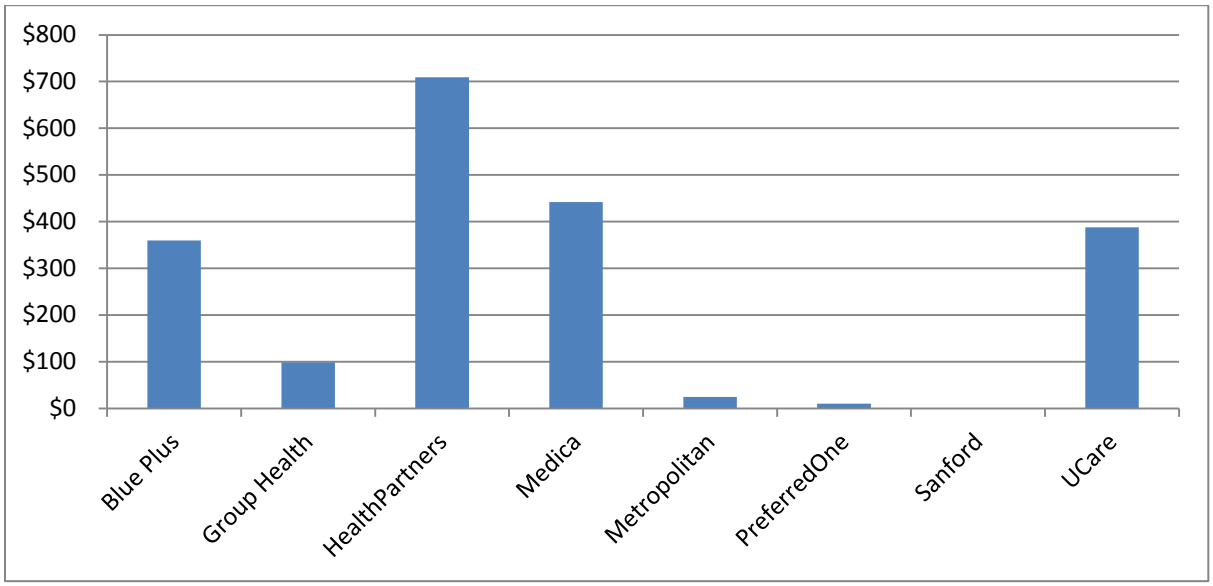
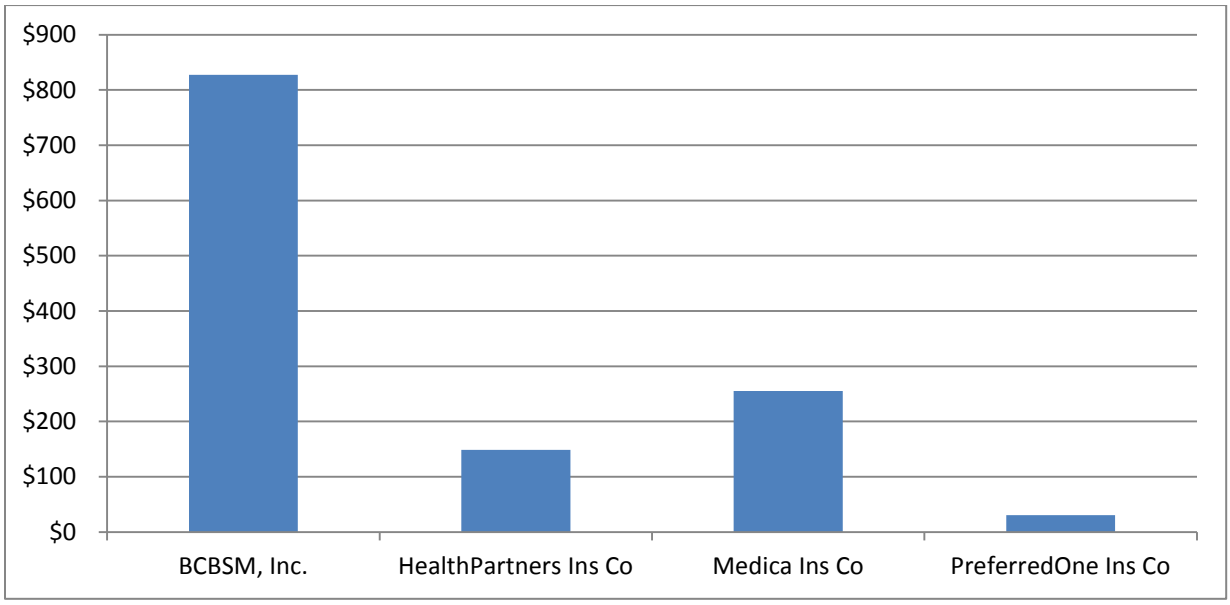
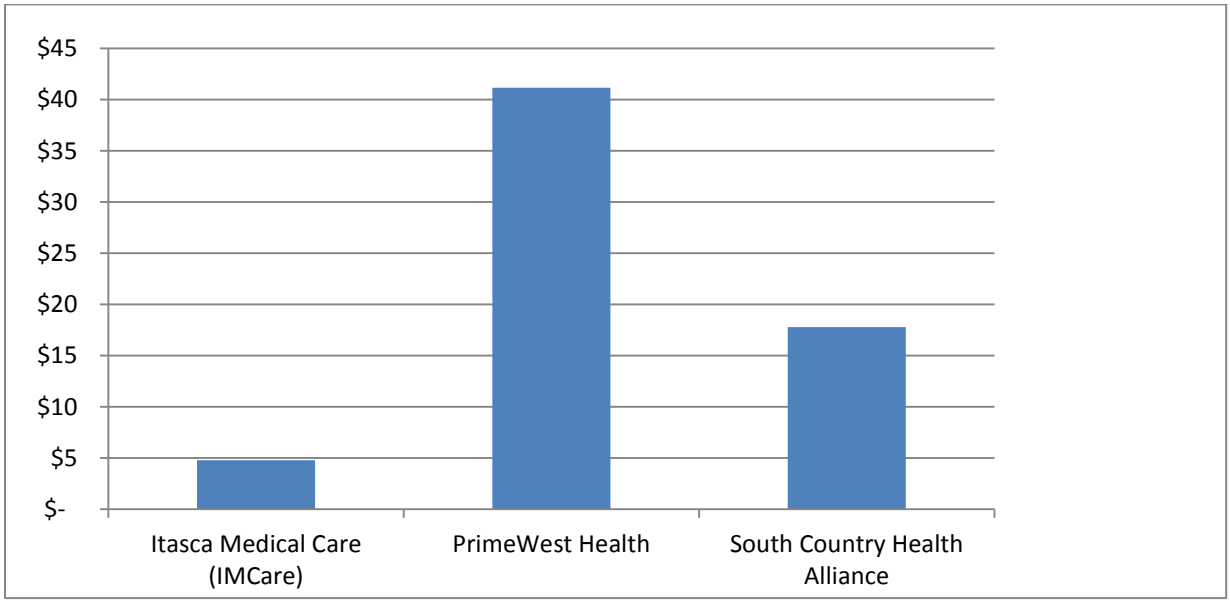


Chart 6. 2012 BCBSM and Insurance Company Capital and Surplus ($000,000)[22]



[21] Source – 2012 Annual Financial Statements.
[22] Source – 2012 Annual Financial Statements.

Chart 7. 2012 County Based Purchasers Capital and Surplus ($000,000)[23]



2. Months of Expenses

Looking at reserves in months of claims and expenses is a traditional method of evaluating reserve adequacy. Until 2004, Minnesota regulated HMOs by requiring them to maintain reserves equal to between one and three months expenses (claims, administration, and minor other adjustments). Our understanding was that this was intended as a measure of minimum solvency, and that during the time this was the regulatory standard, there were no plans that had reserves equal to or greater than 3 months expenses.

This method of analyzing reserves is perhaps a useful and easy measure of reserve adequacy or appropriateness. It is certainly easy to understand and to communicate, but it does not account for differences in the kinds of business written, or of other risks to which an insurer may be subject. Reliance on a method like months of expenses could mask risk issues that could be better addressed by using more sophisticated methods.

The following table shows the capital reserves as a function of number of months expenses over the last three years. A number of things should be noted. Group Health appears quite low. Its expenses include fee income of its hospital subsidiaries that is not associated with insured products. The chart shows also an adjusted value excluding those expenses. HealthPartners, Inc. appears to be quite high, because its capital reserves include the assets of subsidiary companies, while the expenses of those companies are not included. The chart shows the unadjusted results, and also an adjusted result, removing the assets associated with subsidiaries from the calculation. With those two adjustments, the level of capital

[23] Source – 2012 Annual Financial Statements.

reserves in months of expenses as of 2012 is within the old, pre-RBC maximum limit of 4 months for Blue Cross plans regulated under Chapter 62C and HMOs regulated under Chapter 62D, except for Blue Plus which is over the old standard by approximately 1.4 months and HealthPartners and Medica, both of which are over the old standard by less than 0.4 months.

Table 12. Capital Reserves Expressed as Months of Expenses

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
BCBS	4.36	4.26	3.82	3.35	2.80	2.22	2.71	3.35	3.44	3.25
Blue Plus	1.86	2.88	3.30	3.29	3.44	2.70	3.17	3.89	4.11	4.39
Group Health	1.87	1.26	0.93	1.21	1.26	1.34	1.15	1.25	1.30	1.24
Group Health†	3.67	2.79	2.12	3.38	4.13	3.80	2.41	2.69	2.73	2.67
HealthPartners, Inc	1.81	2.83	2.59	2.47	2.65	2.50	2.98	4.12	5.87	6.67
HealthPartners, Inc†	0.87	1.55	1.50	1.50	1.64	1.20	1.42	2.12	3.04	3.38
HPIC	3.21	4.51	3.90	2.44	2.43	1.99	1.80	1.59	1.67	2.06
Medica	2.57	2.87	3.07	3.14	3.68	3.70	3.24	2.85	3.19	3.33
Medica Ins Co	2.45	1.31	1.51	1.39	2.09	2.07	2.27	2.16	2.59	2.22
MHP						0.35	0.70	0.94	1.48	2.26
PrefOne	3.12	2.57	2.51	1.87	1.45	1.10	0.98	1.03	1.22	1.90
PrefOne Ins		*	*	*	*	8.74	3.02	2.54	2.69	2.60
Sanford	*	*	*	*	*	8.14	6.10	5.57	4.78	1.99
UCare	1.77	2.51	2.38	2.34	2.38	2.12	2.06	2.37	2.24	2.15
Weighted Average	2.74	2.97	2.82	2.63	2.69	2.33	2.52	2.86	3.12	3.13
†Group Health adj to remove fee-based income from claims; HealthPartners adj to remove investments in subsidiaries										
*not meaningful because of small amount of business										

Most companies in most years have been below the old statutory standard of three months (or four in the case of BCBSM), but several companies do exceed the old standard. As of 2012, $198 million of capital reserves in excess of the old standard were held. The following table shows the results by year in comparison to the prior standard. In this table, HealthPartners is shown net of adjustment to remove the surplus associated with its investments in subsidiaries, and Group Health is also shown on an adjusted basis to remove the non-risk fee-based revenue from its claims.

Table13. Excess of Prior Regulatory Maximum Surplus Standard ($000,000)

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
BCBS	$ 50	$ 43	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Blue Plus	$ -	$ -	$ 15	$ 19	$ 30	$ -	$ 13	$ 73	$ 96	$ 114
Group Health	$ 14	$ -	$ -	$ 7	$ 17	$ 16	$ -	$ -	$ -	$ -
HealthPartners, Inc	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 4	$ 40
Medica	$ -	$ -	$ 7	$ 12	$ 59	$ 60	$ 27	$ -	$ 25	$ 44
Weighted Average	$ 65	$ 44	$ 23	$ 40	$ 108	$ 77	$ 41	$ 73	$ 125	$ 198

3. Percent of Revenue

This method is approximately equivalent to months of expenses. It has been used as a means for setting a desired range (minimum and maximum) for health plan reserves in at least one jurisdiction, with range values that varied by health plan. Again, it is simple to understand and to communicate, but not sophisticated enough to consider the full range of risks absorbed by a company. However, by doing

relatively sophisticated analysis of a company's risks and then converting the results into a percent of revenue unique to each company, some of the benefit of a more sophisticated method can be obtained. This method is sometimes called SAPOR.

The following table shows the capital reserves of the Minnesota health plans as a percentage of revenue. As in the months of expenses table above, Group Health and HealthPartners, Inc. results are shown both unadjusted, and adjusted for the anomalous circumstances that make comparison difficult. The adjustments remove fee-based income from the Group Health revenue, and subsidiary value from the HealthPartners, Inc. capital reserves. After adjustment, only Blue Plus shows a ratio higher than 30% SAPOR. The others are all in the range of 16% to 28%.

Table 14. Capital Reserves Expressed as a Percent of Revenue (SAPOR)

Company	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
BCBS	34%	35%	32%	29%	24%	18%	22%	27%	27%	27%
Blue Plus	15%	22%	27%	27%	29%	23%	26%	31%	33%	38%
Group Health	16%	11%	8%	10%	11%	11%	9%	10%	11%	10%
Group Health (adj)†	31%	24%	19%	30%	36%	31%	20%	22%	22%	22%
HealthPartners, Inc	15%	23%	21%	20%	22%	20%	24%	33%	46%	51%
HealthPartners, Inc (adj)†	15%	13%	12%	12%	13%	10%	12%	17%	24%	26%
HPIC	26%	32%	29%	19%	19%	16%	14%	13%	13%	17%
Medica	21%	24%	26%	27%	31%	30%	26%	23%	26%	28%
Medica Ins Co	20%	11%	13%	11%	17%	17%	18%	17%	20%	18%
MHP							6%	7%	12%	19%
PrefOne	25%	22%	21%	16%	12%	9%	8%	9%	10%	16%
PrefOne Ins		*	*	*	*	*	25%	21%	22%	21%
Sanford		*	*	*	*	*	56%	49%	42%	22%
UCare	14%	19%	19%	19%	20%	18%	17%	19%	18%	17%

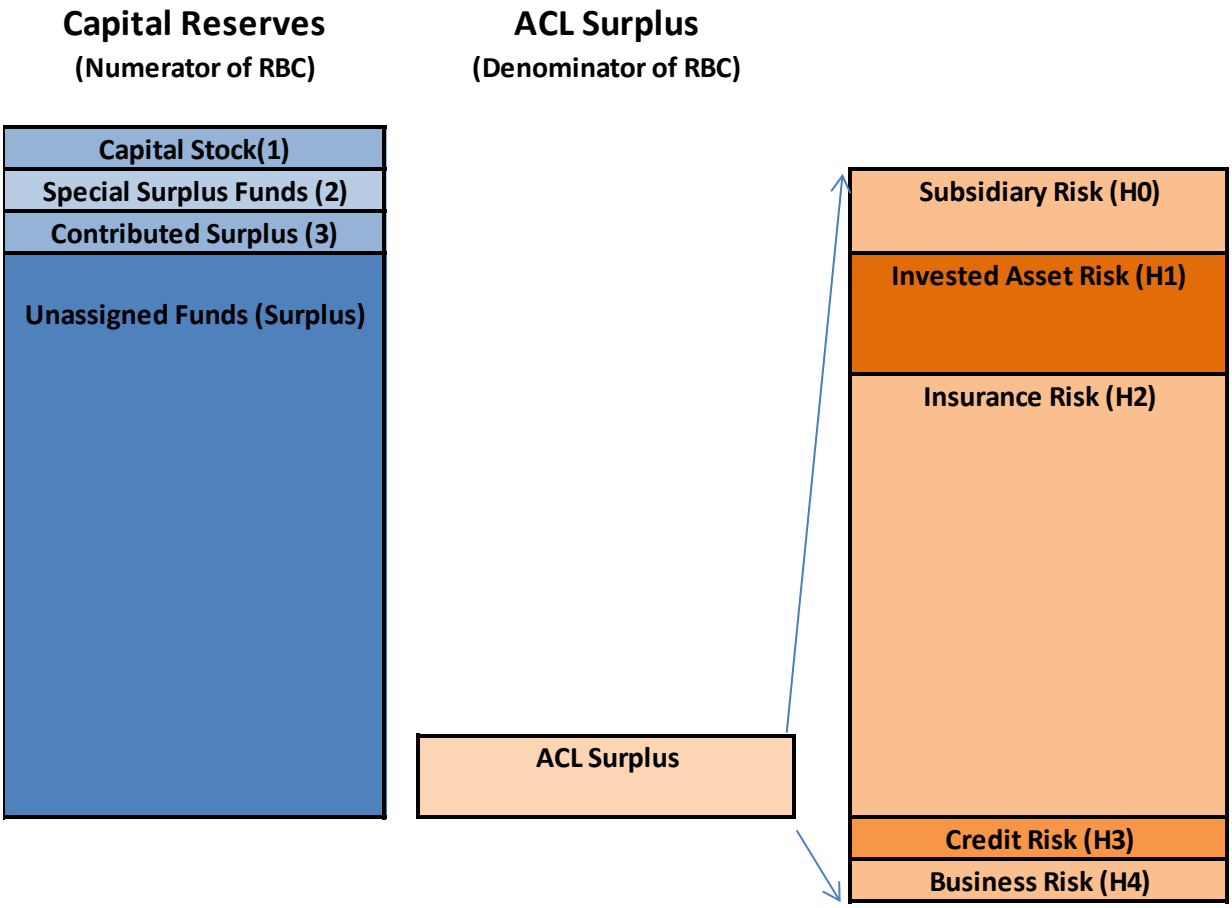
†Group Health adj to remove fee based income from Revenue; HealthPartners Inc adj to remove investments in subsidiaries from surplus

* Not meaningful because of low revenue.

4. Risk Based Capital (RBC)

Risk Based Capital or RBC is a statutory method of evaluating adequacy of capital reserves. The ratio has as its numerator the total capital reserves of a company. The denominator is a number calculated by a complex formula and designated as the Authorized Control Level surplus or ACL. As its name suggests, if a company's ratio declines to 100% of its ACL surplus, the regulator is authorized to assume control of the company to protect the interests of its customers. ACL surplus considers several categories of risk associated with a company, including risks associated with its investments in subsidiaries (H0), invested asset risk (H1), insurance risk (H2), credit risk (H3), and general business risk (H4).

Chart 8. Description of RBC Components



The state of Minnesota has adopted the NAIC Model Act for minimum reserves, and therefore requires the annual submission of a Risk Based Capital Report to the NAIC and the Minnesota Commissioner of Commerce. This requirement is detailed in Minnesota Statutes Ch. 60A.50 for HMOs and Chapter 60A.60 for life/health insurance companies and casualty companies. The full RBC Report is not a public document. Only certain limited RBC information is provided in the public NAIC annual statements, however, including the calculated ACL surplus and the RBC ratio, which is the ratio of Total Adjusted Capital (TAC) to ACL surplus.

The calculation of ACL takes into account risk characteristics of a company's business. It is generally a much more sophisticated analysis than the months of expense approach. It is generally the standard method for evaluating solvency and has been adopted by most states as the minimum solvency standard.

The RBC formula is focused on solvency. The purpose of the RBC formula is to determine the minimum amount of capital for an insurer below which the regulator must intervene in order to protect the interests of the insured members. An insurer's capital and surplus is evaluated relative to this minimum

by the RBC ratio. The intervention taken will vary, depending on the RBC ratio. The calculation follows a formula specified by the NAIC.

The RBC formula takes into consideration the following five major categories of risk:

- Asset risk of affiliates - (H0)
- Other asset risk – (H1)
- Underwriting risk– (H2)
- Credit Risk– (H3)
- General business risk. – (H4)

A brief discussion of the five categories of risk follows.

H0 is a pass through of the RBC risk of subsidiary insurance companies. The ACL of a subsidiary is added directly into the ACL of a parent company.

H1 is asset risk, including invested assets (e.g., stocks, bonds, etc.), furniture and equipment, and investments in non-insurance subsidiaries and affiliates. The RBC calculation adjusts reported assets by a factor to calculate the required capital. Different kinds of assets are assigned different surplus requirements based on the perceived risk of each asset type. U.S. government bonds and those guaranteed by the U.S government are considered to be risk free and do not contribute to the RBC calculation. For all other bond categories the reported value is multiplied by a factor which ranges from 0.3% for the least risky to 30% for bonds in default. A similar process is in place for preferred stocks. Mortgage loans are generally subject to a 5% factor. Owned real estate is generally subject to a 10% factor. Furniture, equipment (including EDP equipment), and software are generally subject to a 10% factor. Common stocks are generally carried at market value in the statutory statement and the RBC factor is 15%. In addition, assets that are concentrated, that represent higher than a certain percentage of a company's portfolio, are assigned a higher surplus requirement.

For a health insurer, **H2,** the underwriting risk category is generally the largest contributor to the RBC calculation. This calculation multiplies incurred claims by a required surplus factor that varies for various types of coverage (for example, stop loss insurance has a higher factor), the protection provided by reinsurance, the risk of rate guarantees beyond 12 months, and the reduction of risk provided by premium stabilization funds and provider arrangements, such as capitation and "withholds."

The credit risk component (the **H3** component) takes into account the risk associated with receivables. An example of a receivable is pharmacy rebates not yet paid. Perhaps the largest receivable for Minnesota HMOs is the amount withheld from Medicaid payments.

The general business risk component (the **H4** component) recognizes risks such as unanticipated fluctuations in administrative expenses.

The RBC formula recognizes that it is unlikely that adverse experience for each of the type of events considered for H1 through H4 risk will occur simultaneously. A covariance formula adjusts the combined effect of the H1 through H4 risks so that the combination of the risk components is less than the sum of them. The H0 risk component is added to the combined result of the H1 through H4 risk. The process described in this paragraph is summarized in the following formula, which determines the Company Action Level:

$$CAL = H0 + \text{Square Root of } (H1^2+H2^2+H3^2+H4^2)$$

The ACL is calculated as 50% of the CAL amount calculated by the formula.
The insurer may be subject to certain action by its regulator, as stated in the statute, based on the ratio of the TAC and the ACL Amount, usually referred to as the RBC ratio. In addition to ACL, the following three other categories of action are defined in the regulation:

- The Company Action Level RBC is 200% of ACL
- The Regulatory Action Level RBC is 150% of ACL
- The Mandatory Control Level RBC is 70% of ACL.

A description of the actions that can be taken by the regulator is included in Appendix E.
The profile section for each of the insurers in this report—see Appendix D—includes data that shows for each year in the 10 year study period the level of surplus, TAC and ACL reported, and the RBC ratio. For each of BCBSM and for all the HMOs included in this study except for Sanford the RBC ratio at year-end 2012 is significantly above the 200% level. The table below indicates the TAC amount, the ACL amount and the RBC ratio at year-end 2012 for each of the HMOs, BCBSM, the insurers, and the CBPs.

Table 15. 2012 Capital and Surplus, ACL Surplus and RBC Ratio

Company	Capital and Surplus	ACL	RBC Ratio
BCBS	$ 827	$ 118	703%
Blue Plus	$ 360	$ 38	942%
Group Health	$ 99	$ 19	527%
HealthPartners, Inc	$ 709	$ 124	573%
HPIC	$ 149	$ 32	468%
Medica	$ 442	$ 57	773%
Medica Ins Co	$ 255	$ 49	516%
MHP	$ 25	$ 5	515%
PrefOne	$ 10	$ 3	357%
PrefOne Ins	$ 30	$ 6	472%
Sanford	$ 1	$ 1	125%
UCare	$ 388	$ 82	476%
IMCare	$ 5	$ 2	216%
PrimeWest	$ 41	$ 7	614%
South Country	$ 18	$ 7	269%

The following charts show the RBC history over the period 2010-2012 of the HMOs, of BCBSM and of the MN insurance company affiliates of HMOs, and of the CBPs.

Chart 9. 2010-12 RBC History, Minnesota HMOs[24]

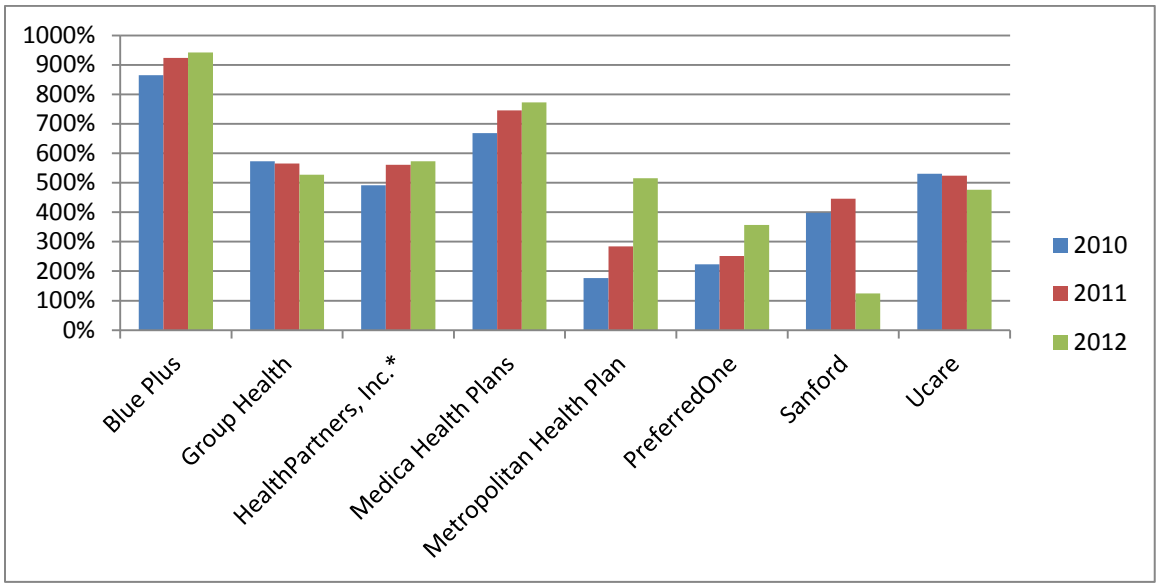
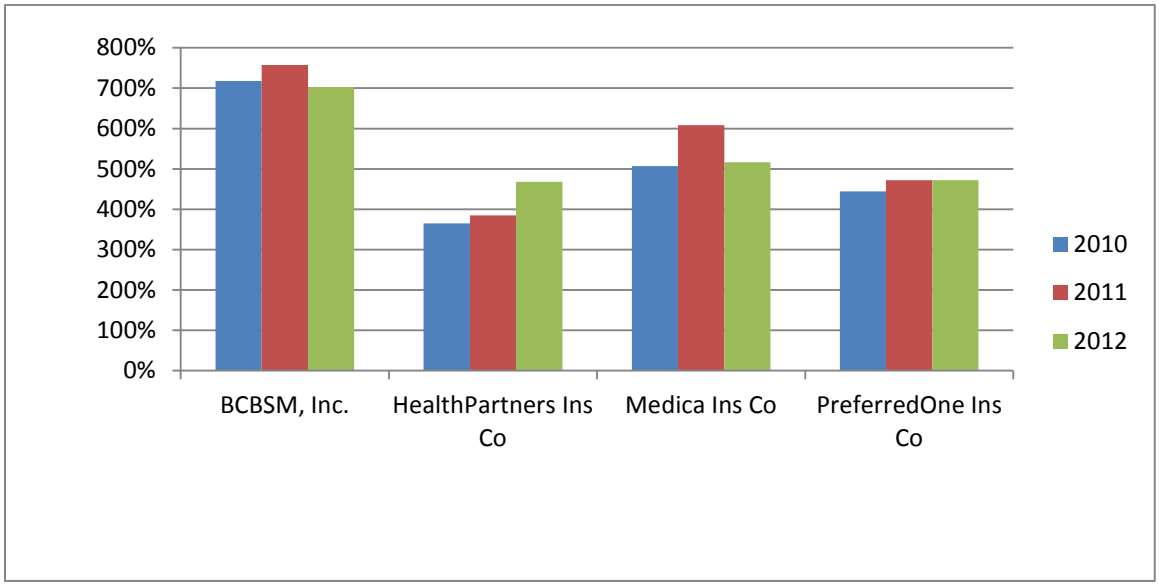
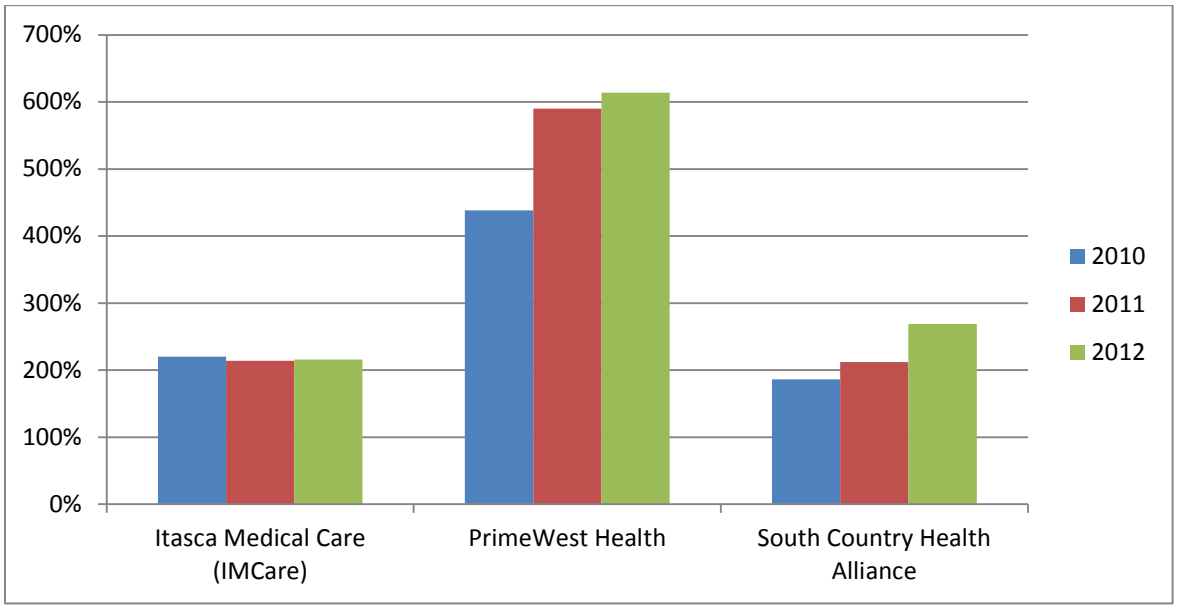


Chart 10. 2010-12 RBC History, BCBSM and MN Insurance Companies [25]



[24] Source – 2010-2012 Annual Financial Statements.
[25] Source – 2010-2012 Annual Financial Statements.

Chart 11. 2010-12 RBC History, Minnesota CBPs [26]



B. Minnesota Capital Reserve Regulation

Minnesota HMOs, like other Minnesota insurers, are currently regulated with regard to statutory surplus under Minnesota Statutes, Section 60A.50 through 60A.592 in the framework of Risk Based Capital (RBC). RBC reporting is prescribed in model National Association of Insurance Commissioners (NAIC) legislation that is incorporated into Minnesota law. Health insurers are required to calculate an RBC ratio each year. The RBC ratio is monitored by the Minnesota Department of Commerce (COMM) for compliance with *minimum standards* of solvency. This method of regulation of insurer capital reserves was implemented in 2004, with application beginning in 2005. Currently there are no upper thresholds in place in Minnesota to regulate upper limits of capital reserves for HMOs, insurance companies, CBPs, or non-profit service corporations.

Minnesota HMOs are regulated under Minnesota Statutes, Section 62D. From 1998 through 2004, the capital reserves of Minnesota HMOs were limited under Minnesota Statutes, Section 62D.042 to a minimum of one month's expenses (claims and administrative expenses) and a maximum of three months' expenses. The introduction of RBC maintained monitoring of minimum solvency under a new framework, but discontinued monitoring of maximum capital reserves. Prior to 1998, the maximum for HMOs under Minnesota Statutes, Section 62D.042 was two months' expenses.

Blue Cross Blue Shield of Minnesota (legally, BCBSM, Inc.) is regulated under Minnesota Statutes, Section 62C. From 1977 through 2004, the capital reserves of BCBSM were limited to a minimum of two months' expenses and a maximum of four months' expenses.

[26] Source – 2010-2012 Annual Financial Statements.

In addition, Minnesota Statutes, Section 62N regulates Community Integrated Service Networks. Prior to the transition to the RBC framework, CBPs who had been licensed under this section of the statutes were subject to a four part test for minimum reserves, and a maximum equal to three times the minimum value. The most relevant part of the test appears to have applied to claims only and not also to administrative expenses, as was the case under the reserve corridors discussed above for HMOs and BCBSM.

The NAIC has developed a model law for an enhanced methodology for solvency monitoring, ORSA. The affected health organizations will be health insurance companies with at least $500 million in annual revenues, or health insurance holding company groups with total insurance and non-insurance revenue of at least $1 billion. Based on current premium volumes, this would appear to affect the BCBSM/Blue Plus organization, the HealthPartners group, the Medica group, and UCare. This will be an intensive technological and management challenge for companies, for regulators, and for rating agencies. It appears likely that it will result in a higher level of what might be considered minimum capital than the 200% RBC Company Action Level, but it is not initially intended to determine a maximum capital limit. This is not a replacement of RBC regulation, but instead another layer of solvency monitoring. The requirements are intended to apply beginning in 2015. Minnesota has not as yet passed the model statute.

As mentioned above, until 2004, Minnesota law set minimum and maximum requirements for health plan reserves. HMOs were required to maintain one to three months of expenses in reserves and Blue Cross was required to hold two to four months of expenses.[27] Representatives of UCare said that if this cap were in place in 2010, it would be equivalent to 670% of risk based capital. Representatives of HealthPartners said that for them it would be equivalent to 720% of risk based capital.[28] In 2005, regulators adopted the NAIC Model Health Risk-Based Capital Act. Since the Model Act does not include standards around upper limits on reserves or surpluses, there are no upper limits on reserves in place for Minnesota.

While there has not been formal legislation, Minnesota carriers have on occasion returned some “excess surplus” back to the state. These returns have taken in a variety of forms. In 2011, UCare presented the state with $30 million to contribute to Minnesota’s $5 billion projected budget deficit. Following this contribution, Governor Dayton signed an Executive Order requiring regular audits and full public disclosure of profits, reserves, and administrative expenses of the managed care plans. It has been suggested that the Administration may ask carriers to return funds to taxpayers if plans are holding

[27] “State Eyes HMO Reserves To Help Balance Budget,” CBS Minnesota, March 21, 2011 (http://minnesota.cbslocal.com/2011/03/21/state-eyes-hmo-reserves-to-help-balance-budget/)
[28] Christopher Snowbeck, “HMO cash cushions at issue in Minnesota Legislature,” St. Paul Pioneer Press, March 10, 2012 (http://www.twincities.com/localnews/ci_20141316/minnesota-health-care-hmo-cash-cushions-at-issue)

excess reserves.[29] In 2003, Medica returned $80 million to its members including $19 million to the state treasury.[30]

There is no Minnesota requirement for community benefits contributions. In 2008, the Minnesota Department of Health (MDH) performed a study related to community benefits provided by nonprofit health plans.

C. Reserves regulation other states

Due to rising health care costs and substantial annual premium increases, there has been significant focus across the country over the past decade on health insurer excess reserves (surplus). There are several states that have commissioned studies on excess surplus and introduced and/or passed legislation on this topic. However, to date, there is very little consistency on how each of these states approaches the regulation of excess surplus, or whether states actually take advantage of existing authority. On the opposite end of the spectrum, there largely is consistency on establishing a minimum level of reserves.

In 1998, the NAIC promulgated the Risk Based Capital for Health Organizations Model Act, which developed minimum surplus requirements associated with each carrier's risk and operational profile. Since then more than 30 states have adopted some form of minimum requirements.[31] Health plan companies hold surplus or reserves to ensure insurer solvency in the case of unforeseen events such as a pandemic or policy or other business risks ("solvency protection"). For this reason, most states have focused on developing safeguards against the insolvency of insurance plans by establishing a minimum-threshold capital reserve framework. In addition, Blue Cross affiliates must meet the higher requirements of the Blue Cross Blue Shield Association (BCBSA).

Prescribing a maximum level of capital reserves has been seen to a limited extent across the U.S., (perhaps among other reasons) because of (1) the lack of existing empirical evidence about appropriate levels of capital reserves and (2) the potential for creating unintended consequences from these changes in what in most states are complex health plan markets.

Nevertheless, this section reports on state initiatives and tools available to constrain capital reserves growth. This section starts initially with a report from the Consumer Union that is not state-specific but includes recommendations to states about reserve regulation. In 2010, a report from Consumers Union

[29] Office of Governor Mark Dayton, Dayton Administration Takes on Health Care to Better Serve Taxpayers, http://mn.gov/governor/newsroom/pressreleasedetail.jsp?id=10288 (March 23, 2011)
[30] Bob Von Sternberg and Jackie Crosby, "UCare gives $30 million to help state budget," StarTribune, March 17, 2011 (http://www.startribune.com/politics/statelocal/118084089.html)
[31] Consumers Union, "How Much is Too Much: Have Nonprofit Blue Cross Blue Shield Plans Amassed Excessive Amounts of Surplus?", July 2010 (http://consumersunion.org/pdf/prescriptionforchange.org-surplus_report.pdf)

suggested, based on an analysis of Blue Cross Blue Shield Plans, that states should regulate health insurer excess reserves using three approaches.

- States should establish minimum and maximum ranges of surplus,
- States should analyze surplus as part of their review process for rate increases, and
- If surplus is found to be excessive, insurers should hold the excess in a rate stabilization reserve designed to offset rate increases, refund to policyholders, or spend the money for charitable purposes consistent with their health care mission such as community health programs.[32]

The report found that some financially strong BCBS plans with large surpluses (defined here as in excess of approximately 600% RBC) were continuing to seek double-digit rate increases. The study found that 7 out of 10 plans examined held more than three times the amount of surplus that regulators consider to the minimum needed for solvency protection. The report characterized the minimum surplus level needed to be equivalent to 200% RBC, the Company Action Level.

Generally speaking, effort by other states to regulate capital reserves through a form of upper threshold do not follow such an explicit guidance, they fall instead into the following categories:

1. Maximum surplus defined for rate review
2. Surplus considered in rate review
3. Maximum surplus defined with excess returned to policyholders or community benefits
4. Surplus review with excess returned to policyholders or community benefits
5. Combination approach
6. Community benefit in other state policies

1. Maximum surplus defined for rate review

In this category, states have defined surplus ranges or have defined a maximum level of surplus. Some states have developed ranges that are specific to each carrier and others have not. Since risk varies significantly by the type of carrier, the complexity and its size, there are many who believe that maximum surplus requirements should vary by carrier. If an insurer goes above the maximum surplus level, some states have the authority to reject a request for a rate increase. Others have the authority to disallow the contribution to reserve (surplus) charge in the premium rates. Insurers build a contribution to reserve (surplus) charge in the premium rates to build up their reserves for insolvency protection. Finally other states have the authority to negotiate lower premiums upon review of the surplus. Based on our research, we would include the states of Maryland, Massachusetts, North Carolina, Pennsylvania, Rhode Island, and Washington in this category.

Since the passage of Chapter 288, the Acts of 2010, the state of Massachusetts limits the contribution to surplus charge for carriers that have a RBC ratio of 300% or greater. The state limits the charge to be

[32] Id.

included in premium rates to 1.9%. For carriers that have an RBC level below 300%, the state allows a contribution to surplus charge of 2.5%.[33]

Over the past few years, **Washington's** Insurance Commissioner Mike Kreidler has tried to pass legislation that would allow him to consider a nonprofit health insurer's surplus when approving a rate increase. This was prompted by the focus on Washington's three largest insurers, Premera Blue Cross, Regence Blue Shield, and Group Health Cooperative, all nonprofit insurers. These insurers' surplus positions have increased over the past 10 years with Regence approaching $1 billion.[34] While these insurers' surplus positions have been increasing, rates for the individual and the small group market have been increasing as well. Over the past 6 years, premiums have increased over 200%.[35]

Opponents of the bill have suggested that health insurance reserves are fragile and a deterioration of the stock and bond markets or a natural disaster could lower reserves significantly. In addition, with the uncertainty of the impact of the Affordable Care Act (ACA), there is an additional need for reserves.[36] Ultimately, the bill did not pass and the Commissioner is not pursuing it, as the Insurance Department is focusing on implementation of the ACA this year.

Washington's proposed bill required the Commissioner to determine whether a carrier's surplus exceeded the three-month average claims expense for each individual and small group rate filing. If it did, the insurer had to submit the following information:

- The net underwriting gain for the past three calendar years. This gain must include investment income.
- Comparison of underwriting gain to prior projections of contribution to surplus and contingency reserves, or risk charges ("contribution"), that were submitted in the proposed rate filings for the past three years.

If the total actual net underwriting gain is greater than the proposed "contribution" the commissioner must disallow the rate unless the insurer takes two actions:

- Reduces the rate by the three year averaged difference between the actual gain and the proposed "contribution," and
- Reduces the "contribution" to zero.

[33] The 188th General Court of the Commonwealth of Massachusetts, Acts of 2010, Chapter 288, https://malegislature.gov/Laws/SessionLaws/Acts/2010/Chapter288 (August 10, 2010)
[34] Washington State Office of the Insurance Commissioner, Nonprofit health insurers' surpluses, http://www.insurance.wa.gov/laws-rules/legislation-rules/legislation/non-profit-health-surplus/ (August 26, 2013)
[35] Carol M. Ostrom, "3 big health insurers stockpile $2.4 billion as rates keep rising," The Seattle Times Company, February 8, 2012 (http://seattletimes.com/html/localnews/2017460805_surplus09m.html)
[36] Roger Stark, "Insurance Commissioner Proposal Would Weaken Insurance Carriers by Lowering their Financial, Reserves,", Washington Policy Center, January 2012 (http://www.washingtonpolicy.org/publications/legislative/insurance-commissioner-proposal-would-weaken-insurance-carriers-lowering-th)

If the gain is equal to the proposed "contribution", the commissioner must disallow the rate unless the carrier reduces the "contribution" to zero. Finally, if a carrier does not have a three-year history and the surplus is greater than the three-month average claims expense, the carrier may not propose a "contribution" in its rates.[37]

Rhode Island's Health Reform Act of 2004 required an assessment of surplus levels of three health plans in the market, Blue Cross Blue Shield of Rhode Island (BCBSRI), UnitedHealthcare of New England (UHCNE), and Neighborhood Health Plan of Rhode Island (NHP). The Lewin Group was engaged to perform this analysis. The Lewin Group relied on SAPOR and created specific target ranges for each of the three carriers. For BCBSRI, the target range was 23-31%, UHCNE 23-28%, and NHP 20-25%. These ranges were set based on company specific analysis of risk factors and of surplus history, with a statistical model designed to develop a level of surplus that would have a 90-95% probability of maintaining solvency over a three-to-seven year adverse underwriting cycle. Rhode Island's Office of the Health Insurance Commissioner (OHIC) has the authority to approve rates and has used these target ranges as guideposts in their rate review process, although the process is not prescriptive. If a carrier's surplus levels are below the target, OHIC may approve higher contributions to surplus, and if they are above the target, OHIC may permit only lower contributions to surplus. There are no official regulations or bulletins and the inclusion of surplus levels as a part of rate review is an informal process. OHIC formally refers to the Lewin Report when finalizing rate decisions in which the surplus levels of an insurer may have been a consideration. This generally allows the report to remain visible.[38]

Maryland also reviews RBC ratios in the context of defined ranges as part of their rate review process. In January 2010, the Maryland Insurance Commissioner established surplus ranges for CareFirst of Maryland Inc. (CFMI) and Group Hospitalization and Medical Services Inc. (GHMSI). These are CareFirst BlueCross BlueShield's (CareFirst) largest companies. The target ranges were developed after a study of CareFirst's surplus was performed. The ranges were 825% to 1075% RBC for CMFI and 700% to 950%

[37] Senate Bill 5247, State of Washington, 62nd Legislature, 2011 Regular Session

[38] The Lewin Group, Considerations for Appropriate Surplus Accumulation in the Rhode Island Health Insurance Market As It Relates to: Blue Cross Blue Shield of Rhode Island, http://www.ohic.ri.gov/documents/Insurers/Regulatory%20Actions/2006%20Reserves%20Study/BCBSRI%20Reserves%20Report.pdf, August 11, 2006
The Lewin Group, Considerations for Appropriate Surplus Accumulation in the Rhode Island Health Insurance Market As It Relates to: Neighborhood Health Plan, http://www.ohic.ri.gov/documents/Insurers/Regulatory%20Actions/2006%20Reserves%20Study/NHP%20Reserves%20Report.pdf, August 11, 2006
The Lewin Group, Considerations for Appropriate Surplus Accumulation in the Rhode Island Health Insurance Market As It Relates to: United HealthCare of New England, http://www.ohic.ri.gov/documents/Insurers/Regulatory%20Actions/2006%20Reserves%20Study/UHC%20Reserves%20Report.pdf, August 11, 2006
Interview with Chris Koller, former OHIC Insurance Commissioner

RBC for GHMSI.[39] This study performed by Invotex suggested that regulators review insurer's surplus every three to five years.[40] In 2012, another study was performed to assess an appropriate target range. Three independent studies were performed resulting in new target ranges, 1,050% to 1,350% for CMFI and 1000% to 1,300% for GHMSI. Among some of the reasons cited contributing to the increased target ranges was the short term uncertainty due to the Affordable Care Act.[41] It is our understanding that no carrier has had RBC at the maximum limit as yet.

In 2005, **North Carolina** considered two proposed bills, one of which would cap the surplus for BCBSNC to 650% RBC and the other of which would allow the Commissioner to consider surplus levels in rate review. Neither of these bills passed the legislature. One of the reasons was that North Carolina already specified that surplus equivalent to 3 to 6 months of expenditures (medical and administrative costs) was reasonable. Many thought the 650% number was an arbitrary number and not specific to a company.[42]

2. Surplus considered in rate review

In this category, states have not defined a maximum surplus, however, they have authority to consider surplus as a part of their rate review process. This is an informal and less prescriptive method of regulating excess surplus. It provides the regulator with flexibility in how to incorporate surplus review as part of the rate review process. Based on our research, we would include the states of Colorado, Oregon and Maine in this category.

Oregon enacted provisions in 2009 that allow (not require) regulators to consider the insurer's financial position including but not limited to profitability, surplus, reserves, and investment savings when determining whether small group or individual market rate increases are "reasonable, and not excessive, inadequate, or unfairly discriminatory." In discussions with Oregon's regulators, in recent history a financial review is part of the rate filing review process. However, it is not the determining factor in whether rates are approved or disapproved. Oregon's approach is not prescriptive and allows the regulator flexibility in how to consider an insurer's financial position in rate review. The rate filing and review process is both robust and public. Public comment is solicited and rate reviews generally result in public hearings. In evaluating solvency, Oregon looks to enterprise risk management analysis more than just to RBC.

[39] Maryland Insurance Administration, Insurance Regulator Issues Report Regarding CareFirst Surplus, http://www.mdinsurance.state.md.us/sa/docs/documents/news-center/news-releases/releases2008-2010/carefirstsurplusreport01-10.pdf (January 8, 2010)
[40] Keith L. Martin, "Report deems surplus for CareFirst, subsidiary 'not excessive'," New Horizon Group, Inc., November 5, 2009, (http://ifawebnews.com/2009/11/05/report-deems-surplus-for-carefirst-subsidiary-not-excessive/)
[41] Maryland Insurance Administration, Consent Order Re: CareFirst Targeted Surplus Ranges, http://www.mdinsurance.state.md.us/sa/documents/MIA-2012-09-006-CareFirst.pdf (September 13, 2012)
[42] Ibid and Email Correspondence with Mike Wells, North Carolina Division of Insurance

Colorado's law allows the Department of Regulatory Agencies (DORA) to consider surplus when reviewing rates. The commissioner may disapprove a rate if he considers the rate to be excessive due to excess surplus.[43]

Maine's Insurance Superintendent denied Anthem BCBS Maine profit margin in its proposed rate increase on the grounds that previously accumulated surpluses were sufficient to absorb underwriting losses.[44] However, the approach to surplus and rate review has been inconsistent over the years depending on the identity of the Superintendent. In addition, Maine only has the authority to review and ***approve*** rates for Maine's Individual Market. During the Individual Market rate hearings, Maine's Attorney General will generally cite surplus levels as one of the reasons to lower profit margins in Anthem's rates.[45]

3. Maximum surplus defined with excess returned to policyholders or community benefits

In this category, states have defined surplus ranges or have defined a maximum level of surplus. Some states have developed ranges that are specific to each carrier and others have not. If an insurer's surplus is beyond a maximum level, the state requires the insurer to return the excess to policyholders in the form of rebates or invest in community benefits. Some states require the insurer to develop a plan that outlines how the surplus will be spent down for approval by the state. While there is no standard definition of community benefits, they can generally be thought of as investments in underserved areas.

In our research, there are two states (Michigan and Massachusetts) that define maximum surplus, but do not explicitly require excess surplus to be returned to policyholders or returned in the form of community benefits.

The state of **Michigan** has capped Blue Cross and Blue Shield of Michigan's (BCBSMI) surplus to an RBC ratio of 1000%. If the surplus is greater than the 1000% for 2 consecutive calendar years, BCBSMI must submit a plan to the commissioner to adjust its surplus to a level below the maximum surplus.[46] The plan has never hit this ceiling, and no monitoring has been in place to address potential unintended or adverse consequences of the limitation.

Since the passage of Chapter 288, the Acts of 2010, the state of **Massachusetts** also limits the RBC ratio to 700%. If a carrier exceeds this limit, the Division of Insurance (DOI) is required to hold a public hearing

[43] Colorado General Assembly, Session Laws of Colorado 2013 First Regular Session, 69th General Assembly, House Bill 13-1266, http://tornado.state.co.us/gov_dir/leg_dir/olls/sl2013a/sl_217.htm (May 13, 2013)
[44] Consumers Union, "How Much is Too Much: Have Nonprofit Blue Cross Blue Shield Plans Amassed Excessive Amounts of Surplus?", July 2010 (http://consumersunion.org/pdf/prescriptionforchange.org-surplus_report.pdf)
[45] Conversations with former Maine Bureau of Insurance Actuary
[46] Legislative Council, State of Michigan, THE NONPROFIT HEALTH CARE CORPORATION REFORM ACT, http://www.legislature.mi.gov/(S(oezrfhaixr55h4j2ksrog245))/documents/mcl/pdf/mcl-550-1204a.pdf (July 23, 2003)

within 60 days. The carrier is required to submit testimony on its financial condition and the continued need for additional surplus. The testimony must include how any additional surplus will be used to reduce the cost of health insurance or to be used for health care quality improvement, patient safety, or health cost containment activities. The DOI Is required to review testimony and to issue a report.[47] It is our understanding that no carrier has reached this RBC level, and no monitoring currently exists to address any potential unintended or adverse effects of the limitation.

In our research, there is only one state that truly falls within this category and that is **Pennsylvania**. Pennsylvania is unique in that they are the only state that has defined surplus ranges for their four Blues plans and in addition has defined the required Insurance Department action. These Department actions not only include spending down surplus but also play an integral part in rate review. Since Pennsylvania is unique, we have devoted a separate section of this report to this state.

4. Surplus review with excess returned to policyholders or community benefits

In this category, states do not define a maximum surplus. However, they informally review surplus and informally negotiate a plan with insurers to return excess funds to policyholders or to invest in community benefits. This is the least prescriptive of the categories we have identified. Based on our research, we would include Washington D.C. and Colorado in this category.

In our research we have found states fall in one or more of the categories above. Below we provide a description of the policies within the states reviewed.

In 2008, **Colorado's** Division of Insurance reached a $155 million agreement to reduce surplus with Kaiser. These funds were to be used to provide premium credits and to invest money in underserved parts of the state. Since then the state has been monitoring reserve levels for Kaiser ($666M) and for Rocky Mountain HMO ($110M), however there has been no regulatory activity as of yet.[48]

In 2008, **Washington D.C.** passed the Medical Insurance Empowerment Amendment Act which requires the Commissioner for the Department of Insurance, Securities, and Banking (DISB) to determine whether surplus of a hospital and medical services corporation is excessive. In addition, it required the Commissioner to order the corporation to reduce excessive surplus through community health reinvestment.[49] In 2009, DISB held a two-day hearing to rule whether a subsidiary of CareFirst (Group Hospitalization and Medical Services Inc., GHMSI) had excessive surplus. If DISB found the reserves to be "unreasonably large," GHMSI would have been required to submit a plan for redistributing the excess

[47] The 188th General Court of the Commonwealth of Massachusetts, Acts of 2010, Chapter 288, https://malegislature.gov/Laws/SessionLaws/Acts/2010/Chapter288 (August 10, 2010)
[48] Michael Booth, "Insurers' enormous cash surpluses prompt calls for rebates or community spending," The Denver Post, March 13, 2011 (http://www.denverpost.com/ci_17603819)
[49] Government of the District of Columbia, Fiscal Impact Statement: "Medical Insurance Empowerment Amendment Act of 2008", http://app.cfo.dc.gov/services/fiscal_impact/pdf/spring09/FINAL-%20B17-934,%20Medical%20Insurance%20Empowerment%20Amendment%20Act%20of%202008.pdf (December 8, 2008)

funds.[50] In 2010, then Commissioner, Gennet Purcell found CareFirst's reserve level to fall within an appropriate range. However, CareFirst's surplus has still been a focus as their reserves have increased 40% from 2008 to 2011. [51]

5. Combination approach

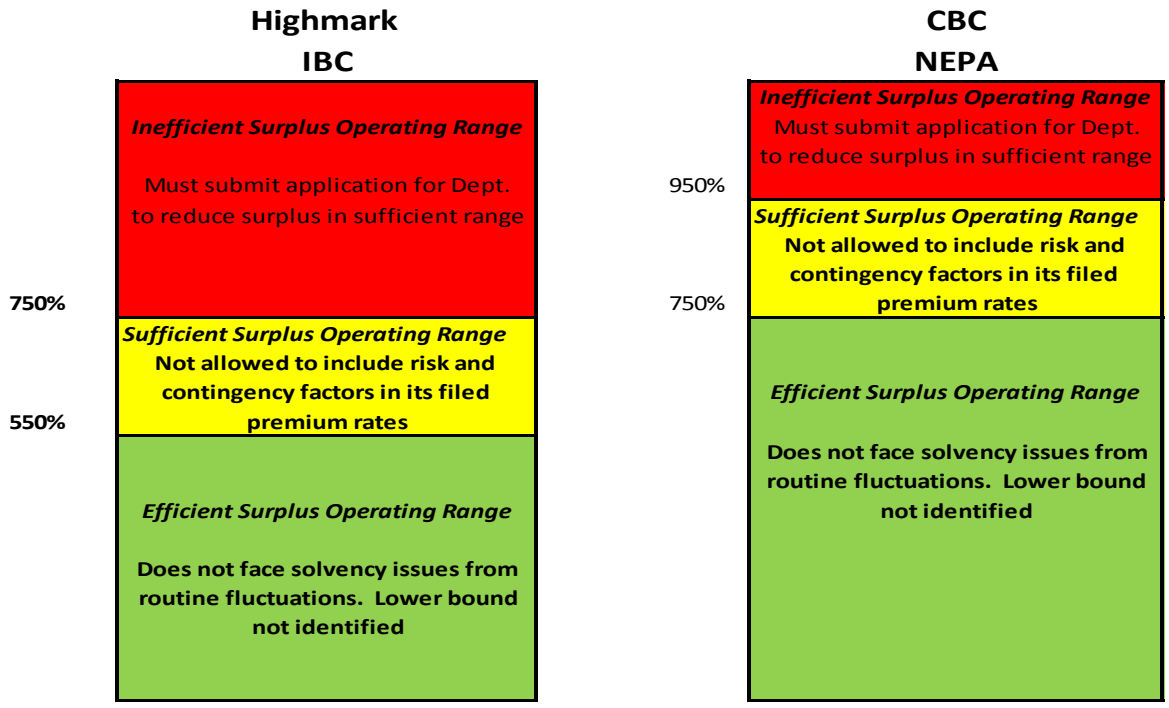
As described earlier, **Pennsylvania** is unique in that its regulation of insurer surplus is much more prescriptive than other states. Pennsylvania could fit into three of the four categories of policy as described above. The Pennsylvania Insurance Department (PID) began investigating reserve levels of their four Blue Plans in 2002. In 2004, PID requested applications from the Blue Plans requiring them to justify their surpluses and explain how contributions were made to the community.[52] In 2005, the PID completed its analysis of the reserve and surplus applications for the four Blue Cross Blue Shield health insurance plans--Capital Blue Cross (CBC), Highmark Inc, Blue Cross of Northeastern Pennsylvania (NEPA), and Independence Blue Cross (IBC).

Using a combination of RBC, Consolidated Risk Factor Ratios (a probabilistic measure developed by Lewin based on an adjusted RBC), and Underwriting Gains/Losses, Pennsylvania developed operating ranges based on RBC/consolidated RBC ratio for the 4 Blues plans.[53] The operating ranges were specific to each carrier to reflect that one may choose to consider carrier size and complexity when developing maximum levels of surplus. A further description of how Pennsylvania calculated these ranges is found in Appendix C. As shown in the figure below, for Highmark and IBC, if the RBC/consolidated RBC ratio is above 750%, the carriers are considered to have inefficient surplus and are required to develop a plan to reduce surplus. This reduction can be in the form of community benefits, rebates, etc. Here Pennsylvania has not only defined a maximum level of surplus specific to each carrier, it also requires the carrier to reduce its surplus through policyholder rebates or community benefits (Category C). If the RBC/consolidated RBC ratio for Highmark and IBC is between 550% and 750%, the carrier is not allowed to include risk and contingency factors in its filed premium rates. Here, Pennsylvania has defined how premium rates will be impacted if reserves are in a sufficient range (Category A). Finally, if the RBC ratio is below 550%, there is no limitation to premium rates. Pennsylvania has developed a different set of ranges for CBC and NEPA which are higher. These companies are smaller and are exposed to greater risk and therefore the ranges established allow for greater surplus. By developing concrete, objective

[50] Keith L. Martin, "District regulators delay CareFirst reserve decision until end of year," New Horizon Group, Inc., September 24, 2009, (http://ifawebnews.com/2009/09/24/district-regulators-delay-carefirst-reserve-decision-until-end-of-year/)
[51] Ben Fischer, "CareFirst's cash reserves in D.C. surge," Washington Business Journal, March 16, 2012, (http://www.bizjournals.com/washington/print-edition/2012/03/16/carefirsts-cash-reserves-in-dc-surge.html)
[52] The Lewin Group, "Considerations for Regulating Surplus Accumulation and Community Benefit Activities of Pennsylvania's Blue Cross and Blue Shield Plans", http://lbfc.legis.state.pa.us/reports/2005/112.PDF (June 13, 2005)
[53] Pennsylvania Insurance Department, Blue Cross Blue Shield Surplus Determination, http://www.portal.state.pa.us/portal/server.pt/community/industry_activity/9276/blues_reserve_and_surplus_determination/623159

definitions specific to each carrier, Pennsylvania has pulled subjectivity out of the regulation of maximum surplus. Now, with ranges defined, the PID can calculate the RBC/consolidated RBC ratios each year to determine the necessary action.

Chart 12. Pennsylvania Surplus Ranges[54]



Each year since 2006, the Pennsylvania Insurance Department has calculated the lower of either the RBC or the consolidated RBC ratio and has published the resulting operating range on their website. The next table shows the operating range for the four Blues plans since inception. As shown, none of the Blues plans have ever had an inefficient surplus, as defined by Pennsylvania lawmakers. However, two of the Blues plans have generally had a sufficient (middle RBC tier) operating surplus in the past 7 years. This means that these plans could not include risk and contingency factors in their filed rates. Over the past 7 years, NEPA moved from sufficient (in the middle tier of RBC) to efficient (in the lower tier of RBC) and IBC moved from efficient (lower RBC tier) to sufficient (middle RBC tier).

[54] Pennsylvania Insurance Department, Statement of 2011 Surplus Levels for Blue Cross and Blue Shield Plans, http://www.portal.state.pa.us/portal/server.pt/document/1228819/bcbs_surplus_statement_2011_pdf

Table 16. Pennsylvania Surplus Levels by Plan[55]

Annual Statement	2005	2006	2007	2008	2009	2010	2011
Highmark	Sufficient	Sufficient	Sufficient	Sufficient	Sufficient	Sufficient	Sufficient
IBC	Efficient	Efficient	Efficient	Efficient	Efficient	Sufficient	Sufficient
CBC	Sufficient	Sufficient	Sufficient	Sufficient	Efficient	Sufficient	Sufficient
NEPA	Sufficient	Sufficient	Sufficient	Efficient	Efficient	Efficient	Efficient

In addition to developing operating ranges, the PID also released a document "Agreement on Community Health Reinvestment," requiring the four Blue plans to pledge approximately 1% of their premium revenue to community benefits from 2005-2010. Sixty percent of the funding was for the adultBasic program, and the remainder to other community benefits as approved by the Insurance Commissioner. The other 40% of the funds were used for community benefits such as the following:

- Non Group premium subsidies
- Funding of Blue Ribbon Foundation
- Support of the Children's Health Insurance Program (CHIP)
- Donations to community clinics serving the uninsured
- Scholarships to nursing education programs
- Other State Programs

In this agreement, the PID negotiated an arrangement requiring the Blue Plans to spend down their surplus without really considering the operating range. Not only did Pennsylvania define ranges for rate review and for spending down surplus, they also negotiated additional funds to be invested in community benefits. (Category 4)

6. Community benefit in other state policies

A few of the states that we reviewed did include policies that required carriers to return "excess surplus" in the form of community benefits. Many feel that nonprofit institutions, hospitals, and HMOs, including in Minnesota, have a financial obligation to provide benefits to communities that are equivalent to their tax-exempt status. While in our research we have not found a universally accepted definition of community benefit in the health insurance context, we believe the conceptual framework

[55] Pennsylvania Insurance Department, Statements of Surplus Levels for Blue Cross Blue Shield Plans, 2005 through 2011, http://www.portal.state.pa.us/portal/server.pt/community/industry_activity/9276/blues_reserve_and_surplus_determination/623159

developed for hospitals may provide useful context.[56] The following table, developed by Lewin, presents an alternative to help with the definition of community benefits.[57]

Table 17. Community Benefit Practices

Category	Community Benefit Practices
Direct Charitable Giving	* Cash Donations to not-for-profit organizations that help fill unmet health needs in the health plan's service area * Value of employees' company-paid time offered in support of the same causes
Safety net health coverage	*Offering of coverage to individuals other insurers will not accept, or price fairly * Subsidized premiums for individual and small-group coverage * Contributions to charity care pools
Participation in public programs	*Contracting with public payer entities to enroll their beneficiaries (e.e. Medicaid, CHIP, Medicare, special state/local coverage programs)
Knowledge dissemination and research	* Health Education or health promotion activities * Conduct or sponsorship of clinical research or health services research

Some states have community benefit reporting requirements such as Massachusetts, Connecticut and Minnesota. However, none of these states require community benefit activities. The Office of the Attorney General in Massachusetts has developed voluntary Community Benefits Guidelines for the state's HMOs. These guidelines were developed in 1996 and then revised in 2009. These Guidelines have the following guiding principles.

> "A. The governing body of each HMO should affirm and make public a Community Benefits Mission Statement, setting forth its formal commitment to provide resources to and support the implementation of its annual Community Benefits Plan.
>
> B. The HMO should demonstrate its support for its Community Benefits Plan at the highest levels of the organization. The hospital's governing board and senior management should be responsible for overseeing the development and implementation of the Community Benefits Plan including designating the programs or activities to be included in the plan, allocating the resources, and ensuring its regular evaluation.
>
> C. The HMO should ensure regular involvement of the community, including that of the representatives of the targeted underserved populations, in the planning and implementation of the Community Benefits Plan.

[56] See for example: The Hilltop Institute, "Hospital Community Benefit after the ACA: The Emerging Federal Framework," Issue Brief, January 2011

[57] The Lewin Group, "Considerations for Regulating Surplus Accumulation and Community Benefit Activities of Pennsylvania's Blue Cross and Blue Shield Plans", http://lbfc.legis.state.pa.us/reports/2005/112.PDF (June 13, 2005)

D. To develop its Mission Statement and Community Benefits Plan, the HMO should conduct a Community Health Needs Assessment, a comprehensive review of unmet health needs of the community by analyzing community input, available public health data and an inventory of existing programs.

E. The HMO should include in its Community Benefits Plan the Target Populations it wishes to support, specific programs or activities that attend to the needs identified in the Community Health Needs Assessment and, measurable short and long-term goals for each program or activity.

F. Each HMO should submit an annual Community Benefits Report to the Attorney General's Office which details 1) the process of developing its Community Benefit Plan; 2) information on community benefit programs, including program goals and measured outcomes; and 3) Community Benefits Expenditures. The hospital shall make the report available to the public."

In addition, the guidelines have identified state-wide priorities that HMOs and hospitals should consider when they are developing their community benefit plans. These priorities include:

- Supporting Health Care Reform: The Attorney General recommends a focus on the uninsured as well as those who are burdened with medical debt.
- Chronic Disease Management in Disadvantaged Population: The Attorney General recommends HMOs to consider developing programs that improve the management of chronic diseases (i.e. diabetes, obesity, and asthma) in vulnerable populations.
- Reducing Health Disparities: The Attorney General recommends that programs are developed to reduce racial and ethnic health disparities.
- Promoting Wellness of Vulnerable Populations: The Attorney General recommends that programs promote health and wellness of particular vulnerable populations with unmet needs in their service areas.[58]

In Fiscal Year 2012, six Massachusetts HMOs provided more than $161 Million in community benefits, of which $124 Million was in the form of health assessments to support the state's Health Safety Net which pays for the care of Massachusetts' uninsured and underinsured. [59] One of the goals of those states that do have reporting requirements is to improve the transparency in community benefits.

There are states that do require community benefit contributions. For example, Maryland does apply a "public service requirement" to CareFirst Blue Cross Blue Shield which includes directing funds equal to

[58] Massachusetts Attorney General, The Attorney General's Community Benefits Guidelines for HMOs, http://www.mass.gov/ago/docs/healthcare/hmo-guidelines.pdf

[59] Massachusetts Attorney General, $161 Million Provided in Community Benefits by Nonprofit HMOs According to Reports Filed with AG Coakley's Office, http://www.mass.gov/ago/news-and-updates/press-releases/2013/2013-07-31-hmo-community-benefits.html (July 31, 2013)

the value of the premium tax toward the public interest. As described above, the Insurance Departments of Pennsylvania and Colorado have required carriers to contribute to community benefits in the past. In addition, Pennsylvania and the District of Columbia formally require carriers to spend down excess reserve in the form of community benefits or rebates.

In Minnesota, there have not traditionally been requirements for delivering certain community benefit or reporting on the volume of community benefit provided. Instead, the state had in place a variety of mechanisms by which HMOs and BCBSMN would communicate how health plan companies deliver services (action plans) and partner to meet public health goals for communities they serve (collaboration plans). In its current form, these carriers, through their trade association, meet the requirement for delivering collaboration plans under Minnesota Statutes, Section 62Q.075 through delivery of plans to the Commissioner of Health every five years.[60]

In summary, there is a great deal of variability in state policy concerning excess reserves or surplus. We have summarized these policies in the states we reviewed in the table Surplus Review Criteria by State contained in Appendix C.

D. Discussion of state policies

It is difficult to quantify the effectiveness of these policies on rate review. States that have the greatest flexibility in considering surplus levels are those where the maximum surplus levels and specific rate actions are not defined. However, because the regulatory framework is not rigid, the regulator is not compelled to take action. In addition, the flexibility causes policies to be more subjective in nature and the resulting outcomes can vary based on "who is in charge" at the time.

States that define maximum levels but not the prescribed rate action in the event a maximum level is crossed can still create some framework, which requires the regulator to take some action if the carrier's surplus levels are greater than the maximum. By defining a maximum surplus, the regulator is provided a leveraging tool to assist with rate negotiations. However, since the rate action is not defined, this type of policy will also be subjective in nature, and there will be some inconsistency on how policies are implemented. In addition, if maximum surplus levels are set too high, then the policy may not be as effective.

Finally, those states that define maximum surplus levels and also define specific rate actions in the form of reductions in profit margins or contributions to reserve have the least flexibility in how the policy is implemented. Once a carrier has reached a maximum surplus level the rate action is already determined. In these cases, the regulator relies more on policy implementation rather than a subjective review of surplus and rates. In these instances, carriers may apply conservative assumptions in their rate

[60] http://www.health.state.mn.us/divs/opi/pm/collaborationplans/

development to counteract the required reduction in profit margins or contribution to reserve charges. This results in a minimal impact to premium rates and perhaps an ineffective policy.

From our review of the states, it appears that the most effective policy regarding excess surplus and rate review would strike a balance between flexibility and a rigid regulatory framework. This may include defining maximum levels and allowing for a range of specific rate actions. In addition, it also appears that more effective policies include maximum reserve levels that are specific to the carrier's own risk profile. Taking a one size fits all approach may lead to too high or too low a surplus level for certain carriers in the market.

Colorado has required excess surplus to be "spent down" in the form of policyholder rebates or community benefits. In 2008, Colorado required Kaiser to pay rebates to policyholders due to excess surplus. The rebates, which were a one-time premium reduction, were approximately $287 annually or $24 monthly.[61] This type of policy may provide premium relief but it is temporary and may not be a significant premium reduction. Other states require carriers to invest in community benefits. However, if community benefits are not defined, this can cause inconsistencies in how a policy is implemented.

As discussed in the section on Minnesota surplus regulation history, Minnesota has previously operated with elements of approach 3, above. Until 2004, there was a defined maximum level of surplus, and there were situations in which excess amounts were returned to the state or to other customers. However, Minnesota does not have a history of using surplus levels as part of rate review, and does not currently have a maximum surplus level in place.

[61] Amy Gillentine, "Kaiser deal has more competitors seeing red," Colorado Springs Business Journal, July 4, 2008 (http://csbj.com/2008/07/04/kaiser-deal-has-more-competitors-seeing-red-20093/)

V. Regulatory and Policy Considerations

Before considering the implementation of a maximum reserve limit, it is important to understand the current health care regulatory environment in Minnesota and nationally. What follows is a discussion of major changes, initiatives, and programs:

A. The Patient Protection and Affordable Care Act (ACA)

The Patient Protection and Affordable Care Act (ACA)[62] has changed the environment in which all health plans and insurance companies operate in multiple ways, and many of these changes have yet to be fully implemented. The major changes that impact a discussion of the capital reserve levels for HMOs are as follows:

1. Medicaid expansion

Minnesota has elected to move forward with the expansion of Medicaid allowed under the ACA. This already has increased and will continue to increase the number of people in the state eligible for Medicaid, and it will revise MNCare as well. Medicaid enrolled membership for HMOs and CBPs are likely going to increase since they are the only carriers that participate in MN Medicaid business. Many of these new members are projected to have been previously uninsured; however, there remains to be very little reliable data on the risk profile of the newly covered public program population. Collectively, we will not truly understand the risk profile of these new members until 2016 as there is a lag in data. This uncertainty can place upward pressure on reserve levels especially for a smaller carrier. If these newly insured members are high utilizers of care, the need for a higher level of reserves becomes more apparent.

2. Subsidies for individuals earning up to 400% of the federal poverty level

Individuals and families who are not eligible for Medicaid may be eligible for subsidized coverage through MNsure. This will increase the affordability of coverage for some, and thus increase membership in the commercialindividual market. The same uncertainty that exists for the newly insured under Medicaid expansion also exists here for the individual market. Carriers participating on the Exchange are more vulnerable to risk. In addition, it is unknown how many members a carrier will enroll which also adds to the uncertainty. Early indications are that enrollment, for a variety of reasons, remains low compared to projections, despite comparably low rates of premiums in the state.

[62] Pub.L. 111–148, 124 Stat. 119, codified as amended at scattered sections of the Internal Revenue Code and in 42 U.S.C. and "Public Law 111–148". *111th United States Congress*. Washington, D.C.: United States Government Printing Office. March 23, 2010. Retrieved 2013-12-22

3. Minnesota high risk pool (Minnesota Comprehensive Health Association or MCHA)

Minnesota has maintained for many years the country's largest high risk pool, in which individuals with pre-existing conditions were able to obtain expensive but subsidized coverage. This has been a separate pool with the potential for substantially higher average medical cost than the regular insured population. Under the ACA, this will population will be transitioned gradually into the non-high risk pool until this process is complete with the closing of MCHA at the end of 2014. Unlike the Medicaid expansion and the subsidies for individuals earning less than 400%FPL, the risk profile of the members enrolled in MCHA is at least somewhat known. However, the current membership is not necessarily indicative of which members will sign up, what differences in products they will have, and what claim costs they will experience. Carriers need to account for higher risk members when setting their target reserve levels.

4. Elimination of pre-existing condition exclusions

Individuals who were not in the MN high risk pool or in the federal Pre-existing Conditions Plan but who were unable to purchase coverage previously because of a pre-existing condition should now find themselves with more options for health coverage. This could change the risk profile of the membership of multiple carriers.

5. Product design requirements

The ACA imposes limits on certain product design elements – e.g., deductible levels, annual maximums, the elimination of life-time limits, provision of certain preventive services without cost sharing and out of pocket maximums. Therefore, the differential regulatory environment with respect to product design flexibility between HMOs and insurers has been lessened somewhat.

6. Minimum MLR requirement

Both HMOs and insurers are now required to refund premiums to members if their MLR is below 80% for individual or small group insurance, or 85% for large group health insurance. This means that if the cost of medical care is less than 80 or 85% of the total premium, members receive a rebate from their carrier. While it should be noted that the 80 and 85% figures include the cost of programs to improve health care quality, which some might argue more properly belongs under administrative expenses, this ratio does mean that carriers can no longer price their products more than 20% above their expected claims cost. This regulation will limit profits and indirectly limit the growth in surplus, even though Minnesota-domiciled carriers have been exposed to limits in the small group and individual markets for a number of years.

7. Federal risk corridor program

The ACA allows for a risk sharing program that places a limit on profits and losses for qualified health plans (QHP). This program will only cover those members that are enrolled through the Exchange within the individual market. This is intended to offset uncertainty and unfavorable risk, but the immediate effect will be that companies will need to adapt to these programs.

8. Accountable Care Organization (ACO) formation

The ACA encourages ACO formation. ACOs are organizations of providers who provide care to members, and assume the associated financial risk of providing care. Medicare Pioneer ACOs and Medicare Shared Savings programs encourage providers to be responsible for the full continuum of care for their patients. As providers develop this capacity for Medicare patients, they are expanding it to other patients as well, which leads to provider interest in accepting risk for other product lines. While the extent of ACO diffusion in Minnesota is not yet well understood, it is clear that experiments in that direction, initially through performance contracts or modest risk-sharing in Medicaid and in the commercial market, point in that general direction.

B. Medicaid bid process

Minnesota recently implemented a bid process for Medical Assistance, Minnesota's Medicaid program. Bids are conducted by the Department of Human Services for Medicaid business for multiple counties each year. Rather than having all HMOs cover members in every county, there is now a maximum of two carriers per county, and in some counties only one HMO will provide coverage. For the counties represented by the CBPs, they are active carriers for public programs. This means that Medicaid membership can fluctuate greatly for any given health plan -- the HMOs we interviewed discussed losing or gaining 20,00 to 30,000 members in a given year.

C. Medicaid payment delays

Minnesota currently withholds 9.5% of certain Medicaid payments to HMOs over the course of the fiscal year. These funds are payable – in whole or in part – the following July. The amount withheld is separated into different pieces:

- A withhold based on performance of 5% of MNCare, PMAP, Minnesota Senior Care Plus (MSC+), and MSHO payments. The withhold occurs each month and 5% of the withheld amount is at risk, payable based on certain specified performance measures, while the other 95% is returned in July of the following year.

- In addition, 4.5% of PMAP, MSC+, and MSHO is withheld each month and returned the following July, while 3% of MNCare is withheld and returned in the same way. These are not performance-based, but represent only a cash flow delay.

In addition, there is a statutory delay in the balance of Medicaid payments, presumably in part to support cash-flow timing for the state. Generally, the June payment is not paid in June, but rather is paid at the same time that the July payment occurs. In 2013 the May payment was also delayed for PMAP, MSHO, and MSC+ and was paid in July. While the delayed payments are admitted assets for statutory accounting, and do not in a technical sense reduce reserves, they represent a significant amount of money that the insurers need to supply themselves to pay claims in the interim. The insurers need to have adequate reserves to pay those claims in advance of receiving the premium.

D. Health plan/provider relationships

While largely limited to performance risk, an increasing acceptance of financial risk by provider groups discussed above is expected to continue. In addition, although they are integrated to different degrees, two carriers – PCHP and HealthPartners – currently have provider organizations within their corporate structure. It is not unreasonable for the trend towards vertical integration to continue in Minnesota's health insurance market. Multiple stakeholders discussed the probability of additional joint ventures between providers and carriers, as well as co-branding opportunities. As risk shifts to providers it would be reasonable to consider how much an insurer would still need in reserves and whether providers should also hold reserves. At the same time, considerations on the provider side about reserving against insurance risk might become relevant.

E. State initiatives concerning rate review

Currently the Department of Commerce (COMM) reviews rates for insurance companies, for BCBSM and for the HMOs. COMM reviews insurance companies by statutory authority and HMOs because MDH has contracted with COMM to do this for them.

The ACA provided funds to eligible states for them to expand and improve their rate review efforts. Minnesota has taken advantage of these funds in a number of ways and as part of it agreed to consider the volume of capital reserves in the rate review process. In addition, MDH, with input from COMM and stakeholders, is developing a study about whether and how to use claims data to inform the State's rate review process.

F. Ongoing studies or audits

There are currently two studies/audits in process in Minnesota dealing with carrier reserves. The Minnesota Legislative Auditor is conducting audits of Medicaid financial results at all Minnesota HMOs.

The Office of the Inspector General at the Centers for Medicare and Medicaid Services (CMS) is also studying financial results, but the details of this study or study focus are not publicly known.

These two efforts follow concerns raised about the level of Medicaid operating results in Minnesota, highlighted in part by an audit by the Segal Company which considered questions regarding the processes and methodologies used to set public program managed care rates for state fiscal years 2003 through 2011.

G. Own Risk and Solvency Assessment (ORSA)

Beginning January 1, 2015 under the NAIC model act for the Own Risk and Solvency Assessment (ORSA), certain health insurance organizations will be required to make and use annual assessments of their risk profiles as part of the Solvency Modernization Initiative. The NAIC model act for ORSA defines it as a confidential internal assessment of the material and relevant risks associated with an insurer's current business plan and the sufficiency of capital resources to support the plan. Management will need to demonstrate that risk management is embedded in their business processes (the Use test).

While the actual timing of the reports is not yet known, health insurers will have to file ORSA summary reports with regulators in their state of domicile each year. The companies will need to build analytical capability to do the modeling and analysis required, and the regulatory effort to understand and monitor the reports will be substantial. These reports will provide important information about how much capital is required of Minnesota HMOs and insurers, and will also provide information that can be used to assess how much capital is enough to support all the obligations and risks of each insurer.

The affected health organizations will be insurance companies with at least $500 million in annual revenues, or insurance holding companies with total insurance and non-insurance revenue of at least $1 billion. Based on current premium volumes, this would appear to affect the BCBSM/Blue Plus organization, the HealthPartners group, the Medica group, and UCare.

This is not a replacement of RBC regulation, but instead another layer of solvency monitoring. It implies an additional level of required capital above the minimum RBC level, reflecting assessment of risks in the following areas:

Table 18. Summary of New Areas of ORSA Risk Assessment

New ORSA Analysis Features	Notes and Examples
Underwriting, including Catastrophic risk	Among the potential considerations would be trend projections under the ACA, in conjunction with downward rate compression and the impact of reinsurance and risk adjustment, non-medical coverage written by affiliated companies, and possible emerging risks, including unlimited lifetime maximums on previously uninsured individuals. RBC already assigns a value to underwriting risk, but that is formulaic. This would be an in-depth analysis of the risks a company has in its business plan.
Market Risk	An example may be the pursuit of higher investment returns to compensate for MLR limitations, with attendant investment risk.
Credit Risk	Including provider related risk with new payment models.
Operational Risk	ACA related risks, computer system failures, problems with feeder systems, other material expenses, expected or unexpected.
Liquidity Risk	Lack of effective external funding, management of Medicaid withholds.
Other “Material” Risks if Identified	Risks related to reputation, litigation, or problems with strategic plan implementation would be some possible examples. Another example would be the "political" risk associated with business changes imposed by legislative or regulatory actions.

Insurers will be expected to use a risk capital metric, which may be a percent of RBC or may be another method. It is expected that they will set a high bar for solvency, with an appropriate confidence level of maintaining the solvency and the rating of the insurer. Informational material provided by the Society of Actuaries suggested levels of 99% confidence or higher.

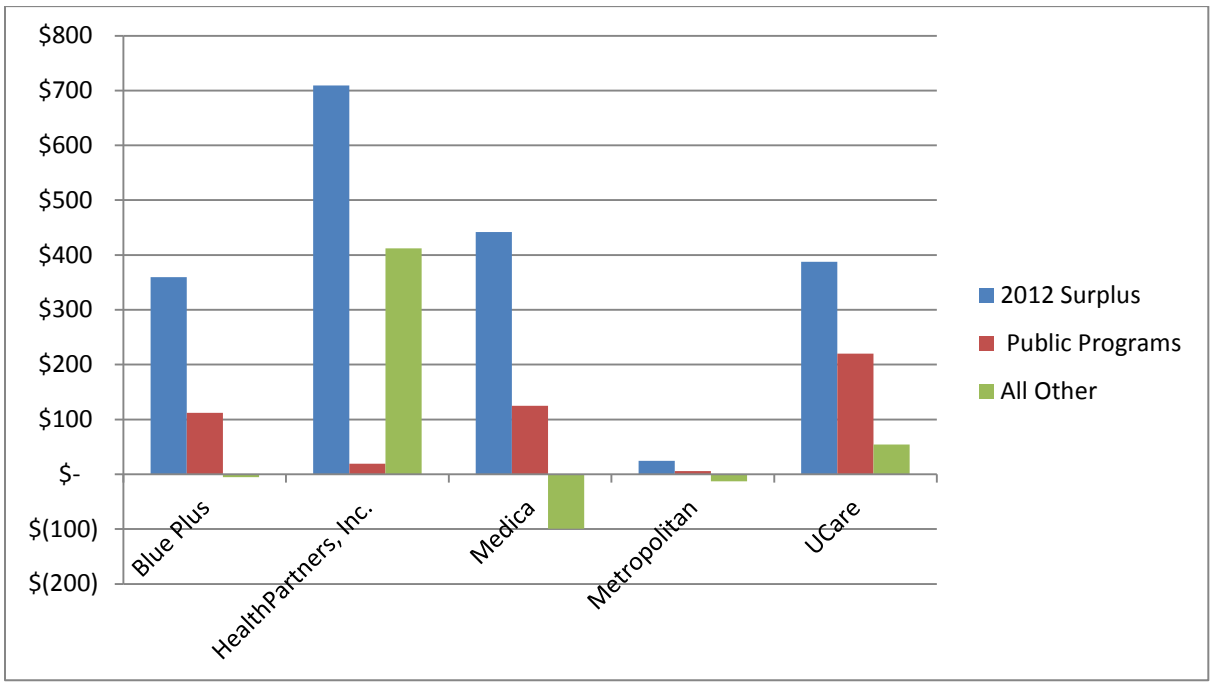
This will be an intensive technological and management challenge for companies, for regulators, and for rating agencies. It appears likely that it will result in a higher level of what might be considered minimum capital than the 200% RBC Company Action Level, but it is not initially intended to determine a maximum capital limit. However, time will tell how ORSA may come to be used. It is possible that it may lead to a scenario where all material risks are accounted for within a certain level of capital, which might then help define the amount of capital that is adequate for solvency. That would allow any free surplus in excess of that amount to be released or used for other purposes.

H. Contribution of public funds to surplus levels

In establishing thresholds for Minnesota HMOs or more generally for the Minnesota health insurance market, there are several additional factors to be considered. The status of HMOs as non-profit entities who do not pay tax may generate an expectation that they will operate efficiently and with relatively moderate reserves. In addition, to the extent reserves are established with profits earned from taxpayer funded programs, it is reasonable to consider whether those reserves should be directed at least in part to taxpayer interests, through a refund, premium subsidy, or other direct benefit. Though once established, insurer reserves operate for the solvency and benefit of all of an insurer's business. Attempting to divide surplus based on the source of earnings that supported its development may be less efficient than maintaining the surplus as an undivided whole. Besides, the insurer is responsible equally for the claims of its insured members.

To examine this issue further, the following chart shows the current levels of capital and surplus and the accumulated profits over the period 2003-2012 for those HMOs active in the public program markets. The profits are shown separately for the public programs, including PMAP, MNCare, MSHO, and SNBC, and for all other business.

Chart 13. Capital and Surplus of MN HMOs, with 10-Year Underwriting Gain History from Public Programs and Other Sources ($000,000)[63]



It appears that net underwriting gains over the last ten years from public programs have made a significant contribution to current levels of capital and surplus at Blue Plus, Medica, and UCare. Gains

[63] Source – 2003-2012 Annual Financial Statements and Minnesota Supplement Forms

from other sources have been most important to capital and surplus levels at HealthPartners, Inc., while of lesser importance at UCare. Blue Plus, Medica, and Metropolitan had net losses from underwriting gains on non-public program sources over the ten-year period. The following table presents the same data in tabular form.

Table 19. Capital and Surplus of MN HMOs, with 10-Year Underwriting Gain History and 10-Year Investment Income History from Public Programs and Other Sources ($000,000)[64][65]

HMO	2012 Surplus	10 Yr Underwriting Gain		10 Yr Inv Income	
		Public Programs	All Other	Public Programs	All Other
Blue Plus	$ 360	$ 112	$ (5)	$ 89	$ 69
HealthPartners, Inc.	$ 560	$ 19	$ 412	$ (3)	$ 118
Medica	$ 442	$ 125	$ (99)	$ 84	$ 127
Metropolitan	$ 25	$ 6	$ (13)	$ 5	$ 0
PreferredOne	$ 10	$ 0	($20)	$ 0	$ 14
Sanford	$ 1	$ 0	($1)	$ 0	$ 0
UCare	$ 388	$ 220	$ 54	$ 66	$ 32
Total	$ 1,785	$ 483	$ 327	$ 241	$ 361

[64] Source – 2003-2012 Annual Financial Statements and Minnesota Supplement Forms

[65] Surplus here excludes the capital reserves of HealthPartners, Inc.'s non-HMO subsidiary HPIC, and includes the consolidated value of the combined business of HealthPartners, Inc. and its HMO subsidiary Group Health.

VI. Discussion of Capital Reserve Threshold Regulation in Minnesota

The Legislature directed MDH to assess methods for establishing upper thresholds on capital reserves in Minnesota and present options for implementing thresholds and potential spend-down requirements for reserves outside the threshold. This section presents considerations addressing the questions:

- Should we have a threshold?
- What considerations exist for *establishing* an upper threshold?
- What considerations exist for *implementing* an upper threshold?

A. Should we have a threshold?

There are a number of considerations when determining whether a threshold limit on capital reserves should be established. Of particular importance is the overall effect of health plan capital reserves on the security and affordability of health care in Minnesota. It is also a desirable goal for Minnesota health plans to have adequate capital reserves to ensure that they will be able to meet regulatory solvency requirements even under a period of potential adverse circumstances, and that they be able to undertake activities that support their mission to deliver quality, affordable health care. On the other hand, the extent to which health care reserves may be funded by public taxpayer money demands scrutiny of the appropriateness of margins on public programs and the build-up of reserves. It is important to consider the role of competition and the role of other regulatory actions that can and have been taken on limiting the build-up of reserves.

1. Considerations that support establishing a threshold

Reserves in HMOs have been substantially funded through tax-payer resources: As shown earlier, an estimated 24.9 percent of the $1.785 billion in 2012 HMO reserves were accumulated through earnings from Minnesota public health insurance programs; investment income allocated to public program product lines accounted for another 11.5 percent. These earnings were generated from valid contracts between the state and HMOs. However, accumulation of these funds originally intended for health care access, in capital reserves may not be an efficient use of public resources. This is particularly the case as further increases in capital reserves will only marginally add to financial solvency. While the policy rationale appears particularly strong with regard to tax-payer funded capital reserves, efficiency concerns also extend to commercial policies funded through private premium payments.

Historically, oversight of and contracting with an industry that is substantially motivated by non-profit principles has not constrained net income growth: Mechanisms such as rate filing, rate review, and contract negotiations have not meaningfully constrained growth in capital reserves over the past 10 years. Profits appear to have exceeded assumptions built into health plan pricing models for HMOs and affiliated insurance companies.

Lack of upper limits on capital reserves reduces pricing transparency for HMOs and affiliated insurance companies and provider organizations: Interdependencies and formal business relationships through service agreements and risk contracts between HMOs and affiliated insurance companies and provider organizations currently provide legal mechanisms to financially subsidize lines of businesses, creating the potential for opaqueness in pricing of health insurance products.

Some levels of insurance uncertainties have been moderated in the Minnesota insurance market over the past ten years, reducing the need for high reserves: Historically, the health insurance business was associated with substantial uncertainties such that pricing estimates were low for some periods, relative to costs, followed by periods of "catching-up" where premiums were high compared to claims costs. This phenomenon, labeled the business cycle, has been moderated in Minnesota over the past decade, presumably indicating that the exposure to some kinds of unanticipated risks has been declining in this market.

After a period of adjustment, changes in the health insurance market will likely further reduce the need for high levels of capital in the health insurance market: Changes in the health insurance market, accelerated by private sector delivery system reforms and provisions of the Affordable Care Act, have the potential to reduce administrative and transaction costs in the health insurance market by reducing the need for underwriting and marketing, as well as risk management (in the individual market). Provided that payment reform in Minnesota continues to mature from performance contracts to risk-sharing contracts, a greater portion of insurance risk will be borne by medical providers.

High and increasing reserves may act as a disincentive to share/transfer risk with medical providers: Many policy makers view payment reform through financial risk sharing between providers and health plans as a critical tool to managing health care cost growth. High and growing reserves can reduce health plan incentives to pursue meaningful risk (and profit) sharing with providers.

Concentrated markets may require lower reserves. The market for health insurance coverage in Minnesota is moderately concentrated, with certain sub-markets (individual or public program coverage) being characterized by higher concentration. In comparison with highly competitive markets, in which many sellers hold smaller shares of the market, moderately concentrated may require lower capital reserves.

2. Considerations that do not support establishing a threshold

The following items suggest that either there should not be an upper threshold on reserves or that any limit should be very high. These items surfaced from our discussions with stakeholders and our financial and policy analysis.

Health plan solvency is a critical public policy concern for regulators, health plan enrollees, and policy makers. Financial solvency and the confidence in it are important factors for health care market

stability, guaranteed access to services for enrollees and financial predictability for providers. Restricting reserves paired with cycles of adverse health experience could challenge a carrier's solvency.

Ordinarily, competitive markets will act as tools to restrain excessive capital reserve growth: Health plans and health plan products that produce greater than normal returns will fall in their level of competitiveness in the market over time, thereby reducing the ability for further reserve accumulation.

Changes to the state's Medicaid program are reducing the potential for consistently high returns from the program: The Medicaid competitive bid process, paired with the movement to establish Medicaid Accountable Care Organizations (Health Care Delivery System Demonstration, or HCDS) have reduced the margins from public programs and thereby the potential for further reserve build-up. In addition, the program has the potential to move a large number of lives from one carrier to another as a result of the competitive bid process, creating new uncertainties and potentially requiring nimbleness in risk management.

Medical Loss Ratio (MLR) limitations of the Affordable Care Act (ACA) may constrain capital reserve growth: The MLR provisions of the ACA, which penalize carriers for not meeting requirements for spending a minimum amount of premium revenue on medical costs (claims expenses), cost containment activities and quality improvement initiatives, are likely to somewhat limit the pace of capital reserve aggregation going forward. This is at least true for carriers with commercial business lines, the lines of business subject to MLR provisions. These provisions potentially also function to constrain the ability of health plans to recover from a reduction in reserves due to health care market or business risk.

For not-profit companies capital reserves are important to their credit rating. Unlike for profit insurance companies, non-profit HMOs cannot access capital markets to raise capital. Instead, they rely on borrowing in the bond market to finance parts of their operations and investments. Maintaining capital reserve levels consistent with bond covenants and lender expectations will help maintain lower cost of borrowing.

As a result of the ACA, there are significant changes occurring over the next few years in the Minnesota health insurance market that are associated with considerable financial uncertainties: In particular, the Medicaid expansion, enrollment of high-risk individuals into non-group insurance products, the evolution of the Minnesota's health insurance exchange with unknown risk profiles, and shifts in enrollment in response to premium rate competition come with uncertainties against which high reserves provide a margin of protection. The unknown degree of effectiveness of risk adjustment and reinsurance mechanisms, particularly for smaller health plans and in the early years, may require financing of operational losses through capital reserves.

Capital reserves represent a source of funding for infrastructure investments: Given numerous changes underway resulting from delivery system reform in Minnesota and implementation of the ACA in the state, health plan companies are in the process of making sizable IT infrastructure investments that are funded from reserves. For the major companies, efforts related to implementing significant changes to the medical classification system that underlies all health care payment transactions (ICD-10), strengthening analytic capabilities to adapt to the changing health care market environment and

meeting new federal reporting requirements under the ACA reportedly add up to nearly $100 million in investments, roughly equivalent to 100 RBC points.

New solvency criteria under development by the NAIC may require higher capital reserves of plans subject to the changes. The NAIC is in the process of modernizing its solvency criteria, including by assessing risks that are currently not fully incorporated in the RBC framework, such as market, credit, operational and liquidity risks. Beginning in 2015, certain large health plan companies (including the four largest Minnesota HMOs and affiliated insurers) will be required to annually complete the Own Risk and Solvency Assessment (ORSA). This is likely to demonstrate capital reserve needs higher than current regulatory floors. While not intended as a framework to assess upper threshold of capital reserves, a comprehensive assessment of risks and the corresponding development of standards for reserves, may implicitly define levels of reserves that are adequate for solvency, so that there may be a better basis for identifying amounts that could be considered unnecessary or excessive. There may be value in assessing the impact of these changes before establishing Minnesota-specific upper thresholds for capital reserves.

B. Questions and considerations for Establishing Upper Thresholds on Capital Reserves

1. What entities should a limit apply to?

Should a limit apply to just HMOs, or should it apply across the market? There were a number of opinions expressed by stakeholders, with a general preference for regulating all entities equally, but there was a range of opinions as to whether a limit for HMOs should be accorded higher, lower or the same limits as insurance companies. In general, our respondents thought any limit should apply equally to HMOs and other insurers to promote fairness in the market. However, some people felt that HMOs may need more capital than insurers, because of difficulty in raising capital by other means.

Some of our most important considerations include:

- Our analysis and discussions with stakeholders suggest that establishing capital reserve limits just on HMOs might imbalance the market by resulting in changes to organizational structures of HMOs and further movement of commercial business from non-profit HMOs to affiliated for-profit insurance companies.
- Further, upper thresholds on capital reserves have the potential to disproportionately affect HMOs ability to make financial investments in infrastructure and market share in Minnesota and beyond, given that, unlike insurance companies, they are not able to raise resources in capital markets.

- On the other hand, because of the significant tax advantages enjoyed by HMOs (and not by insurance companies), HMOs might be better positioned to work under a lower capital reserve limit than other insurance carriers in the state.
- While in the interest of a balanced playing field there may be value in instituting a threshold across the whole health plan market, there are practical and legal challenges related to applying a threshold to non-domestic companies that also underwrite non-health policies. Because capital reserves are maintained for an entire company to cover all product lines across business operations in all markets, reserve thresholds would potentially apply to companies that generate business outside of Minnesota. At the same time, establishing upper limits just on Minnesota-domiciled companies may put them at a disadvantage to non-domestic carriers.

2. How should a limit be expressed?

There was general agreement that RBC is a better measure of capital adequacy than other measures, because it takes into account the entire risk profile of an insurer, including the risk associated with affiliate companies, investment risk, credit risk, and administrative expense and other business risk. Some of the companies continue to monitor months of expenses. This is a traditional measure, and easy to understand. In addition, for most companies there is a relatively stable relationship between RBC and months of expenses, except for some special circumstances Involving one company with a substantial amount of fee-based revenue related to self-insured customers of its hospital subsidiaries, and another company with large assets related to its subsidiaries.

Our detailed considerations included:

- The ratio of capital reserves to the number of months of expenses is a measure that is easily understood by experts and laymen. It is also one that Minnesota carriers are familiar with, given that it was used in the state's previously existing capital reserve corridor, and some carriers continue to monitor their reserves using this measure.
- On the other hand, there seems to be broad agreement that the RBC framework is a better measure of capital reserve adequacy, because it is more successful at taking into account the broad set of risks a health plan company carries, including those posed by affiliated insurers, fee-based income from serving self-insured businesses, and provider affiliation in vertically-integrated organizations. Also, there may be value in further alignment with the RBC framework given the NAIC continuously updates the model to more fully capture financial risk.
- At the same time, for most companies there is a relatively stable relationship between the RBC framework, and months of expenses or SAPOR, the measure considered by some of the other states in the context of reserve regulation, suggesting that the impact of choosing a particular method for expressing capital reserves may be somewhat marginal, as long as structural differences among companies are considered.

3. Can one standard be used across all companies, or are there differences that should be considered?

One standard is relatively easy to understand and administer. Also, once you start making adjustments, it may be hard to stop, and the process could become cumbersome, lack transparency, and become subject to political pressure.

On the other hand, companies have significant differences that may make a single standard appear unfair. It is potentially dangerous to boil down very complex entities to a single number, and then use it to put restrictions on how they manage their business. It risks unfairness, unintended consequences, and perhaps adverse outcomes for Minnesota consumers. The following are some examples of differences, but these are only examples. The differences in business models and risk profiles are quite significant. It should be noted that in those states that have imposed maximum reserve limits, limits have generally been set on a company-specific basis.

For example, HealthPartners, Inc. is a holding company with significant investments (both admitted and non-admitted) in affiliated companies, including an extensive hospital network. HealthPartners, Inc.'s assets from these affiliated companies are not available to pay its HMO health claims, and it might be inappropriate to consider them in setting a limit. Because HealthPartners, Inc.'s assets and RBC include the affiliated entities, the apparent months of expenses represented by HealthPartners, Inc.'s surplus is deceptively high.

Group Health is a staff model HMO with significant hospital assets. Its financial statements include fee-based revenue not related to premium paying insurance. It is likely that this business is self-insured. Group Health Plan's RBC is adjusted to reduce its claims by the amount of this fee based revenue. It would appear appropriate also to remove them in calculating months of claims and expenses, if that were the means of determining a limit.

Company structures are quite different from each other and quite complex. Many companies have substantial investments in insurance and non-insurance affiliates. While those investments have value and are part of a company's net worth, they may not be available to pay claims, and so may not support solvency as well as ordinary invested assets. For example, HealthPartners, Inc. has substantial insurance and health delivery system subsidiaries. The subsidiaries have value, and are included in HealthPartners, Inc.'s financial statements and in its RBC calculation. BCBSM, on the other hand, reports under a Minnesota permitted practice which allows them to exclude the value of their subsidiaries from their financial reports and RBC analysis.

Carriers' corporate structure results and treatment of assets produces variations in the treatment and composition of surplus across the industry. For example, BCBSM has been permitted to pay substantial dividends to its parent, Aware Integrated. These dividends have amounted to $220 million during the last three years. While Aware is also non-profit, the dividends have reduced BCBSM's surplus. Excess

earnings by BCBSM have been passed out of the company and would therefore not be subject to a possible capital reserves limit.

In summary, legislators may wish to consider:

- Smaller companies may experience greater financial volatility and might therefore require higher reserve limits.
- Companies' product mix may also affect the need for differential reserve limits. For example, carriers who only serve public program enrollees in what was historically an actuarially approved "cost plus" environment may require lower capital reserves than carriers who bear underwriting risk in the commercial market or participate in the Department of Human Services' competitive bidding process.
- Health plan companies with a diversity of affiliated businesses on their balance sheets would have to be treated consistently by regulators – for instance the practice of admitted assets would have to be applied more consistently – or more complex firms would require higher reserve limits to protect against more complex risks.
- While segregation of capital reserves -- tracking reserves by distinct product lines separately -- may appear desirable from a policy perspective, because of the additional transparency of the use of public resources, doing so would undermine the actuarial standards related to protecting a company's overall business. In addition, if would be an inefficient use of capital to establish separate surplus lines and likely result in raising overall capital reserve needs.

4. Should a limit be retrospective, resulting in a claw-back of gains made in past years down to a set maximum level, or should it be prospective, resulting in a gradual management down to the maximum level over a period of time?

There would be significant legal barriers to clawing back profits already earned under fair contracts. There was a preference by consumer representatives to claw back, but universal recommendation by insurers that if there is a limit, it should be prospective, and should be managed over at least a two year period.

5. What is an appropriate limit level?

There was a wide variety of opinions. In general, consumer representatives thought that somewhere from 200% to 400% RBC would be appropriate, and that excess surplus should be returned to the customers, or used to promote access to health care.

Insurers generally thought that a limit was not necessary, but that if there was a limit, it should be at least three to four months expenses, which might translate to a range of about 650% to 850% RBC. The county-based purchasers were generally comfortable with a limit in the range of 600%.

In looking at the guidelines observed in other states that have set guidelines for maximum surplus, the upper limits have ranged from a low of 750% to 1000% RBC or more. In very few states is an upper limit actually used in the rate review and approval process and none of the states has an active program of recovering surplus already built up, other than the rate review process.

Actuarial modeling through a Monte Carlo-type approach could provide additional guidance about the level of reserves necessary, for example, to provide a 95% probability of remaining above the Company Action Level RBC (200% RBC) or any other specified level over a period of time. This kind of analysis could be done taking into account past volatility in surplus, but the past may not be predictive of the future because of changes in the market that may have made it less volatile (reduced competition and better data analysis dampening the underwriting cycle); more volatile (changes due to the ACA, other changes in provider payment models, Medicaid bid process); or make it more difficult to build surplus (MLR requirements, for example).

After considering the input of the stakeholders and reviewing the financial results, it appears that a reasonable level might be in the range of 800% RBC or higher. More insight can be obtained into this once the ORSA assessment reports begin to be filed and analyzed.

6. If a capital reserves limit is imposed, and if it results in returns to customers, should a share of excess profits be returned to CMS with regard to those profits generated for Medicare or the Medicare share of dual-eligible state programs?

It seems that such a return might be necessary, if a carrier is found to have excess reserves, and if those excess reserves are determined to be a result of payments made by CMS, and if excess reserves are required to be returned to or for the benefit of other payers.

7. Can surplus be segregated by market segment for the purpose of implementing a limit?

The surplus exists for the protection of all of a company's business, and it would be an inefficient use of capital to set up separate surplus by line of business, as well as being inconsistent with statutory accounting. However, it would be possible to apportion surplus on a surrogate basis, for example, earnings over a period of time, in order to divide any excess amounts on an equitable basis. However, it should be noted that in some cases some lines of business may have generated earnings while others have generated losses. It is not possible to limit reserves generated by earnings in some lines, while not recognizing that the other lines of business need surplus, too, even if there is not a history of earnings on those lines.

8. What should be done with any return of excess surplus?

There was a strong reaction that allowing premium holidays or a similar prospective return through the market would tend to destabilize the market. Medica returned surplus through a one-half month

premium holiday in 2003, and it is still fresh in the mind of the other companies, who felt that it caused business to move. On the other hand, excess surplus funds could be returned retrospectively as rebates to commercial customers, or could be used to reduce state programs premiums. Excess funds could also be directed to community benefits, but many people thought that community benefits are not the primary mission of HMOs, and that deciding which community benefits were appropriate might present a difficult problem.

C. Considerations for implementing upper thresholds

Implementing a capital reserves limit could entail significant regulatory start-up expense and a monitoring effort. In particular, the following considerations might require more and more intensive monitoring:

Time periods: Compliance with upper thresholds should likely be managed over a period of two years to account for potential short-term volatility in financial performance and capital reserve trends introduced by changes to the health plan market place

Oversight: In the interest of fairness between health plan companies, implementation of upper thresholds must be coupled with appropriate oversight over factors potentially affecting capital reserve levels, including IBNR practices, pricing of administrative services arrangements across affiliated businesses, allocation practices of investment income and administrative expenses across affiliated organizations, provider payment policies, and major capital and investment expenses, including investments in affiliated businesses. Finding a balance between appropriate levels of oversight and reasonable levels of administrative burden associated with the policy change will be an important challenge in the implementation.

- **Additional reporting** might be required if a need develops to separate experience between the Medicare and state-based programs. They are not currently reported completely separately. Some of the HMOs report dual eligible programs as Medicare, and some report them as Medicaid, while the CBPS seem to report them on a split basis. If they are to be split, it would be appropriate to modify the Minnesota Health Supplement to collect the required information, some of which may need to be reconstructed historically.

  Also, data should be collected and analyzed to determine whether funds are flowing outside the HMOs to other entities, and to monitor reserve accumulation over time. In particular, regulators may want to review administrative expense agreements to assess whether they provide fair value for the price charged, and may want to review provider payment decisions, particularly where payments to provider subsidiaries in excess of a fair market level may move surplus out of HMOs.

- **Investments in subsidiaries** create particular difficulties. Regulators should work with companies to determine whether investments in subsidiaries are consistent with the mission of HMOs, and to determine whether the current valuations of those subsidiaries as admitted or non-admitted assets represents a fair description of the true net worth of a company. Currently, BCBSM has a permitted practice that allows its subsidiaries to be non-admitted. Other companies, notably HealthPartners, have admitted assets for at least part of their investments in subsidiaries. These investments affect the reported surplus and the RBC ratio, and it will be necessary to have a way of reflecting them that is fair in any surplus monitoring protocol.

- **Conservatism in reported liabilities** may become a more important issue for companies that are close to a surplus maximum level. Determining whether there is excessive conservatism and what the appropriate level of conservatism may be would be difficult. Minnesota could issue a regulation on the acceptable amount of conservatism in IBNR, for example, and monitor compliance as part of its regular financial examinations.

- **Intercompany management agreements** could potentially be a way of moving surplus. It may be necessary to have additional reporting and analysis to ensure that intercompany management agreements are at a fair price. Again, a regulation stipulating that these agreements be set at a fair price, along with monitoring as part of regular financial examinations would bring clarity to this practice. It should be noted that, under minimum MLR requirements, there will be little incentive for over-paying for administrative expense functions.

Modeling the effects of ACA on a company by company basis is a huge undertaking. Obviously, the companies themselves would have to take this on, but it would be appropriate for the state to exercise oversight in the form of collecting reports from the companies detailing the anticipated effects of ACA on their business, particularly if it affects the implementation of a surplus limitation.

Methods of expending excess capital reserves: At this point, health plans and their boards decide how to manage their reserves, including by determining how to spend down earnings not intended as surplus. In interviews, representatives from HMOs and CBPs spoke of strategies currently in place including making community benefit decisions and varying provider payments based on financial performance of the health plan business. In order to prevent unintended consequences resulting from expending excess capital reserves, such as shifts in market share, implementation of upper thresholds will benefit from discussions between regulators, health plan members and health plans, as well as from broad criteria established by the Legislature about permissible uses of capital reserve funding.

VII. Summary

As directed by the Minnesota Legislature, MDH, in consultation with the Minnesota Department of Commerce and Human Services, and with assistance of a team of actuarial consultants, researched a set of questions concerning the implementation of upper thresholds for capital reserves for Minnesota HMOs.

The research, which encompassed analysis of health plan financial data, a study of insurance regulation in Minnesota and in other states, an analysis of available literature on the topic, and interviews with a wide range of stakeholders, concluded that there are numerous considerations in favor of as well as against implementing at this time upper thresholds of capital reserves for Minnesota HMOs.

One of the most significant considerations in favor of implementing an upper threshold for capital reserves is that HMO reserves of $1.785 billion in 2012, which equated between 2.1 months and 3.3 months of expenses, were substantially funded by underwriting earnings (24.9 percent) and investment gains (11.5 percent) from public health care programs. Accumulation of these resources, which were initially intended for health care access, in health plan capital reserves may not represent an effective use of tax-payer funded resources. This appears particularly the case, as these resources as for many HMOs only add marginally to stronger financial solvency.

Most prominent among the considerations that would favor not implementing reserve thresholds at this time are the significant health care market uncertainties over the next few years that are associated with implementation of state and federal reforms in Minnesota and the development of new and expanded solvency criteria (ORSA) by the NAIC. Factors including the Medicaid expansion; the transition of high-risk individuals into the non-group insurance market; the evolution of a Minnesota's health insurance exchange, MNsure; the implementation of risk adjustment mechanisms, re-insurance and risk corridors; the substantial investments in information technology necessitated by health reform provisions; and the payment reform efforts targeted at creating greater shared accountability between providers and payers, have the potential to result in significant financial uncertainties.

Should the Legislature choose to move forward with implementation of upper reserve thresholds at this time, our research indicate that the Legislature may wish to consider the following:

- **Whether to establish limits only for HMOs:** There are tradeoffs between a more narrowly applied limit and a wider one, in that the former would potentially create a competitive disadvantage for HMOs and continue regulatory differences between health insurance providers of different organizational form. The latter option, to apply limits consistently to health plan companies, will be met with considerable practical challenges, related to applying the limit to non-domiciled insurance companies, who hold reserves for books of business exceeding Minnesota.
- **The range of options available to express capital reserve thresholds:** Other than familiarity with the RBC framework, there do not appear to be strong arguments in favor of a single

method of expressing capital reserves. When adjusting for organizational dependencies between carriers, there appear to be relatively stable relationships between all commonly used methods, including months of expenses, RBC, and SAPOR. The advantage of the RBC approach resulting from its relative sophistication in assessing a broad set of risks might be offset by the complexity of the approach, which would not be present by a "month of expenses" framework.

- **Whether more than one standard may be required:** While a single standard would establish simplicity and transparency in regulation, it would at the same time treat companies of different sizes, with substantial organizational variation and diversity in insurance risk alike, possibly resulting in an uneven playing field.
- **Various perspectives on appropriate levels of thresholds:** While there are a number of tools and modeling approaches available and in use to determine appropriate levels of reserves, there is not a single "right" approach. The analysis team received recommendations reaching from establishing reserve levels as low as between 200 percent and 400 percent of RBC to highs of 650 percent to 850 percent of RBC. Given the near-term uncertainties, establishing immediate reserve thresholds below 800 percent of RBC may be not prudent.

Finally, should the Legislature move forward with establishing reserve thresholds at this time, it may wish to consider establishing parameters concerning appropriate oversight, the compliance window, and the process for expending excess reserves.

In the interest of preventing unintended consequences resulting from rapid spend-down of existing reserves and implementing upper thresholds on a level playing field, the Legislature may wish to establish mechanisms to monitor factors that can affect change in reserves, including IBNR practices, pricing of administrative services arrangements between affiliated companies, allocation practices of investment income, provider payment policies, investments in affiliated businesses and major capital expenditure. To avoid volatility in financial reserves and limit administrative burdens in the implementation, compliance with upper thresholds should likely be implemented over at minimum a period of two years, and with clear definitions concerning permissible uses for expending excess capital reserves. The establishment of such permissible uses would likely benefit from further discussions between Legislators, regulators and, importantly, rate payers, including the Department of Human Services and the State Employee Group Insurance Programs.

Should the Legislature conclude that at this time establishing upper thresholds to capital reserves in the health care market are not in the public interest, it still has available a set of tools with which to manage the policy goal of balancing affordable health care premiums with sufficient financial solvency and efficient use of tax-payer funded resources:

- The Department of Human Services under the Dayton Administration has used a number of tools to limit HMO and CBP net income from Minnesota public health care programs, including competitive bidding and the establishment of caps on profits. These tools hold promises for constraining the pace of HMO capital reserve growth.
- Some states authorize health plan regulators to consider capital reserves as one factor when approving premium rate growth. Even in an environment, where the MLR provisions of the ACA

are somewhat likely to constrain health plan premium growth through penalty payments for years where minimum loss ratios (premiums volume spent on claims) targets are not met, considering existing volumes of reserves could help moderate future premium growth. As a grantee of the federal Department of Health and Human Services Rate Review program, the state of Minnesota may have resources available to assess what processes and expertise would need to be developed.

- Minnesota health plans already submit a substantial volume of information to regulators and the Department of Human Services. There may nevertheless be a benefit in greater transparency concerning consistency in allocation mechanisms of administrative expenses and investment income, the uniform allocation of Medicare and Medicaid revenue and expenses to reporting categories, the pricing of business service arrangements with affiliated companies, and changes in provider payment policies.
- Legislative deliberations on future considerations to establish capital reserve thresholds may benefit from periodic reports on IBNR reserve assumptions and statistical (Monte Carlo) modeling of the likelihood of health plan insolvency. Such analysis would be more powerful than the preliminary work conducted for this report, because it would likely capture more volatile periods in 2014 and 2015 associated with health insurance market reforms.
- Future deliberations may also benefit from better understanding how the move of Minnesota's health care market towards greater financial risk sharing between health plan companies and health care providers may result in a shift of health insurance risk that could solvency requirements.
- Finally, the Legislature may wish to require that health plan companies engage rate payers, including plan enrollees and the Department of Human Services, in structured discussions outside of a regulatory framework about appropriate uses of existing capital reserves, including through investments in population health, health and health insurance literacy, and other measurable community benefit activities.

Appendices

Appendix A. Health Plan corporate organizational structure

The following information about holding company organizational structure was obtained from Schedule Y of the Health Plan financial statements.

Blue Plus
HMO Minnesota dba Blue Plus is a not-for profit tax-exempt Minnesota HMO. It is an affiliated company of BCBSM, Inc., which is a taxable non-profit health service corporation, providing indemnity health benefits. Both companies are subsidiaries of Aware Integrated, Inc., a not-for-profit holding company with many other health related subsidiaries, none of which appear to be health insurers, hospitals or provider groups.

Health Partners, Inc.
Health Partners, Inc. is a not-for-profit tax-exempt Minnesota network model HMO, and is also the holding company for an organization which includes insurers, administrators and hospitals and provider groups. Health Partners, Inc. is the parent company for Group Health Plan, Inc., dba Group Health, Inc., a Minnesota not-for-profit tax-exempt staff model HMO, which itself has a subsidiary Physicians Neck and Back Clinics, and a parent relationship to Hudson Hospital, Inc. and Westfields Hospital, Inc., both Wisconsin hospitals. Those hospitals are also shown in the organization chart as being subsidiaries of HPI-Ramsey, which coordinates all the hospitals belonging to the Health Partners subsidiaries. Health Partners, Inc. also has a subsidiary Health Partners Administrators, Inc., which is a third party administrator licensed in 14 states. Health Partners Administrators, Inc. has five subsidiaries, including organizations that provide support staff for medical and dental clinics, and Health Partners Insurance Company, which provides indemnity health insurance plans as well as reinsurance for self-insured plans administered by Health Partners Administrators, Inc. Because of statutory accounting rules, analysis of reserves of Health Partners, Inc. includes the reserves and the RBC authorized control level surplus requirements of its subsidiary health insurers Group Health Plan, Inc. and Health Partners Insurance Company.

Medica Health Plans
Medica Health Plans is a not-for profit tax-exempt Minnesota HMO and a subsidiary of Medica Holding Company. Medica Holding Company also owns Medica Insurance Company, a health insurer offering indemnity health insurance, through another subsidiary, Medica Affiliated Services. Medica Health Plans and Medica Insurance Company are therefore affiliated plans, but do not have an ownership interest relative to each other.

PreferredOne Community Health Plan
PreferredOne Community Health Plan is a not for profit tax-exempt Minnesota HMO, owned by Fairview Health Services, North Memorial Health Care and PreferredOne Physician Associates. PreferredOne Community Health Plan has a reciprocal management agreement with PreferredOne Administrative Services, Inc., which has a 100% wholly owned subsidiary PreferredOne Insurance Company. PreferredOne Community Health Plan and PreferredOne Insurance Company are therefore affiliated companies, but without an ownership increase in each other.

Sanford Health Plan of Minnesota

Sanford Health Plan of Minnesota is a not-for-profit tax-exempt Minnesota HMO that is a subsidiary of Sanford Health, itself a subsidiary of Sanford. Sanford Health Plan of Minnesota is an affiliated company of Sanford Health Plan (South Dakota), which is also a subsidiary of Sanford Health.

UCare Minnesota

UCare Minnesota is a not-for-profit tax-exempt Minnesota HMO. It has a wholly-owned subsidiary company UCare Health, Inc., which is a nonprofit service insurance corporation domiciled in Wisconsin and licensed as a foreign insurer in the State of Minnesota. No other affiliated companies are shown in its organization chart.

Metropolitan Health Plan

Metropolitan Health Plan's financial statements do not include a holding company organizational chart, perhaps because Metropolitan Health Plan does not have affiliated companies.

Gunderson Lutheran

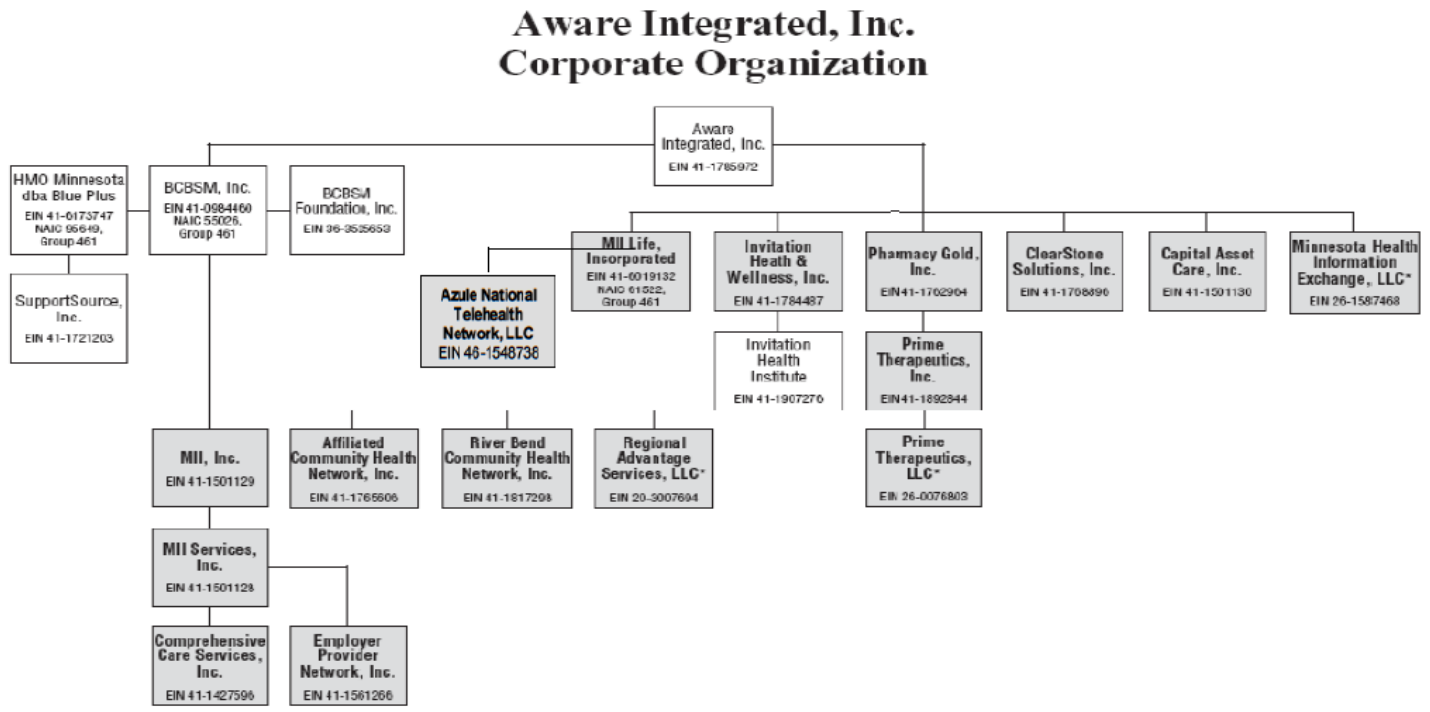
Gunderson Lutheran did not file a 2012 financial statement, because it is new to Minnesota in 2013. No information was gathered about its ownership structure or affiliated companies.

ANNUAL STATEMENT FOR THE YEAR 2012 OF THE HMO Minnesota d/b/a Blue Plus

SCHEDULE Y - INFORMATION CONCERNING ACTIVITIES OF INSURER

MEMBERS OF A HOLDING COMPANY GROUP

PART 1 - ORGANIZATIONAL CHART



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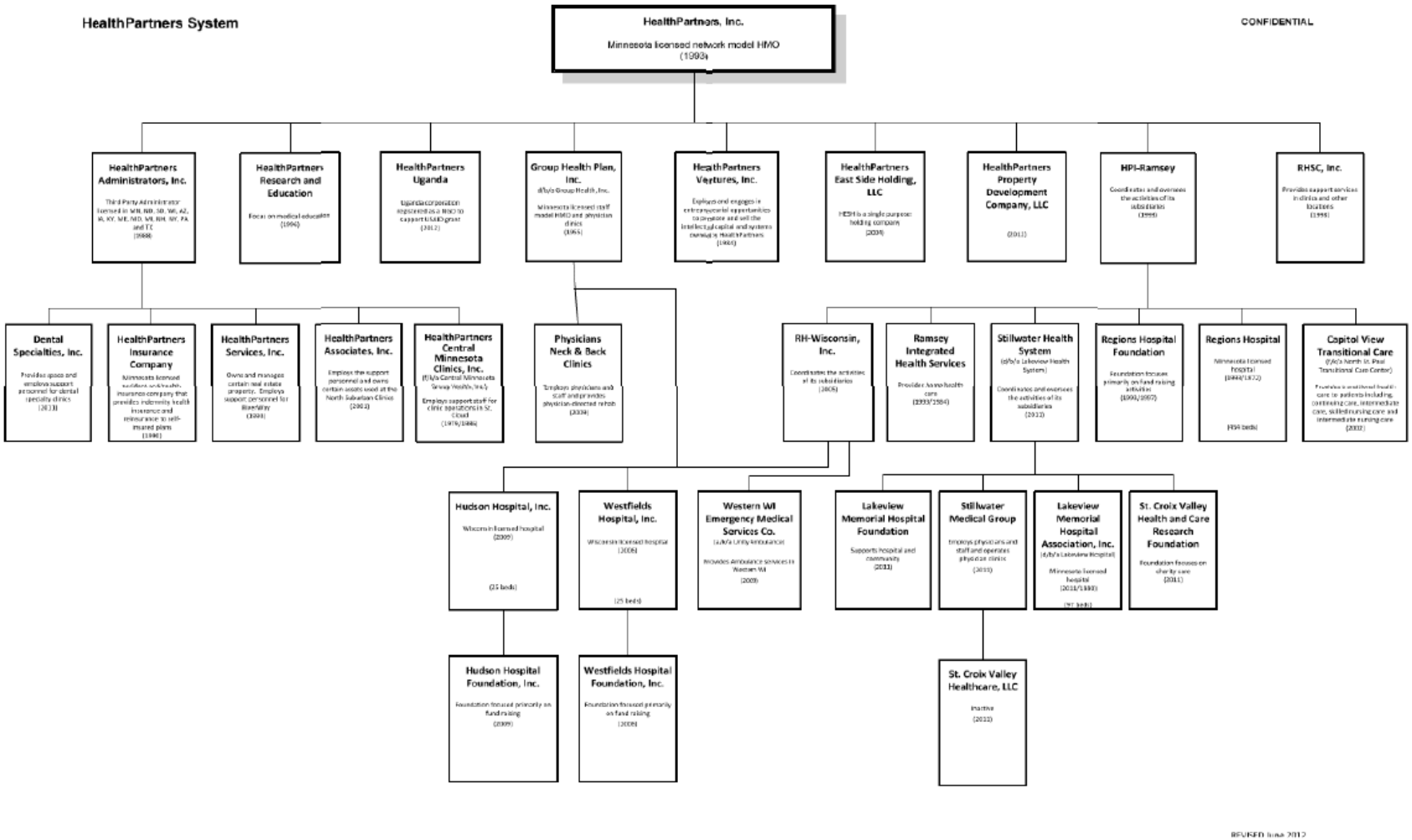
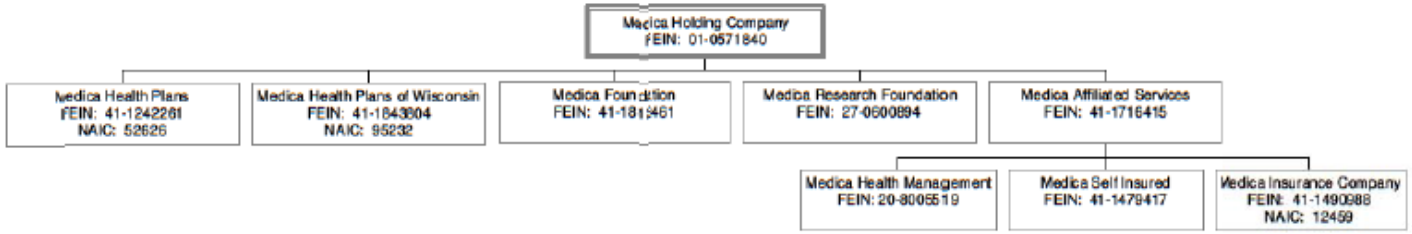
Bolded and Shadowed Entities are For-Profit.
* Minority Ownership Interest

4/2012

ANNUAL STATEMENT FOR THE YEAR 2012 OF THE HealthPartners, Inc.

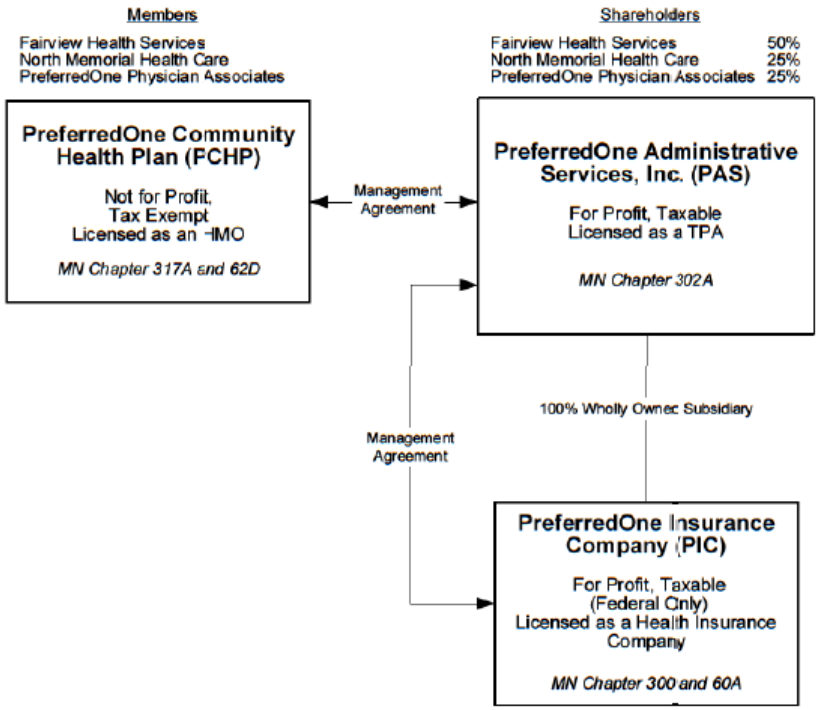


ANNUAL STATEMENT FOR THE YEAR 2012 OF THE Medica Health Plans



ANNUAL STATEMENT FOR THE YEAR 2012 OF THE PreferredOne Community Health Plan

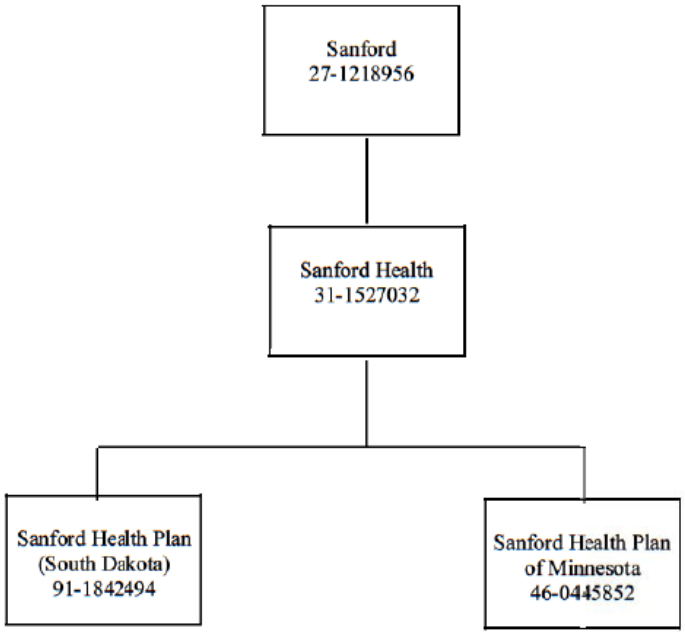
SCHEDULE Y - INFORMATION CONCERNING ACTIVITIES OF INSURER MEMBERS OF A HOLDING COMPANY GROUP
PART 1 - ORGANIZATIONAL CHART



ANNUAL STATEMENT FOR THE YEAR 2012 OF THE SANFORD HEALTH PLAN OF MINNESOTA

SCHEDULE Y - INFORMATION CONCERNING ACTIVITIES OF INSURER MEMBERS OF A HOLDING COMPANY GROUP

PART 1 - ORGANIZATIONAL CHART

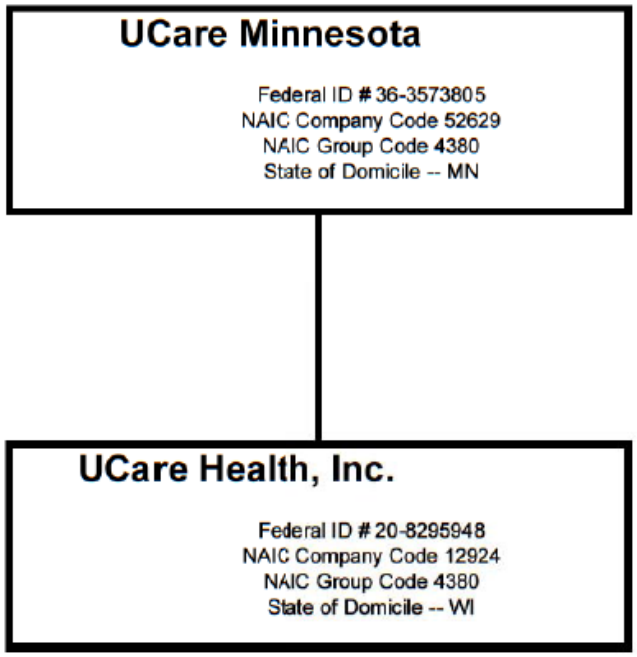


ANNUAL STATEMENT FOR THE YEAR 2012 OF THE UCare Minnesota

SCHEDULE Y - INFORMATION CONCERNING ACTIVITIES OF INSURER

MEMBERS OF A HOLDING COMPANY GROUP

PART 1 - ORGANIZATIONAL CHART



Appendix B. Lines of business

The following products are offered by Minnesota HMOS and insurance companies:

1. **Commercial comprehensive** – this line of business includes major medical coverage, Preferred Provider Organizations (PPOs), and managed care products. Most employer coverage for working individuals and their dependents falls in this category**.** This category, depending on the license of the carrier, includes both HMO and non-HMO products. This is coverage that is fully funded by employers and their members – there is no state or federal contribution to premiums. Under the terms of the ACA, the current Minnesota high risk pool will become part of the general pool to be underwritten by the health plans. Some larger employers self-insure, and use the services of a third-party administrator. Several of the HMOs have affiliated companies that provide administration, and affiliated insurance companies that write comprehensive business directly and provide stop loss coverage for self-insured customers of the administration affiliates.
1. **Medicare Advantage** – this is an insured product, offered by HMOs, which provides traditional Medicare coverage, Medicare Supplemental coverage, and frequently Medicare Part D – prescription drug coverage. It is regulated by CMS. Members continue to purchase Medicare Part B (and Medicare Part D if necessary.)
2. **Medicare Cost** – this is an insured product in which the carrier is at risk only for the Medicare Part B and supplemental coverage. The federal government remains the primary carrier for Medicare Part A benefits. Members continue to purchase Medicare Part B and D if necessary. This product is expected to be phased out over the next few years, as CMS is encouraging Medicare Advantage plans instead of Medicare Cost plans.
3. **MSHO** – Minnesota Senior Health Options -- MSHO is offered by HMOs and CBPS. It "combines separate health programs and support systems into one health care package. It is for people ages 65 and older who are eligible for Medical Assistance (MA) and enrolled in Medicare Parts A and B" (DHS website). Members thus receive both Medicare and Medicaid benefits from one entity, making it easier for providers to coordinate a member's care. It is interesting to note, however, that carriers report this program differently on their NAIC financial statements, with some putting it under Medicare and others under Medicaid. The Minnesota Health Supplement, however, breaks the program out separately.

4. **PMAP** – Prepaid Medical Assistance Program. This program encompasses traditional Medicaid enrollees – low income children, their parents, pregnant women, and individuals with disabilities. This program is jointly funded by CMS and Minnesota.
5. **PMAP Plus** – this Medicaid program expands the eligibility requirements for Medicaid, and is able to be offered due to the state's 1115waiver. This waiver enables Minnesota to offer additional benefits to Medicaid members so long as the overall program is budget neutral from the Federal Government's perspective. "The PMAP+ waiver is currently approved until Dec. 31, 2013. On August 9, 2013, DHS submitted a request to the Centers for Medicare & Medicaid Services (CMS) to extend the waiver. This request includes modifications in Minnesota's Medical Assistance program and changes to MinnesotaCare to align the program with the requirements for a Basic Health Plan (BHP) under the Affordable Care Act." (DHS website**).(Will need an update on this)**
6. **Minnesota Care** – This program, funded primarily by the state, is for people who do not meet the traditional Medicaid eligibility requirements but who are sufficiently low income to not be able to afford coverage on their own or to have coverage available through an employer.
7. **Special Needs Basic Care (SNBC)-** This program is a voluntary managed care program for people with disabilities ages 18-64 who qualify for Medical Assistance.
8. **General Assistance Medical Care (GAMC)** – Provides health care coverage to adults without dependent children who have very low income. Apparently last reported by any of the carriers in 2010.

In Minnesota, the state programs – Numbers 4 through 9—are offered by HMOs only.

Appendix C. Other States and Studies

We reviewed the academic and non-academic literature to inform this study and found that most studies had been:

(a) Initiated by state legislatures or state administrations
(b) Many focused in their analysis on BCBS affiliate plans that are non-profit

Details of other studies

2010 Consumers Union Study[66]

In 2010, Consumers Union published a study which examined surplus of the 10 Blue Cross and Blue Shields plans for 9 years. The results of this study are shown in Table 1 below. The study found that 7 out of 10 plans examined held more than three times the amount of surplus that regulators consider to the minimum needed for solvency protection. The report from Consumers Union suggests that states should regulate health insurer excess reserves using three approaches.

- States should establish minimum and maximum ranges of surplus
- States should analyze surplus as part of their review process for rate increases
- If surplus is found to be excessive, insurers should hold the excess in a rate stabilization reserve designed to offset rate increases, refund to policyholders, or spend the money for charitable purposes consistent with their healthcare mission such as community health programs.

[66] Consumers Union, "How Much is Too Much: Have Nonprofit Blue Cross Blue Shield Plans Amassed Excessive Amounts of Surplus?", July 2010 (http://consumersunion.org/pdf/prescriptionforchange.org-surplus_report.pdf)

Table 1 – Consumers Union Study BCBS plans

TABLE 1 - Total Surplus ($Millions) and RBC Scores (Percentages) of Ten Nonprofit BCBS Plans 2001-2009									
BCBS Plans	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**
Alabama	433.7	452.3	514.6	554.4	587.2	694.6	744.5	656.4	6498
	754%	694%	720%	673%	664%	747%	773%	581%	497%
Arizona	159.9	213.7	294.9	367.1	438.5	573.9	648.3	653.3	717.1
	904%	1112%	1256%	1451%	1464%	1567%	1568%	1565%	1455%
Massachusetts	525.7	616.1	887.6	1091	465.4	628.2	705.7	614.2	723.9
	481%	491%	616%	620%	543%	695%	708%	640%	724%
Michigan	1300.6	1532.3	1898.1	2243.7	2461	2501.4	2406.1	2227.4	2562.2
	493%	573%	633%	793%	892%	787%	691%	659%	650%
New York (Excellus)	393.9	473.2	629	777.8	960.8	1132.3	1187.2	857.9	965.1
	361%	441%	507%	563%	640%	664%	643%	472%	542%
North Carolina	439.1	485.7	743.2	865.5	980.2	1110.9	1285.9	1258.7	1423.8
	580%	648%	963%	930%	916%	893%	936%	857%	911%
Oregon (Regence)	266.3	235.6	282.2	366.4	466.9	533.5	552.2	486.1	565.2
	446%	385%	478%	706%	964%	820%	745%	563%	724%
Pennsylvania (Northeastern)	409.2	370.9	404.7	393.4	409.9	461.7	462.3	338.7	250.7
	1051%	1103%	1007%	946%	921%	876%	814%	711%	557%
Tennessee	614.1	602.5	648.4	787.2	908	936.1	1152.6	903.9	1137.1
	1098%	1022%	1181%	1198%	1206%	1100%	1311%	891%	1024%
Wyoming	68.4	67.1	81.1	87	94.9	109.6	118.5	112.1	144
	1154%	1153%	1129%	1101%	1136%	1222%	1170%	1237%	1411%
Avg RBC Score	732%	762%	849%	898%	935%	937%	936%	818%	850%

Massachusetts Division of Health Care Finance and Policy [67]

In 2008, Massachusetts required the Division of Health Care Finance and Policy (DHCFP) and the Division of Insurance to conduct a study of reserves, endowments, and surpluses of health insurers and hospitals. Hinckley, Allen & Tringale along with its subcontractors were engaged to perform this study. The study included a review of Massachusetts laws and regulations, a review of laws and regulatory practice in other states, and an analysis of the surplus and other financial characteristics of the eight

[67] Massachusetts Division of Health Care Finance and Policy, Study of the Reserves and Surpluses of Health Insurers in Massachusetts, http://www.mass.gov/chia/docs/r/pubs/10/insurer-reserve-report-05-2010.pdf (May 2010)

major health insurance plans active in Massachusetts. The tables below show a history of RBC ratios and statutory surplus over a ten year period.

Table 2 – DCHFP Study Massachusetts health plans RBC Ratios

	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
BCBS	742%	517%	481%	491%	616%	620%	543%	695%	708%	640%
HMO Blue	NA	NA	NA	NA	NA	NA	558%	524%	516%	427%
BCBS & HMO Blue[1]	742%	517%	481%	491%	616%	620%	552%	585%	586%	505%
Fallon	261%	271%	509%	462%	405%	484%	553%	551%	566%	372%
Harvard-Pilgrim	193%	187%	221%	364%	383%	407%	513%	510%	539%	517%
Health NE	67%	103%	132%	151%	166%	210%	305%	348%	363%	369%
Neighborhood	NA	266%	177%	112%	314%	520%	418%	438%	613%	540%
Tufts	162%	210%	253%	259%	398%	472%	654%	811%	790%	535%
UHNE	79%	193%	427%	604%	605%	710%	739%	766%	1015%	1013%
All Companies	309%	312%	355%	391%	494%	538%	558%	595%	615%	515%

[1]BCBS & HMO Blue combined RBC Ratio based on weighted average.

Table 3 – DCHFP Study Massachusetts health plans statutory surplus

	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
BCBS[1]	132	175	214	262	419	508	465	628	706	614
HMO Blue	230	266	312	354	468	583	764	840	881	707
BCBS & HMO Blue	362	441	526	616	888	1,091	1,229	1,468	1,586	1,321
Fallon	32	39	64	60	78	106	134	154	171	123
Harvard-Pilgrim	129	118	112	170	211	243	290	322	373	387
Health NE	3	6	8	10	12	17	25	31	36	38
Neighborhood	-	27	22	16	38	60	70	98	133	153
Tufts	68	106	158	189	293	337	404	481	547	436
UHNE	12	35	61	83	100	88	91	90	119	125
All Companies	607	772	951	1,144	1,618	1,942	2,244	2,643	2,967	2,583

[1]BCBS is shown net of HMO Blue during the time they were reported together.

Some major findings of this study include that surplus levels have increased steadily over the decade studies except over half the plans experience a drop in surplus in 2008. In addition, the levels of surplus are greater than minimum regulatory requirements. However, it is important when assessing surplus to consider other items such as underwriting cycle, trends in administrative expense and insurer investments. The study had the following recommendations:

- The Division of Insurance should consider adopting upper RBC threshold review levels for health insurers. An RBC ratio of 700-900% was recommended as an appropriate standard for upper threshold review.

- The Division of Insurance should consider establishing guidelines for the proportion of health plan surplus that may be invested in equity investments depending on the health plan's RBC ratio.
- The state should enhance health insurer reporting to include information on self-insured and administrative services only business, administrative costs, medical expenses and provider payment arrangements.
- The state should require Third Party Administrators (TPAs) to be registered or licensed.

Determination of Ranges: Pennsylvania Insurance Department, 2005[68]

The Pennsylvania Insurance Department undertook an extensive actuarial, accounting and legal analysis to determine an appropriate surplus range for each Blues plan. The Department believed that adding additional dollars to surplus had a diminishing return on the probability of default or ruin. However, the Department recognized that underwriting risk is a significant operational risk and considered many comments including those from the carriers. Some carriers suggested using the amount of claims and expense payment in reserve as an appropriate measure of surplus. However, the Department felt that this measurement alone did not consider the underwriting volatility associated with size and diversity of a carrier. Carriers also claimed that Blues plans did not have access to capital markets through the issuance of equity securities like some of their competitors. The Department refuted this argument suggesting that there is more scrutiny on returns for companies who can rely on capital markets. In addition, not for profits also have less operational constraints. The Department recognized that much of the underwriting risk can be managed and reduced through diversification, pooling, reinsurance, and other techniques. Lastly the Department recognized that there is a correlation between rates and surplus and suggest it is appropriate to consider surplus in the rate review process.

The Department relied on three methods of analysis to develop a unique sufficient operating range for each Blues Plan. The first method was analyzing the NAIC Risk Based Capital Ratio. The second method was calculating a consolidated risk factor ratio. The third method was a detailed actuarial analysis of relative underwriting risk and underwriting risk leverage. Below is additional description of these analyses.

In addition to evaluating the NAIC RBC ratio for each of the Blues plans, the Department developed their own metric, the consolidated risk factor ratio. The Department treated each Blue Plan and its insurance company subsidiaries and affiliates, listed on Schedule Y of the Annual Statement as one corporation. The Department took the following steps to calculate the consolidated risk factor ratio.

1. Divide each Blue Plan and its affiliates by type of entity: Property and casualty, life, and health

[68] Pennsylvania Insurance Department, Statements of Surplus Levels for Blue Cross Blue Shield Plans, 2005 through 2011,http://www.portal.state.pa.us/portal/server.pt/community/industry_activity/9276/blues_reserve_and_surplus_determination/623159

2. For each Blue Plan and its health affiliates, calculate the RBC values by sub-category. The affiliates were treated as part of one corporation, rather than as separate entities producing only asset and credit risk. An alternate combined company RBC was modeled.
3. The sub-category values were summed within each entity and then across all entities.
4. Using resulting values, the Department applied the Health RBC formula.
5. If the Blue Plan had non-health affiliates, the Department applied the relevant formula, property and casualty or life.
6. The Department combines the results of the different formulas and divided them into the Blue Plan's total adjusted capital values to produce a "consolidated risk factor ratio."

Both ratios, the NAIC RBC ratio and the consolidated risk factor ratio, take the risks of subsidiaries and affiliates into consideration. However, the actual formulas used to include the risks of subsidiaries and affiliates differ within the ratios. This is why the Department uses both ratios when performing their evaluation. Once both ratios are calculated, the Department chooses the lower ratio as the metric for evaluation for each plan. Since the Department is using the lower ratio, it was considered a conservative approach.

The actuarial analysis included analyzing measures such as surplus to premium ratio and surplus to reserve ratio. In addition, other statistical measures were used to measure underwriting risk differences. Since there is less risk when a parent company has subsidiaries and affiliates, the Department consolidated balance sheets and financial information when performing their analysis. One conclusion from these analyses was that the larger more diversified Blue Plans are comparatively less exposed to variations in underwriting results than the smaller Plans. A second conclusion was that Highmark is less exposed to underwriting volatility due to its high premium value and high surplus. Finally, they concluded that Highmark and Independence Blue Cross (IBC) were comparable and Capital BlueCross (CBC) and BlueCross of Northeastern Pennsylvania (NEPA) were comparable and that operating ranges could be developed for Highmark and IBC and another range for CBC and NEPA.

In finalizing ranges, the Department considered that 50% of all insurers operate at RBC ratios above 600%. Therefore for Highmark and IBC they have defined a sufficient range of 550% to 750%. The choice of range accommodates the differences in underwriting risk between Highmark and IBC. IBC's Health RBC and consolidated risk factor ratios are lower than Highmark's. For CBC and NEPA, the sufficient surplus operating range is defined as 750% to 950%. A higher level of capitalization is recognized as sufficient for CBC and NEPA because they are not as diversified and they have limited access to capital. If the Blue Plan's level of surplus is outside the sufficient levels, the Department will require the Blue Plan to justify the level or provide a plan to the Department illustrating how it will reduce its surplus level to within sufficient range.

Pennsylvania Study, The Lewin Group[69]

In 2005, Pennsylvania's Legislative Budget and Finance Committee engaged The Lewin Group to perform a study on the "regulation and disposition of the reserves and surpluses of health insurers". As the study was to begin, Pennsylvania's Insurance Commissioner released the Determination and Order which defined acceptable ranges for the Blue plans' level of surplus capital. This Determination and Order is described above. Lewin concluded that the Commissioner's ruling set reasonable bounds for the Pennsylvania Blue plans' accumulation of surplus. Lewin also performed an assessment on community benefit activities. Since at the time a did not exist formal definitions of community benefits, Lewin identified key community benefit practices which are shown in Table 4 below.

Table 4 – Lewin Group, Community Benefit Practices

Category	Community Benefit Practices
Direct Charitable Giving	* Cash Donations to not-for-profit organizations that help fill unmet health needs in the health plan's service area * Value of employees' company-paid time offered in support of the same causes
Safety net health coverage	*Offering of coverage to individuals other insurers will not accept, or price fairly * Subsidized premiums for individual and small-group coverage * Contributions to charity care pools
Participation in public programs	*Contracting with public payer entities to enroll their beneficiaries (e.e. Medicaid, CHIP, Medicare, special state/local coverage programs)
Knowledge dissemination and research	* Health Education or health promotion activities * Conduct or sponsorship of clinical research or health services research

Before 2005, the community benefit activities of the Pennsylvania Blues plans were influenced by expectation and company mission. More recent statutes require the Blues to bid to provide for services to Pennsylvania's CHIP and Medicaid programs and to guarantee issue to the individual market. In 2005, the Commissioner required the four Blues plans to commit nearly one billion dollars from 2005-2010 to community health reinvestment. Sixty percent was required for the adultBasic (Medicaid) plan and the rest were to be distributed through other outlets such as the individual market premiums, CHIP, donations to community clinics and scholarships to nursing programs.

Lewin researched other states and found no consensus on the level of community benefits for Blues plans or not-for-profit insurers. Lewin suggests that the Pennsylvania Insurance Department establish well defined criteria for what types of community benefit would be accepted under the agreement.

[69] The Lewin Group, "Considerations for Regulating Surplus Accumulation and Community Benefit Activities of Pennsylvania's Blue Cross and Blue Shield Plans", http://lbfc.legis.state.pa.us/reports/2005/112.PDF (June 13, 2005)

Rhode Island Carrier Studies, The Lewin Group[70]

In 2004, Rhode Island required an assessment of surplus levels of three health plans in the market Blue Cross and Blue Shield of Rhode Island (BCBSRI), UnitedHealthcare of New England (UHCNE), and Neighborhood Health Plan (NHP). In 2006, the state engaged the Lewin Group to perform this analysis. This study consisted of interviews with key stakeholders, research on Rhode Island laws and practices, assessing the Rhode Island market focusing on risks, and assessing the financial performance and determining a surplus range for each plan.

Lewin performed a detailed analysis on BCBSRI and NHP financials and developed surplus ranges based on these analyses. For UHCNE, due to the complexity of the organization and its relationship with the parent company, UnitedHealth Group Inc., they developed a target range for a hypothetical for profit insurer in Rhode Island with some characteristics of UHCNE.

Lewin indicates that health insurers in Rhode Island face a highly regulated market which can limit a plan's flexibility and increase risks. In addition they state that there are advantages and disadvantages for a health plan to participate in a government markets i.e., Medicaid and Medicare. Plans that participate in these programs benefit from large member enrollment and greater revenue stream. However there is greater risk and plans are subject to government premium constraints and have less flexible benefit design inherent in these programs.

The Lewin Group relied on SAPOR (surplus as a percent of revenue) and created specific target ranges for each of the three carriers. For BCBSRI, the target range was 23-31% (equivalent at the time to an RBC range of approximately 550%-775%), UHCNE 23-28% (equivalent at the time to an RBC range of approximately 650%-800%), and NHP 20-25% (equivalent at the time to an RBC range of 550%-700%). Note that the equivalence between SAPOR and RBC may vary over time, as there are differences in how they are calculated and in what risks are addressed. These ranges were set based on company specific analysis of risk factors and of surplus history, with a statistical model designed to develop a level of surplus that would have a 90-95% probability of maintaining solvency over a three-to-seven year adverse underwriting cycle

[70]The Lewin Group, Considerations for Appropriate Surplus Accumulation in the Rhode Island Health Insurance Market As It Relates to: Blue Cross Blue Shield of Rhode Island, http://www.ohic.ri.gov/documents/Insurers/Regulatory%20Actions/2006%20Reserves%20Study/BCBSRI%20Reserves%20Report.pdf, August 11, 2006
The Lewin Group, Considerations for Appropriate Surplus Accumulation in the Rhode Island Health Insurance Market As It Relates to: Neighborhood Health Plan, http://www.ohic.ri.gov/documents/Insurers/Regulatory%20Actions/2006%20Reserves%20Study/NHP%20Reserves%20Report.pdf, August 11, 2006
The Lewin Group, Considerations for Appropriate Surplus Accumulation in the Rhode Island Health Insurance Market As It Relates to: United HealthCare of New England, http://www.ohic.ri.gov/documents/Insurers/Regulatory%20Actions/2006%20Reserves%20Study/UHC%20Reserves%20Report.pdf, August 11, 2006

Maryland, 2010 and 2012[71][72]

In January 2009, the Maryland Insurance Administration (MIA) engaged the firm, Invotex to review and analyze the surplus of CareFirst of Maryland, Inc. (CFMI) and Group Hospitalization and Medical Services, Inc. (GHMSI) both companies of CareFirst Inc. (CFI). Invotex was charged with recommending an appropriate surplus for CFMI and GHMSI on an individual and consolidated basis, develop an analytic framework for the Commissioner to use to evaluate whether surplus is excessive, recommend whether the evaluation should be on an individual or consolidated basis, and recommend appropriate RBC requirements on an individual or consolidated basis.

One of the principal findings is that there are relationships among the affiliates within CareFirst and that creates more inefficiencies for managing risk and surplus. Because it is not certain that CFI could provide timely sufficient financial assistance if there was a need, Invotex recommended the MIA review CFMI and GHMSI surplus on an individual basis.

Invotex recommended a targeted surplus range of 825 to 1075 RBC for CFMI and 700 to 950 RBC for GHMSI. CFI also retained two firms to independently develop ranges, Milliman and Lewin Group. All independent reviews came to a similar conclusion. Invotex recommended the MIA adopt the following procedure.

- Every three to five years, CFMI and GHMSI identify a targeted surplus range
- The targeted surplus range is subject to regulatory review and approval
- When the surplus is within the targeted surplus range, CFMI and GHMSI may include risk contingency factors in rate filings, to maintain the companies within their respective appropriate surplus range given their unique risk profiles, growth trends and other factors
- When the surplus falls below the targeted surplus range, CFMI and GHMSI should include risk contingency factors in rate filings
- When the surplus exceeds the targeted surplus range, CFMI and GHMSI would propose a plan to bring the surplus down to the targeted surplus range.

Other conclusions include that the targeted surplus range for CFMI and GHMSI could be lower if the structure of the CFI group allowed an efficient movement of capital within the CFI group. Invotex recommended that the CFI group, regulators and policymakers explore impediments to a fully integrated company. Until this happens CFMI and GHMSI must be reviewed separately.
In 2012, CareFirst established new target surplus ranges for CFMI and GHMSI. MIA employed the services of RSM McGladrey Inc. (McGladrey) to evaluate the target surplus ranges established by CFMI

[71] The Maryland Insurance Administration, Report on CareFirst Premiums and Surplus, http://www.mdinsurance.state.md.us/sa/docs/documents/home/reports/carefirstsurplusreport-final010610.pdf, January 2010
[72] Maryland Insurance Administration, Consent Order Re: CareFirst Targeted Surplus Ranges, http://www.mdinsurance.state.md.us/sa/documents/MIA-2012-09-006-CareFirst.pdf (September 13, 2012)

and GHMSI. McGladrey interviewed CFI management to understand the process in developing the target ranges. These target ranges were developed by reviewing the results of two independent actuarial studies commissioned by CFI. McGladrey reviewed these studies, interviewed the consultants and stress tested the results by offering alternate assumptions which the consultants used to recalculate the surplus levels needed. McGladrey made many key observations and recommendations, some are shown below:

- The target ranges for CFMI 1050% to 1350% and GHMSI 1000% to 1300% appear reasonable
- The target ranges have increased due to the uncertainties of the impact of the Affordable Care Act.
- CFMI's forecasted RBC as of September 30, 2011 was 750% to 800% which is below the target. GHMSI's forecasted RBC as of September 30, 2011 was 1075% to 1125% which is above the minimum in the target range. The ability to increase surplus is limited due to competitive market conditions, low interest rate environment, the ACA, and the implementation of ICD-10.
- The legal structure of CareFirst is inefficient with regards to surplus and liquidity management. NAIC's Own Risk & Solvency Assessment (ORSA) Guidance Manual suggests that an assessment of group wide capital adequacy should consider "restrictions on the fungibility of capital within the holding company system including the availability and transferability of surplus resources."

Surplus Review Criteria by State

State	Maximum Surplus Level for Rate Review	Rate Action	Maximum Surplus Level for Rebates or Community Benefits	Insurance Department Action	Policy Category
Massachusetts	>300% RBC	1.9% contribution to reserves; if RBC below 300% 2.5% contribution to reserves	>700% RBC	Hearing held, DOI to issue a report	A. Maximum Surplus Defined for Rate Review C. Maximum Surplus Defined with Excess Returned to Policyholders or Community Benefits
Washington State (Proposed & Rejected)	>3 mos Claims Expense and Historical UW Gain > Historical Contribution to Surplus Charge	Require rate reduction and contribution to reserves charge must equal zero.			A. Maximum Surplus Defined for Rate Review
Rhode Island	SAPOR target: BCBSRI at 23-31%, UHCNE at 23-28%, NHPRI at 20-25%	Commissioner considers ranges during rate review and negotiations			A. Maximum Surplus Defined for Rate Review
Maryland	1050%-1350% RBC CMFI; 1000%-1300% RBC GHMSI	Review surplus as part of rate review			A. Maximum Surplus Defined for Rate Review
North Carolina (Proposed & Rejected)	650% RBC	Review surplus as part of rate review			A. Maximum Surplus Defined for Rate Review
Oregon	None Established	Review surplus as part of rate review			B. Surplus Review as part of Rate Review
Colorado	None Established	Review surplus as part of rate review	None established	Informal agreement in 2008; Kaiser paid back $155 M in rebates and community benefits	B. Surplus Review as part of Rate Review
Maine	None Established	Review surplus as part of rate review			B. Surplus Review as part of Rate Review
Michigan			1000% RBC BCBSMI	Carrier must provide plan to Commissioner	C. Maximum Surplus Defined with Excess Returned to Policyholders or Community Benefits
Pennsylvania	550%-750% RBC Highmark/IBC; 750%-950% RBC CBC/NEPA	Disallow risk and contingency factors in filed rates	>750% RBC Highmark/IBC; >950% RBC CBC/NEPA	Carrier must provide plan to Insurance Department to reduce surplus; required plans to pledge 1% of premium to community benefits from 2005-2010	A. Maximum Surplus Defined for Rate Review C. Maximum Surplus Defined with Excess Returned to Policyholders or Community Benefits
Washington DC	None Established	N/A	None established	Has authority to reduce excessive surplus through community benefits	D. Surplus Review with Excess Returned to Policyholders or Community Benefits

Appendix D. Company Profiles

BCBSM Profile

BCBSM, Inc., doing business as "Blue Cross Blue Shield of Minnesota," (BCBSM) is a non-profit health service plan organized within Minnesota Statutes Chapter 62C. BCBSM is a 100% owned subsidiary of Aware Integrated, Inc., a holding company with many other health related subsidiaries, including Blue Plus, an HMO[73]. Blue Plus is a 100% owned subsidiary of BCBSM.

BCBSM currently has about $3.1 billion in annual revenue, while its HMO subsidiary has about $1.0 billion in revenue. BCBSM derives approximately 52% of its revenues from Comprehensive Medical insurance marketed to commercial customers, 9% of its revenue is from Medicare Supplement, 15% is FEHBP and 14% is derived from Medicare Cost and Medicare Advantage programs. Approximately 11% of revenue is classified as "other health" as described in more detail below. Comprehensive Medical revenue has grown at a 4% compound rate over the 10 year period. Comprehensive Medical's share of revenue has declined from 62.7% to its current level largely due to the introduction and growth of the Medicare line of business. The Medicare line of business started in 2005 and has grown rapidly to its current size.

BCBSM offers Medicare Advantage and Medicare Cost products, both of which are reported in the Medicare line of business in the annual statement. Financial results of the Medicare Part D product are reported in the annual statement in the "Other" line of business.

In 2012 BCBSM reported $312.4 million of revenue in the "Other Health" column of the annual statement. The amount of revenue was distributed as follows: Stop Loss $163.5 million, Medicare part D $148.0 million and Vision $0.9 million.

BCBSM does not write ASO. It does however write ASC plans.[74] [75]

[73] 2012 Annual Statement, Schedule Y Part 1 & Part 1A
[74] 2012 Annual Statement, Note 18 A and 18B, Notes to Financial Statement
[75] The ASC products is generally offered by BCBSM only to employers with 100 or more employees. The ASC product is a self-insured product that is funded by employers on a "cash" basis. BCBSM has employer solvency risk with the ASC product.

Table 1. Revenue by Line of Business ($1,000,000) - BCBSM

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Comprehensive	1,117.1	1,244.9	1,408.1	1,571.9	1,660.5	1,693.9	1,655.9	1,605.9	1,593.6	1,588.5
Medicare Suppl	336.1	353.6	372.5	319.2	326.6	342.2	352.1	317.3	290.3	276.5
Dental Only	-	-	-	-	-	-	-	-	-	-
FEHBP	204.8	232.4	252.0	282.0	319.2	349.1	366.2	391.6	412.2	445.6
Medicare	-	-	4.5	5.2	82.0	136.1	120.9	199.4	317.5	434.4
Medicaid	-	-	-	-	-	-	-	-	-	-
Other Health	122.3	127.4	140.0	319.2	300.3	297.5	299.7	304.6	306.1	324.5
Total	1,780.4	1,958.3	2,177.1	2,497.6	2,688.7	2,818.8	2,794.9	2,818.9	2,919.6	3,069.5

BCBSM reported $194 million of total net underwriting gains in the last ten years, with considerable variation by line of business and year. The Comprehensive Medical line experienced cumulative losses of $155.1 over the ten year period. Within the Other Health line, the ASC business reported losses of $273 million during this 10 year period[76]. ASC losses however have been offset by gains related to stop loss coverage that these groups purchase. Stop loss gains over the same ten-year period were $297 million. The Medicare Supplement and the Medicare lines had a ten year underwriting gain of $192 million and $109 million respectively. Every line had at least some losses and some gains in different years.

For the most recent year, 2012, BSBCM reported a net underwriting gain of $1.8 million compared to an underwriting gain of $153.3 million for 2011. Contributors to the 2012 underwriting results were losses of $40.6 million and $44.4 million for Comprehensive Medical and Other Health offset by gains of $24.9 million and $63 million for the Medicare Supplement and Medicare lines respectively. Contributing to the loss in the Comprehensive Medical was a provision for a deficiency reserve of $77.6[77] million. The loss on ASC business of $59 million was included in Other Health. Net underwriting gains do not take into account investment earnings and realized capital gains.

For each of the ten years included in this analysis, BCBSM reported a loss on its ASC business. The annual loss ranged from $7 million in 2003 to $59 million in 2012. The loss attributable to ASC business for the 10 year period is $273 million. ASC business is generally sold to larger groups. Groups which are self-insured typically purchase stop loss insurance; offsetting the loss of $272.9 million are gains reported on stop loss business of $297 million for the same period, and also reported in Other Health.

Typically, health insurance contracts are renewed for a twelve month period. It is quite unusual for an insurer to provide long term rate guarantees (i.e. more than 12 months). BCBSM reported in it 2012 statement that it assumed rate adequacy risk by providing rate guarantees for in excess of 15 months for approximately $130 million of business[78].

[76] Presumably this loss includes any investment adjustments.
[77] 2012 Annual Statement, Note 30, Notes to Financial Statement
[78] 2012 Annual Statement, General Interrogatory Part 2, Interrogatory 9.2

Table 2. Underwriting Gain or (Loss) by Line of Business ($1,000,000) - BCBSM

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Comprehensive	19.5	(44.7)	(54.1)	(42.3)	(42.9)	0.9	(37.9)	12.5	74.4	(40.6)
Medicare Suppl	56.8	13.0	3.2	(4.1)	(4.8)	12.3	28.0	33.8	29.0	24.9
Dental Only	-	-	-	-	-	-	-	-	-	-
FEHBP	(0.0)	(0.1)	4.0	1.6	1.4	0.8	1.1	2.0	0.3	(1.1)
Medicare	-	-	(2.1)	(7.6)	(11.8)	17.0	15.1	1.9	33.8	63.0
Medicaid	-	-	-	-	-	-	-	-	-	-
Other Health	20.4	14.7	41.2	6.9	(30.9)	(6.2)	4.8	15.2	15.8	(44.4)
Total	96.6	(17.1)	(7.6)	(45.6)	(88.9)	24.8	11.2	65.4	153.3	1.8

Table 3. Underwriting Gain or (Loss) as a percentage of Revenue - BCBSM

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Comprehensive	1.7%	-3.6%	-3.8%	-2.7%	-2.6%	0.1%	-2.3%	0.8%	4.7%	-2.6%
Medicare Suppl	16.9%	3.7%	0.9%	-1.3%	-1.5%	3.6%	8.0%	10.7%	10.0%	9.0%
Dental Only	-	-	-	-	-	-	-	-	-	-
FEHBP	0.0%	0.0%	1.6%	0.6%	0.5%	0.2%	0.3%	0.5%	0.1%	-0.2%
Medicare	-	-	-45.7%	-147.3%	-14.4%	12.5%	12.5%	0.9%	10.7%	14.5%
Medicaid	-	-	-	-	-	-	-	-	-	-
Other Health	16.6%	11.6%	29.5%	2.2%	-10.3%	-2.1%	1.6%	5.0%	5.2%	-13.7%
Total	5.4%	-0.9%	-0.3%	-1.8%	-3.3%	0.9%	0.4%	2.3%	5.3%	0.1%

Taking into consideration investment income, capital gains and miscellaneous income, BCBSM reported a pre-FIT gain $59.3 million for 2012. Over the course of the ten year period, its pre-FIT income has ranged from a loss of $15.3 million (2007) to a net profit of $185.2 million (2011). As a percentage of revenue, net profit has ranged from loss of 0.6% (2007) to a profit of 7.6% (2003) with an average pre-tax profit margin over the ten year period of 2.3%.

Table 4. Net Income Before FIT ($1,000,000) - BCBSM

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Und. Gain	96.6	-17.1	-7.6	-45.6	-88.9	24.8	11.2	65.4	153.3	1.8
Net Inv. Income	20.0	28.2	34.6	48.7	54.4	44.3	37.9	39.8	41.3	41.3
Cap Gains	9.8	17.0	14.3	3.5	48.8	-38.4	-7.7	31.8	20.1	32.1
Other	9.8	(9.7)	0.4	(21.3)	(29.6)	(18.6)	(16.3)	(16.3)	(29.6)	(15.9)
Net Pre-FITIncome	136.2	18.5	41.7	-14.7	-15.3	12.1	25.1	120.6	185.2	59.3

BCBSM has built up capital reserves of approximately $827 million as of year-end 2012. The surplus has grown in seven of the last nine years, with decreases in 2007 and 2008. Over the ten year period, surplus has grown at an annual compound rate of 3.5%. Major contributors to the surplus decrease in 2007 and 2008 were an underwriting loss of $88.9 million in 2007 and realized and unrealized investment losses of $38.4 million and $92.8 million respectively in 2008 (see tables 4 and table 13).

Impacting the company's surplus level are deficiency reserves that the company has established. The company reported deficiency reserves of $48.5, $48.6 million and $77.6 million for 2010, 2011 and 2012 respectively[79]. For year-ends 2010 through 2012 the deficiency reserve calculation does not reflect the benefit of investment income[80].

[79] Deficiency reserve amounts are reported in the "Notes to Financial Statements" (Note 30) and the "Underwriting and Investment Exhibit Part 2D" of the Annual Statement.
[80] Taking into account estimated investment income would reduce the calculated deficiency reserve.

BCBSM's surplus is reduced by dividends paid to its parent, Aware Integrated, Inc. Over the ten year period BCBSM paid $238 million in ordinary dividends to its parent, as permitted by Minnesota Statutes. It paid $220 million in ordinary dividends in the most recent three years.[81]

BCBSM owns 100% of Blue Plus. If reported on an NAIC basis, the value of Blue Plus would be reported as an admitted asset on BCBSM financial statements. BCBSM has been required by the Department of Commerce to report its investment in Blue Plus as a non-admitted asset since 1993. If Blue Plus had been reported as an admitted asset, BCBSM surplus would increase by approximately $360 million.[82] It should be noted however that BCBSM has assumed solvency risk for Blue Plus, resulting from a "keep well" agreement.[83]

The company's surplus, expressed as a percentage of revenue (SAPOR), has ranged from a low of 18.4% (2008) to a high of 35.3%, (2004). SAPOR dropped by 5.6% in 2008, but since then it has increased from 18.4% to the current level of 27%.

Table 5. Capital and Surplus Analysis ($1,000,000 or %) - BCBSM

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Surplus	608.4	691.8	692.9	712.6	645.7	518.1	628.8	762.8	793.7	827.5
Growth in Surplus		83.36	1.16	19.72	(66.99)	(127.53)	110.67	134.01	30.88	33.77
Growth Percentage		13.7%	0.2%	2.8%	-9.4%	-19.8%	21.4%	21.3%	4.0%	4.3%
Suplus as % of Revenue	34.2%	35.3%	31.8%	28.5%	24.0%	18.4%	22.5%	27.1%	27.2%	27.0%

BCBSM RBC Ratio[84], expressed as the ratio of reported surplus and the Authorized Control Level ("RBC" ratio) is 703% for year-end 2012. For the ten year period the RBC ratio has ranged from a low of 489% (2008) t0 a high of 819% (2003). The RBC ratio has decreased from 819% to 703% over the ten year period. The RBC ratio decreased six times from the prior year level during the ten year period, with the largest decrease taking place during 2008 when the RBC ratio decreased from 596% to 489%, a decrease of 107 percentage points.

As noted above, Blue Plus is a non-admitted asset of BCBSM by permission of the regulator. If it had been reflected as an admitted asset, BCBSM's 2012 RBC ratio would have been affected by the assets in the denominator and the risk requirement ACL of Blue Plus in the denominator. The likely effect would have been slightly higher RBC.

It was noted above that BCBSM paid ordinary dividends to its parent during the 2003 through 2012 timeframe. If the $220 million of dividends paid in the latest three years had not been paid, BCBSM's 2012 surplus would be $1,047 million and its RBC ratio would be substantially higher than the reported value.

[81] BCBSM states that dividends paid by BCBSM and received by Aware Integrated are used for investments in affiliated organizations and strategic initiatives. As Aware is a not-for-profit company, this is its primary source of capital.
[82] 2012 Annual Statement, Notes to Financial Statements, Note 1
[83] 2012 Annual Statement, Notes to Financial Statements, Note 10
[84] Total Adjusted Capital is a derived amount. It is the surplus reported in the annual statement with certain specified adjustments. In most instances they are the same.

Another measure of the level of Capital Reserves expresses it as months of claims and expenses.[85] Capital Reserves have been equal to from 2.2 months (2008) to 4.4 months (2003) claims and expenses during the last ten years. For the most recent three years, this measure has been in the range of 3.3 months.

BCBSM and its subsidiary Blue Plus are licensees of the "Blue" brands through the Blue Cross Blue Shield Association. In conjunction with its licensing agreement Blue Plus is subject to monitoring of it RBC ratio and licensure action when its RBC ratio drops below specified levels. BCBSM and Blue Plus would be subject to intensified monitoring by the association if the RBC ratio were to drop below 375%. BCBSM and Blue Plus must maintain a minimum RBC ratio of 200%. If the RBC ratio were to drop below 200%, the Association would commence action to terminate the license to use the "Blue" brands.[86]

BCBSM, as part of its administrative services agreement with Blue Plus, has agreed to make investments in Blue Plus in order to maintain the surplus of Blue Plus at or above the statutory minimum, provided that such an investment does not cause BCBSM's surplus to "fall below 2.2 months of its statutory reserve requirements or as otherwise set forth in the terms of its administrative agreements."[87]

Table 6. Risk Based Capital Analysis ($1,000,000 or %) - BCBSM

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Surplus	608.4	691.8	692.9	712.6	645.7	518.1	628.8	762.8	793.7	827.5
Total Adjusted Capital	609.2	692.6	693.9	715.3	648.3	520.2	631.9	762.8	793.7	827.5
Authorized Control Level	74.4	85.4	92.2	107.5	108.9	106.3	108.5	106.2	104.8	117.6
RBC Ratio	819%	811%	753%	666%	596%	489%	583%	718%	757%	703%
MN Minimum Surplus	297.1	170.7	184.4	214.9	217.7	212.5	216.9	212.4	209.7	172.7
Surplus as % of MN Minimum Surplus	205%	405%	376%	332%	297%	244%	290%	359%	379%	479%
Surplus as Months Claims & Expenses	4.4	4.3	3.8	3.3	2.8	2.2	2.7	3.3	3.4	3.2

Currently BCBSM actively markets Comprehensive Medical, Medicare Supplement, Medicare and Stop Loss products. BCBSM also participates in the Federal Employees Health Benefit Plan (FEHBP). The company entered the Medicare market in 2005.

The Comprehensive Medical line of business experienced a variable loss ratio during the 10 year period. The highest loss ratio was 91.1% (2006) and the lowest loss ratio was 82.1% (2011). The average loss ratio over the 10 year period was 87.3%.

The Medicare Supplement product line similarly experienced an average loss ratio for the ten year period of76.3%, with the lowest loss ratios realized in the most recent years.

The Medicare line of business experienced an average loss ratio over the eight year period of 79.4%. The most recent year, 2012, experienced the lowest loss ratio (73.5%).

[85] This measure of surplus differs slightly from the minimum reserve requirement that was in effect in Minnesota for the first two years of the ten year period under review.
[86] The discussion in this paragraph is based on Blue Cross Blue Shield Association documents provided by BCBSM staff.
[87] 2012 Annual Statement, Note 10 of the Notes to Financial Statements

The FEHBP line of business experienced a very stable loss ratio in the range of 94% for each year.

The "Other Health" line of business, a significant portion of which is stop loss coverage, experienced an average loss ratio over the 10 years of 76.9% and 79.8% for the most recent year.

Table 7. Loss Ratio by Line of Business - BCBSM

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Comprehensive	85.4%	87.6%	89.6%	91.1%	89.1%	87.4%	88.1%	84.6%	82.1%	87.7%
Medicare Suppl	68.0%	77.0%	81.4%	83.8%	81.7%	77.6%	74.5%	72.6%	73.0%	73.5%
Dental Only	-	-	-	-	-	-	-	-	-	-
FEHBP	93.3%	94.4%	92.8%	94.2%	94.5%	94.8%	94.7%	94.5%	94.8%	94.9%
Medicare	-	-	98.5%	65.6%	92.8%	75.4%	70.7%	82.2%	76.4%	73.5%
Medicaid	-	-	-	-	-	-	-	-	-	-
Other Health	74.4%	80.3%	68.3%	85.1%	91.3%	78.6%	73.7%	67.3%	70.1%	79.8%
Total	82.2%	86.0%	87.2%	89.7%	89.2%	85.6%	84.9%	82.6%	81.1%	84.6%

The number of member months reported in the annual statement has increased over the ten year period examined in this analysis. Member months have increased from 7.9 million to 8.1 million. In contrast, revenue per member month has increased by 111%. The PMPM revenue has grown by an annual compound rate of 5.8%. The PMPM revenue has increased each year, increasing by 4.2% for the most recent year.

Table 8. Member Months - BCBSM

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Member Months (000)	7,864.7	8,227.7	8,756.6	9,558.7	9,594.8	9,277.0	8,704.7	8,219.6	8,083.4	8,152.1
Growth over Prior Year		4.6%	6.4%	9.2%	0.4%	-3.3%	-6.2%	-5.6%	-1.7%	0.8%
PMPM Revenue	226.37	238.01	248.63	261.29	280.22	303.85	321.08	342.95	361.18	376.53
Growth in PMPM Revenue		5.1%	4.5%	5.1%	7.2%	8.4%	5.7%	6.8%	5.3%	4.2%

BCBSM expenses[88] have increased each year except for 2011, when they decreased by 2.5% compared to the prior year. Over the 10 year period, administrative expenses averaged 13.6% of revenue. Administrative expenses expressed on a PMPM basis follow a similar pattern and average an 8.8% increase per year. The high level of annual increase may reflect a change in the mix of business over time.

BCBSM, supplies all administrative services to its subsidiary Blue Plus in accordance with an administrative services agreement. BCBCM charged Blue Plus $62 million[89] for its administrative services in 2012.

[88] The sum of administrative and claim adjudication expenses
[89] Blue Plus 2012 Annual Statement, Notes to Financial Statements, Note 10

Table 9. Claim Adjudication and Administrative Expenses - BCBSM

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Expenses (000,000)	211.3	262.7	280.5	313.4	367.2	382.3	405.6	407.6	397.5	460.7
Growth over Prior Year		24.3%	6.8%	11.7%	17.2%	4.1%	6.1%	0.5%	-2.5%	15.9%
Expense as % of Revenue	11.9%	13.4%	12.9%	12.5%	13.7%	13.6%	14.5%	14.5%	13.6%	15.0%
PMPM Expense	26.87	31.93	32.03	32.79	38.27	41.21	46.59	49.59	49.17	56.51
Growth in PMPM Expense		18.8%	0.3%	2.4%	16.7%	7.7%	13.1%	6.4%	-0.8%	14.9%

For each accounting period the company estimates its liability for claims incurred but not reported ("IBNR"). The IBNR is generally the largest liability reported on the company's balance sheet. For statutory accounting company management generally estimates this amount on a conservative basis by including a specified margin. The annual statement provides a test of the adequacy of the prior year reserve. An anticipated margin of 8-10% in the reconciled reserve is common and may generally be viewed as reasonable. However actual results from year to year will vary. Health Plans maintain a margin in their IBNR reserve because the actual liability is not known at the time it is estimated and it is subject to variation. Not much can be concluded from the adequacy and/or margin in any one year's reconciliation. BCBSM's margin in the claim reserve, expressed as a percentage of the reconciled reserve has ranged from as high as 21% (2002 yearend claim reserve) to as low as 0% (2011 year-end claim reserve). The average claim reserve margin during the 10 year period covering 2002 through 2011 is 6.9%. If there were excessive margins in the claim reserve, such excessive margins would reduce the company's reported surplus. However, BCBSM's margins were within a typical range for the industry.

Table 10. Claim Reserve Reconciliation ($1,000,000 or %) - BCBSM

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Reported Prior Yr Reserve	229.3	243.2	302.3	314.7	320.2	344.1	369.6	428.5	427.7	450.5
Reconciled Reserve	189.4	223.2	288.1	304.7	310.2	327.5	350.2	396.6	393.8	450.4
Margin in Reserve	39.9	20.0	14.2	10.0	9.9	16.6	19.5	31.9	33.8	0.1
Margin as % of Reconciled Reserve	21.1%	9.0%	4.9%	3.3%	3.2%	5.1%	5.6%	8.1%	8.6%	0.0%
Margin as % of Surplus	6.6%	2.9%	2.0%	1.4%	1.5%	3.2%	3.1%	4.2%	4.3%	0.0%

At year-end 2012, approximately 67% of the company's invested assets consisted of long term bonds. The percentage of BCBSM's invested assets in common stocks has ranged from 16% to 34% and is currently at 24%. Common stocks are valued at market and in certain market conditions can be more volatile than other more widely used investment vehicles. However, they do offer the possibility of superior returns, which could ultimately make health premiums lower. Common stocks create a somewhat higher Authorized Control Level amount under the RBC formula[90], and therefore result in a lower RBC ratio for the same amount of capital reserves. However, because they can be riskier than other investments, it is appropriate for them to require more capital. The effect on BCBSM is not great. BCBSM deploys risk management strategies that mitigate equity investment risk, including purchasing

[90] The 2012 RBC formula applies a factor of 15% to common stocks, in contrast to a factor of 3% for high quality bonds.

and selling stock options. The stated purpose of this strategy is to "reduce the net market exposure of the entire equity portfolio."[91]

Table 11. Invested Assets by Type ($1,000,000) - BCBSM

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Bonds	513.0	561.5	551.2	702.7	703.9	648.4	731.7	1,098.5	1,025.6	1,010.9
Stocks - Preferred	1.0	0.9	0.6	9.1	7.9	4.8	0.1	0.0	0.0	-
Stocks - Common	283.5	410.4	434.9	502.2	400.4	269.0	408.6	337.4	246.1	361.1
Mortgage Loans- First	-	-	-	-	-	-	-	-	-	-
Mortgage Loans - Other	-	-	-	-	-	-	-	-	-	-
RE - Occupied	87.9	87.3	97.2	95.9	93.5	89.9	86.8	81.3	82.5	1.3
RE - For Income	-	-	-	-	-	-	-	-	-	-
RE Other	-	-	-	-	-	-	-	-	3.9	-
Cash & Equivalent	350.1	327.0	291.4	171.4	147.7	201.1	217.5	35.4	212.4	128.8
Other Invested Assets	3.6	3.8	6.8	8.4	54.5	149.3	39.9	57.4	16.2	9.1
Total Invested Assets	1,239.1	1,391.0	1,382.2	1,489.7	1,407.8	1,362.5	1,484.6	1,610.0	1,586.6	1,511.2

Table 12. Invested Assets by Type (% of Total) - BCBSM

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Bonds	41%	40%	40%	47%	50%	48%	49%	68%	65%	67%
Stocks - Preferred	0%	0%	0%	1%	1%	0%	0%	0%	0%	0%
Stocks - Common	23%	30%	31%	34%	28%	20%	28%	21%	16%	24%
Mortgage Loans- First	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Mortgage Loans - Other	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
RE - Occupied	7%	6%	7%	6%	7%	7%	6%	5%	5%	0%
RE - For Income	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
RE Other	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Cash & Equivalent	28%	24%	21%	12%	10%	15%	15%	2%	13%	9%
Other Invested Assets	0%	0%	0%	1%	4%	11%	3%	4%	1%	1%
Total Invested Assets	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Realized capital gains are reflected in the income statement (Statement of Revenue and Expenses). The change in unrealized capital gains is not reflected in the income statement but is a direct credit to the company's surplus account. The amounts of realized and unrealized capital gains are highly variable, with 2008 showing a large negative swing and 2009 through 2012 showing a significant positive swing.

Table 13. Capital Gains ($1,000,000) - BCBSM

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Realized Cap. Gains (Net of FIT)	9.8	17.0	14.3	3.5	48.8	(38.4)	(7.7)	31.8	20.1	32.1
Unrealized Cap. Gains	72.1	73.1	40.7	38.8	(9.2)	(92.8)	76.4	103.1	7.7	8.4

[91] 2012 Annual Statement, Notes to Financial Statements, Note 8

Blue Plus Profile

HMO Minnesota, doing business as "Blue Plus," is an HMO. It is a "controlled affiliate" company of BCBSM, Inc., which is a Nonprofit Health Service Corporations providing indemnity health benefits. Blue Plus does not have any outstanding shares. The ultimate controlling entity of Blue Plus is Aware Integrated, Inc., a holding company with many other health related subsidiaries, which include BCBSM, Inc, and MII Life, Incorporated (both licensed insurers). None of the related subsidiaries are hospitals or provider groups[92].

Blue Plus currently has about $1.0 billion in annual revenue, while its affiliated company BCBSM, Inc. has about $3.1 billion in revenue. Blue Plus has approximately 34% of its business in Medicare, 62% in Medicaid programs, and 4% in Comprehensive Medical insurance marketed to commercial customers. The commercial Comprehensive Medical line of business included MNCare prior to 2011. In 2011 and later, MNCare has been reported as part of the Medicaid line of business. Comprehensive medical insurance, excluding MNCare, has declined gradually from about one-fourth of the business in 2003 to its current level. Medicaid business has fluctuated each year and increased in 2011, but declined by 18% in 2012. The Medicare line of business started in 2005 and has experienced moderate growth since 2006. It includes MSHO business.

For Blue Plus, its Medicare enrollment is all in the MSHO program, while its Medicaid business was about 70% PMAP and 30% MNCare in 2012.

Blue Plus does not write ASO or ASC plans.[93]

Table 1. Revenue by Line of Business ($1,000,000) - Blue Plus

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Comprehensive	365.8	345.9	324.7	318.1	307.4	300.3	310.2	324.5	55.6	37.6
Less MNCare	(203.3)	(195.6)	(185.4)	(164.7)	(168.6)	(176.2)	(216.3)	(256.0)	-	-
Adjusted Comprehensiv	162.5	150.3	139.3	153.4	138.8	124.1	93.9	68.5	55.6	37.6
Medicare Suppl	7.0	6.5	5.4	4.1	3.0	2.2	1.8	1.3	1.1	0.8
Dental Only	4.8	3.7	0.0	-	-	-	-	-	-	-
FEHBP	-	-	-	-	-	-	-	-	-	-
Medicare	-	-	4.9	231.9	272.2	289.0	306.4	331.4	311.0	323.7
Medicaid	250.3	229.6	273.1	217.2	230.7	283.7	346.9	375.7	721.0	593.3
Add MNCare	203.3	195.6	185.4	164.7	168.6	176.2	216.3	256.0	-	-
Adjusted Medicaid	453.6	425.2	458.5	381.9	399.3	459.9	563.2	631.7	721.0	593.3
Other Health	-	-	-	0.6	2.6	3.2	2.0	1.6	1.7	1.5
Total	627.9	585.7	608.1	772.0	815.9	878.4	967.4	1,034.5	1,090.3	956.9

[92] 2012 Annual Statement, Schedule Y Part 1 & Part 1A
[93] 2012 Annual Statement, Note 13A&B, Notes to Financial Statement

Blue Plus reported $107 million of total net underwriting gains in the last ten years, with considerable variation by line of business and year. The Medicare business had $127 million of total net gains over the 10 year period, while the Medicaid business was quite volatile and had total net losses of $42 million. Every line had at least some losses and some gains in different years. For the most recent year, 2012, Blue Plus reported a net underwriting loss of $45 million. This underwriting loss was largely the result of a loss of $55 Million in the Medicaid line, a significant contributor to the reported loss in the Medicaid line was an increase of the deficiency reserve of $18.4 million. Net underwriting gains do not take into account investment earnings and realized capital gains.

Table 2. Underwriting Gain or (Loss) by Line of Business ($1,000,000) - Blue Plus

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Comprehensive	(1.3)	24.1	21.1	(2.3)	(12.7)	(22.3)	7.9	1.7	3.8	2.9
Less MNCare	(7.6)	(27.7)	(11.3)	(4.7)	(10.2)	15.2	(3.9)	(3.4)	-	-
Adjusted Comprehensive	(8.9)	(3.6)	9.8	(7.0)	(22.9)	(7.1)	4.0	(1.7)	3.8	2.9
Medicare Suppl	1.5	1.3	0.7	0.8	0.8	0.5	0.4	0.4	0.3	0.2
Dental Only	(0.2)	(0.3)	(0.0)	-	-	-	0.0	-	-	-
FEHBP	-	-	-	-	-	-	-	-	-	-
Medicare	-	-	(1.0)	39.0	39.6	0.5	(0.3)	11.1	31.1	6.7
Medicaid	3.2	9.1	2.5	(32.6)	(22.5)	5.3	12.7	35.6	(0.6)	(54.9)
Add MNCare	7.6	27.7	11.3	4.7	10.2	(15.2)	3.9	3.4	0.0	0.0
Adjusted Medicaid	10.8	36.8	13.8	(27.9)	(12.3)	(9.9)	16.6	39.0	(0.6)	(54.9)
Other Health	-	-	(0.8)	(1.3)	2.2	2.9	(0.2)	(0.1)	(9.8)	-
Total	3.3	34.2	22.5	3.5	7.4	(13.1)	20.6	48.8	24.8	(45.1)
Check	3.3	34.2	22.5	3.5	7.4	(13.1)	20.6	48.8	24.8	(45.1)

Table 3. Underwriting Gain or (Loss) as a percentage of Revenue - Blue Plus

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Comprehensive	-0.3%	7.0%	6.5%	-0.7%	-4.1%	-7.4%	2.5%	0.5%	6.8%	7.8%
Less MNCare										
Adjusted Comprehensive	-5.5%	-2.4%	7.0%	-4.6%	-16.5%	-5.7%	4.3%	-2.5%	6.8%	7.7%
Medicare Suppl	21.7%	20.2%	13.7%	20.1%	26.2%	22.2%	24.3%	26.4%	30.0%	28.1%
Dental Only	-4.0%	-6.9%	-501.6%	-	-	-	-	-	-	-
FEHBP	-	-	-	-	-	-	-	-	-	-
Medicare	-	-	-21.2%	16.8%	14.5%	0.2%	-0.1%	3.4%	10.0%	2.1%
Medicaid	1.3%	4.0%	0.9%	-15.0%	-9.7%	1.9%	3.7%	9.5%	-0.1%	-9.3%
Add MNCare	3.7%	14.2%	6.1%	2.9%	6.0%	-8.6%	1.8%	1.3%		
Adjusted Medicaid	2.4%	8.7%	3.0%	-7.3%	-3.1%	-2.2%	2.9%	6.2%	-0.1%	-9.3%
Other Health	-	-	-	-215.7%	87.2%	90.2%	-7.6%	-4.2%	-585.8%	0.0%
Total	0.5%	5.8%	3.7%	0.5%	0.9%	-1.5%	2.1%	4.7%	2.3%	-4.7%

Taking into consideration investment income, capital gains and miscellaneous income, Blue Plus reported a loss of $4.4 million for 2012. Over the course of the ten year period, its pre-FIT income has ranged from a loss of $16.2 million to a net profit of $70.9 million. As a percentage of revenue, net profit has ranged from loss of 1.8% (2008) to a profit of 7.6% (2004) with an average profit margin over the ten year period of 3.3%.

Table 4. Net Income Before FIT ($1,000,000) - Blue Plus

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Und. Gain	3.3	34.2	22.5	3.5	7.4	-13.1	20.6	48.8	24.8	-45.1
Net Inv. Income	7.6	8.9	9.8	13.4	18.1	15.1	14.3	14.4	15.4	15.0
Cap Gains	-0.9	1.2	-0.5	0.4	2.3	-18.2	-6.1	7.8	10.3	25.7
Other	3.6	0.2	0.0	-	(0.0)	0.0	0.0	(0.0)	0.0	0.0
Net Pre-FITIncome	13.7	44.5	31.9	17.3	27.8	-16.2	28.7	70.9	50.6	-4.4

Blue Plus has built up capital reserves of approximately $360 million as of year-end 2012. The surplus has grown in each of the last nine years as compared to the year before except 2008, in which it decreased by $34 million. Major contributors to the decrease in 2008 were an underwriting loss of $13 million, realized investment losses of $18 million and a change in unrealized losses of $17 million (see Table 4).

Also impacting the company's surplus level are deficiency reserves that the company has established. The company reported deficiency reserves of $11.0, $10.6 million, $32.4 million and $51.6 million for 2009, 2010, 2011 and 2012 respectively[94]. The major portion of the deficiency reserve amount in each year is related to the Medicaid line of business. The yearend 2009 deficiency reserve reflected the benefit of investment income. For yearends 2010 through 2012 the deficiency reserve calculation does not reflect the benefit of investment income[95]. For yearend 2011 Blue Plus reported a deficiency reserve related to the Medicaid line of $29.8 million, this can be compared to the reported 2012 underwriting loss for the Medicaid line of business of $36.5 million ($54.9 million less the $18.4 million change in premium deficiency reserve), suggesting that the reported deficiency reserve was too low.

The company's surplus, expressed as a percentage of revenue (SAPOR), has ranged from a low of 15.3% to a high of 37.6%, which was achieved at yearend 2012. SAPOR dropped by 6% in 2008, but since then it has increased from 22.9% to the current level. Much of the 2012 growth in surplus, when measured as a percentage of revenue, is due to a 12% decline in annual revenue, resulting from the decline in Medicaid from 2011-2012 described above.

Table 5. Capital and Surplus Analysis ($1,000,000 or %) - Blue Plus

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Surplus	96.3	130.3	162.5	210.2	234.8	200.8	250.9	317.6	357.2	359.6
Growth in Surplus		34.06	32.17	47.76	24.58	(33.99)	50.07	66.69	39.65	2.41
Growth Percentage		35.4%	24.7%	29.4%	11.7%	-14.5%	24.9%	26.6%	12.5%	0.7%
Suplus as % of Revenue	15.3%	22.3%	26.7%	27.2%	28.8%	22.9%	25.9%	30.7%	32.8%	37.6%

Blue Plus Total Adjusted Capital[96], expressed as the ratio of reported surplus and the Authorized Control Level ("RBC" ratio) is 942% for yearend 2012. That is the highest ratio of the last 10 years. Blue Plus's RBC ratio has increased over the ten year period, going from a low 418% to 942% at yearend 2012. The

[94] Deficiency reserve amounts are reported in the "Notes to Financial Statements" and the "Underwriting and Investment Exhibit Part 2D" of the Annual Statement. The Underwriting Investment Exhibit Part 2D also includes a premium reserve for portability which is determined using a gross premium methodology and a Medicare rate credit, which are not included as part of the PDR.
[95] Taking into account estimated investment income would reduce the calculated deficiency reserve.
[96] Total Adjusted Capital is a derived amount. It is the surplus reported in the annual statement with certain specified adjustments. In most instances they are the same.

RBC ratio decreased from the prior year level once during the ten year period, when it decreased from 751% to 595% at yearend 2008, a decrease of 156 percentage points. Other measures of surplus can be considered:

- Blue Plus calculates and reports it minimum statutory surplus in its Annual Statement. For 2003 and 2004 the calculation was largely based on reported amounts of incurred claims, claim adjustment expenses and administrative expenses. For 2005 and later years the minimum statutory surplus level is 200% of the Authorized Control Level. Blue Plus' surplus as a function of the minimum statutory surplus ranged from 186% (2003) to 471% (2012).
- Another measure of the level of Capital Reserves expresses it as months of claims and expenses.[97] Capital Reserves have been equal to from 1.86 months to 4.39 months claims and expenses during the last ten years. The growth in this measure has been consistent from year to year, except for 2008 in which the ratio dropped to 2.70 months as compared to the 3.44 months the year previously. The last two years were the first in which the ratio was over 4 months.

Blue Plus and BCBSM are licensees of the "Blue" brands through the Blue Cross Blue Shield Association. In conjunction with its licensing agreement Blue Plus is subject to monitoring of it RBC ratio and licensure action when its RBC ratio drops below specified levels. Blue Plus would be subject to intensified monitoring by the association if its RBC ratio drops below 375%. Blue Plus must maintain a minimum RBC ration of 200%. If the RBC ratio drops below 200%, the Association would commence action to terminate the license to use the "Blue" brands.[98]

BCBSM, as part of its administrative services agreement with Blue Plus, has agreed to make investments in Blue Plus in order to maintain the surplus of Blue Plus at or above the statutory minimum, provided that such an investment does not cause BCBSM's surplus to "fall below 2.2 months of its statutory reserve requirements or as otherwise set forth in the terms of its administrative agreements."[99]

Table 6. Risk Based Capital Analysis ($1,000,000 or %) - Blue Plus

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Surplus	96.3	130.3	162.5	210.2	234.8	200.8	250.9	317.6	357.2	359.6
Total Adjusted Capital	96.3	130.3	162.5	210.2	234.8	200.8	250.9	317.6	357.2	359.6
Authorized Control Level	23.0	19.9	21.4	28.8	31.3	33.8	35.7	36.7	38.7	38.2
RBC Ratio	418%	656%	758%	729%	751%	595%	703%	865%	924%	942%
MN Minimum Surplus	51.8	45.3	42.9	57.7	62.5	67.5	71.4	73.4	77.3	76.3
Surplus as % of MN Minimum Surplus	186%	288%	379%	364%	375%	298%	351%	432%	462%	471%
Surplus as Months Claims & Expenses	1.9	2.9	3.3	3.3	3.4	2.7	3.2	3.9	4.1	4.4

[97] This measure of surplus differs slightly from the minimum reserve requirement that was in effect in Minnesota for the first two years of the ten year period under review.
[98] The discussion in this paragraph is based on Blue Cross Blue Shield Association documents provided by BCBSM staff.
[99] 2012 Annual Statement, Note 10 of the Notes to Financial Statements

Currently Blue Plus actively markets Comprehensive Medical, Medicare Supplement, Medicare Advantage and Medicaid products. The company marketed Dental Only products in 2003 and 2004 and reported a minimal amount of premium for this line in 2005. The company entered the Medicare Advantage market in 2006. The company also reports a small amount of Other Health premium.

The Comprehensive Medical line of business experienced a generally improving loss ratio during the 10 year period. The highest loss ratio was 98.1% (2008) and the lowest loss ratio was 79.3% (2012). The average loss ratio over the 10 year period was 88.2%.

The Medicare Supplement product line similarly experienced a generally declining loss ratio over the 10 year period. The average loss ratio for the ten year period was 63.9%, with the lowest loss ratios realized in the most recent years.

The Medicare line of business experienced an average loss ratio over the eight year period of 87.5%. The most recent year, 2012, experienced the highest loss ratio (91.9%) and was experienced in 2006 with 79.6%.

The Medicaid line of business experienced an average loss ratio of 92.5% with results varying from 88% in 2004 to 106% in 2006. The reported loss ratio for 2012 is 97.5%.

Table 7. Loss Ratio by Line of Business - Blue Plus

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Comprehensive	90.9%	80.0%	84.4%	89.7%	97.1%	98.1%	89.3%	89.2%	83.8%	79.3%
Less MNCare										
Adjusted Comprehensive	91.4%	83.0%	82.8%	91.3%	95.6%	95.1%	86.7%	83.2%	83.8%	79.3%
Medicare Suppl	67.9%	69.3%	72.7%	67.9%	61.4%	64.6%	63.2%	61.2%	52.9%	58.0%
Dental Only	93.3%	94.1%	530.7%	-	-	-	-	-	-	-
FEHBP	-	-	-	-	-	-	-	-	-	-
Medicare	-	-	84.0%	79.6%	80.3%	93.5%	94.1%	91.8%	85.3%	91.9%
Medicaid	93.4%	88.0%	91.2%	105.8%	100.9%	89.3%	88.1%	81.9%	88.9%	97.5%
Add MNCare										
Adjusted Medicaid	92.1%	83.3%	88.9%	98.2%	99.8%	93.4%	89.0%	85.5%	88.9%	97.5%
Other Health	-	-	-	0.0%	10.0%	-0.1%	54.5%	0.0%	0.2%	0.0%
Total	91.7%	83.1%	87.3%	91.0%	92.2%	93.3%	90.2%	87.2%	87.4%	94.7%

The number of member months reported in the annual statement has declined over the ten year period examined in this analysis. Member months have declined from 2.3 million to 1.7 million. This is most likely due to the decline in volume of the Comprehensive Medical line of business. Comprehensive Medical revenue declined from $366 million in 2003 to $38 million in 2012. In contrast, revenue per member month has increased by 111%. The pmpm revenue increases have shown significant swings, with 32% increase in 2006 and decreases in the most recent two years.

Table 8. Member Months - Blue Plus

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Member Months (000)	2,339.5	2,068.6	2,015.0	1,943.7	1,766.7	1,701.3	1,680.6	1,777.9	1,886.7	1,693.1
Growth over Prior Year		-11.6%	-2.6%	-3.5%	-9.1%	-3.7%	-1.2%	5.8%	6.1%	-10.3%
PMPM Revenue	268.41	283.11	301.80	397.18	461.80	516.32	575.60	581.83	577.89	565.21
Growth in PMPM Revenue		5.5%	6.6%	31.6%	16.3%	11.8%	11.5%	1.1%	-0.7%	-2.2%

Blue Plus expenses[100] have increased each year except for 2012, when the decrease partially offset a very large increase in 2011. Over the 10 year period, administrative expenses averaged 8.3% of revenue. Administrative expenses expressed on a pmpm basis follow a similar pattern. The average annual pmpm increase is 6.8%. The high level of annual increase may reflect a change in the mix of business over time.

Blue Plus' parent, BCBSM, supplies all administrative services. BCBCM charged Blue Plus $62 million[101] for its administrative services in 2012.

In 2011 Blue Plus recorded a charitable contribution of $10 million to the BCBSM Foundation. This was reported as part of the company's General Administrative Expenses.[102]

Table 9. Claim Adjudication and Administrative Expenses - Blue Plus

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Expenses (000,000)	44.8	55.7	60.3	63.5	66.5	74.5	76.8	77.9	90.5	77.4
Growth over Prior Year		24.3%	8.3%	5.2%	4.8%	12.0%	3.0%	1.4%	16.2%	-14.5%
Expense as % of Revenue	7.1%	9.5%	9.9%	8.2%	8.2%	8.5%	7.9%	7.5%	8.3%	8.1%
PMPM Expense	19.15	26.92	29.94	32.67	37.66	43.81	45.70	43.82	47.96	45.72
Growth in PMPM Expense		40.5%	11.2%	9.1%	15.3%	16.3%	4.3%	-4.1%	9.5%	-4.7%

For each accounting period the company estimates its liability for claims incurred but not reported ("IBNR"). The IBNR is generally the largest liability reported on the company's balance sheet. For statutory accounting company management generally estimates this amount on a conservative basis by including a specified margin. The annual statement provides a test of the adequacy of the prior year reserve. An anticipated margin of 8-10% in the reconciled reserve is common and may generally be viewed as reasonable. However actual results from year to year will vary. Health Plans maintain a margin in their IBNR reserve because the actual liability is not known at the time it is estimated and it is subject to variation. Not much can be concluded from the adequacy and/or margin in any one year's reconciliation. Blue Plus's margin in the claim reserve, expressed as a percentage of the reconciled reserve has ranged from as high as 51% (2003 yearend claim reserve) to as low as 4.5% (2008 yearend claim reserve). The margin in the 2011 claim reserve was 8.5% of the reconciled claim reserve. Excessive margins in the claim reserve reduce the company's reported surplus.

Table 10. Claim Reserve Reconciliation ($1,000,000 or %) - Blue Plus

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Reported Prior Yr Reserve	79.8	89.5	80.9	69.0	93.7	97.6	110.0	134.4	140.0	137.9
Reconciled Reserve	62.3	59.4	68.5	63.6	80.0	83.8	105.2	119.4	127.5	127.1
Margin in Reserve	17.5	30.0	12.4	5.4	13.7	13.9	4.8	15.1	12.5	10.8
Margin as % of Reconciled Reserve	28.1%	50.5%	18.2%	8.5%	17.1%	16.6%	4.5%	12.6%	9.8%	8.5%
Margin as % of Surplus	18.2%	23.0%	7.7%	2.6%	5.8%	6.9%	1.9%	4.7%	3.5%	3.0%

[100] The sum of administrative and claim adjudication expenses
[101] 2012 Annual Statement, Notes to Financial Statements, Note 10
[102] 2011 Annual Statement, Page 42 Overflow Page

At yearend 2012, approximately 77% of the company's invested assets consisted of long term bonds. The percentage of Blue Plus' invested assets in common stocks has ranged from 7% to 22% and is currently at 21%. Common stocks are valued at market and are relatively more volatile than other investments usually made by health plans. However, they offer the possibility of superior returns, which could ultimately make health premiums lower. Common stocks create a somewhat higher Authorized Control Level amount under the RBC formula[103], and therefore result in a lower RBC ratio for the same amount of capital reserves. The effect on Blue Plus is not great. Blue Plus has a strategy of purchasing and selling stock options. The stated purpose of this strategy is to "reduce the net market exposure of the entire equity portfolio."[104]

Table 11. Invested Assets by Type ($1,000,000) - Blue Plus

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Bonds	173.1	175.0	200.8	252.8	259.4	241.7	277.1	344.8	393.5	386.0
Stocks - Preferred	-	-	-	1.5	1.8	0.9	-	-	0.0	-
Stocks - Common	15.0	27.3	29.9	73.9	85.9	53.4	70.1	85.5	68.1	105.6
Mortgage Loans- First	-	-	-	-	-	-	-	-	-	-
Mortgage Loans - Other	-	-	-	-	-	-	-	-	-	-
RE - Occupied	5.8	5.6	5.4	5.2	5.0	4.8	4.6	4.4	4.2	-
RE - For Income	-	-	-	-	-	-	-	-	-	-
RE Other	-	-	-	-	-	-	-	-	-	-
Cash & Equivalent	7.8	20.3	6.5	21.2	39.8	29.1	9.9	0.4	17.3	11.6
Other Invested Assets	0.0	0.0	0.1	0.5	4.0	4.3	0.8	1.7	4.0	1.2
Total Invested Assets	201.7	228.1	242.8	355.1	396.0	334.2	362.4	436.9	487.1	504.3

Table 12. Invested Assets by Type (% of Total) - Blue Plus

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Bonds	86%	77%	83%	71%	66%	72%	76%	79%	81%	77%
Stocks - Preferred	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Stocks - Common	7%	12%	12%	21%	22%	16%	19%	20%	14%	21%
Mortgage Loans- First	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Mortgage Loans - Other	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
RE - Occupied	3%	2%	2%	1%	1%	1%	1%	1%	1%	0%
RE - For Income	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
RE Other	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Cash & Equivalent	4%	9%	3%	6%	10%	9%	3%	0%	4%	2%
Other Invested Assets	0%	0%	0%	0%	1%	1%	0%	0%	1%	0%
Total Invested Assets	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Realized capital gains are reflected in the income statement (Statement of Revenue and Expenses). The change in unrealized capital gains is not reflected in the income statement but is a direct credit to the company's surplus account. The amounts of realized and unrealized capital gains are highly variable, with 2008 showing a large negative swing and 2012 showing a large positive swing.

[103] The 2012 RBC formula applies a factor of 15% to common stocks, in contrast to a factor of 3% for high quality bonds.
[104] 2012 Annual Statement, Notes to Financial Statements, Note 8

Table 13. Capital Gains ($1,000,000) - Blue Plus

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Realized Cap. Gains (Net of FIT)	(0.9)	1.2	(0.5)	0.4	2.3	(18.2)	(6.1)	7.8	10.3	25.7
Unrealized Cap. Gains	3.6	0.2	0.8	6.1	(3.3)	(16.7)	21.0	4.3	(9.2)	3.8

HealthPartners, Inc., Group Health Plan, Inc. and HealthPartners Insurance Company Profiles

HealthPartners, Inc. ("HPI") is a Minnesota network model HMO. HPI is also a holding company with many subsidiaries, including Group Health Plan, Inc. ("GHI") a Minnesota staff model HMO, as well as an integrated health care delivery organization, a variety of specialty clinics, a third party administrator, and an insurance company, HealthPartners Insurance Company ("HPIC"). HPIC was formerly known as Midwest Assurance Company, and was renamed in 2007.

As of 2012, HPI had about $1.4 billion in annual revenue and covered approximately 235,000 members. In 2012, GHI reported almost $1.0 billion of annual revenue on 53,000 members, and HPIC reported about $0.9 billion. The three companies taken together therefore had approximately $3.3 billion of total revenue.

For 2012, HPI reported 56% of its revenue as Comprehensive, 4% Dental, and 40% Medicaid, with minimal amounts of Medicare Supplement and Medicare. Commercial business has declined over the last few years, while Medicaid business has increased from 15% in 2008 to 40% in 2012. Up through 2008, HPI had approximately 25% of its business in Medicare Advantage, but that share dropped substantially in 2009 and has decreased since then. HPI reported $100 million of MSHO revenue as part of Medicaid business in its NAIC statement.

As of 2012, GHI reported 55% of its business as Comprehensive, 4% Dental, 5% FEHBP and 36% Medicare. All of the business identified as Medicare was reported as Medicare Cost in the Minnesota Supplement. GHI reported Medicaid business in 2008, but in no other year.

HPIC had 93% of its business in the Comprehensive line, with less than 2% Dental and 5% in stop loss. HPIC's business includes supplemental medical and dental coverage for HPI members in Minnesota and Western Wisconsin, as well as stop loss for self-insured business administered by its direct parent, HealthPartners Administrators, Inc., a third-party administrator. The following tables reflect an amended 2011 statement for HPI correcting the originally reported amounts for dental only and Medicaid. The totals for all lines of business in aggregate are unaffected.

Table 1A. Revenue by Line of Business ($1,000,000) - HealthPartners, Inc.

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Comprehensive	757.1	765.9	838.7	931.8	993.4	1,089.9	1,118.0	1,048.8	862.4	770.7
Medicare Suppl	7.3	6.5	5.3	2.6	1.9	1.7	1.4	1.1	0.9	0.8
Dental Only	53.6	48.7	53.1	52.9	56.9	63.1	67.4	61.3	49.0	50.6
FEHBP	13.1	8.8	8.8	4.2	2.6	4.3	-	-	-	-
Medicare	116.2	121.6	164.0	212.8	242.0	252.8	18.5	12.6	1.3	1.6
Medicaid	183.0	187.3	215.0	255.5	287.7	228.8	385.5	395.5	438.5	555.5
Other Health	-	-	-	-	-	-	-	-	-	-
Total	1,130.3	1,138.7	1,284.9	1,459.7	1,584.4	1,640.5	1,590.7	1,519.3	1,352.1	1,379.2

Table 1B. Revenue by Line of Business ($1,000,000) - Group Health Plan, Inc.

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Comprehensive	275.4	338.7	354.1	438.9	452.5	479.6	475.8	489.6	497.1	532.5
Medicare Suppl	-	-	-	-	-	-	-	-	-	-
Dental Only	3.2	3.4	3.3	1.9	2.4	3.1	4.3	4.3	35.2	37.4
FEHBP	66.2	80.7	91.5	95.2	93.1	79.4	88.0	68.5	58.1	48.0
Medicare	140.8	120.1	110.5	47.2	29.8	27.4	273.1	262.6	340.8	350.4
Medicaid	-	-	-	-	-	98.0	-	-	-	-
Other Health	-	-	-	-	-	-	-	-	-	-
Total	485.6	542.9	559.4	583.1	577.8	687.5	841.1	825.0	931.1	968.4

Table 1C. Revenue by Line of Business ($1,000,000) - HPIC

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Comprehensive	26.1	37.1	65.0	137.4	177.3	285.0	409.0	621.4	810.2	822.2
Medicare Suppl	-	-	-	-	-	-	-	-	-	-
Dental Only	5.0	5.9	6.6	7.6	8.7	10.8	9.8	11.2	13.0	12.9
FEHBP	-	-	-	-	-	-	0.0	0.0	0.3	0.1
Medicare	-	-	-	-	-	1.3	1.2	0.0	0.2	0.4
Medicaid	-	-	-	-	-	-	-	-	-	-
Other Health	12.3	12.5	10.8	10.6	15.8	23.4	27.4	30.9	37.7	45.1
Total	43.4	55.4	82.4	155.6	201.9	320.4	447.4	663.5	861.4	880.7

HPI reported $419 million of total net underwriting gains in the last ten years, with considerable variation by line of business and year. Over the 10 year period, underwriting gains were 3% of revenue. The Comprehensive line of business had $296 million of total net gains over the 10 year period (3.2% of revenue), while Medicare had $69 million (6.1%) and Medicaid business had total net gains of $46 million (1.3%). The company experienced significant variability in the reported underwriting gains for all of the major lines of business. For the most recent year, 2012, HPI reported a net underwriting gain of $102 million or 7.4% of revenue. For 2012, 63% of the underwriting gain was derived from the Comprehensive line of business, 6% from Dental, and 31% from Medicaid. Medicaid had been unprofitable through 2006, but has shown increasing profits each year since 2007. In the most recent year, 2012, underwriting gains were 5.7% of Medicaid revenue and 8.4% of Comprehensive revenue.

GHI reported $12 million of total net underwriting gains in the last ten years, with considerable variation by line of business and year. The Comprehensive line of business had a loss of $25 million or -0.6% of revenue over the 10 year period, while Medicare had a gain of $33 million or 2.0% of revenue and Medicaid business had total net gains of $5 million or 5%. However, Medicaid business was only reported in one year, 2008. For the most recent year, 2012, GHI reported a net underwriting gain of $15 million. The Medicare line of business reported a gain of $25 million or 7% in 2012, while Comprehensive and Dental both reported losses, of $10 million (1.8%) and $1 million (2.7%), respectively.

HPIC reported $159 million (4.3% of revenue) of total net underwriting gains in the last ten years, with considerable variation by line of business and year. The Comprehensive line of business had a total net underwriting gain of $131 million (3.9%) of revenue over the 10 year period, while Stop Loss had $25 million or 11.1% and Dental business had total net gains of $2.6 million or 2.9%. For the most recent

year, 2012, HPIC reported a net underwriting gain of $13.5 million. The Comprehensive line of business reported a gain of $7.5 million or 1% in 2012, while Stop Loss reported a gain of$ 5.6 million (12.5%).

Net underwriting gains do not take into account investment earnings and realized capital gains.

HPI entered into an agreement in 2011 with the State of Minnesota to limit its net underwriting gain on certain Medicaid products to 1% for the Medical Assistance (PMAP) and MinnesotaCare (MNCare) programs.[105] HPI held a liability at year-end 2011 of $31 million in connection with this agreement. The agreement does not apply for 2012. HPI believes that it does not owe any rebates with regard to minimum loss ratio requirements of 80% on small group and 85% on large group business for 2012.[106]

Table 2A. Underwriting Gain or (Loss) by Line of Business ($1,000,000) - HealthPartners, Inc.

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Comprehensive	8.2	23.9	4.3	17.2	17.1	21.6	20.1	47.9	71.8	64.4
Medicare Suppl	0.1	0.0	0.5	0.4	0.2	0.5	0.3	0.2	0.1	0.2
Dental Only	0.2	(0.7)	(1.1)	(1.4)	(1.5)	(1.7)	(0.5)	1.6	7.6	6.5
FEHBP	(1.2)	(0.5)	2.7	0.6	(1.3)	(0.3)	-	-	-	-
Medicare	25.1	3.0	18.3	10.8	11.0	5.6	(1.8)	(2.4)	(0.2)	(0.1)
Medicaid	(10.3)	(9.4)	(12.3)	(11.8)	0.2	4.6	13.9	22.9	12.3	31.6
Other Health	-	-	-	-	-	-	-	-	-	-
Total	21.9	16.3	12.4	15.9	25.7	30.3	32.0	70.2	91.6	102.5

Table 2B. Underwriting Gain or (Loss) by Line of Business ($1,000,000) - Group Health Plan, Inc.

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Comprehensive	12.5	(5.4)	(13.8)	(18.7)	1.9	12.6	(4.9)	(0.6)	1.2	(9.6)
Medicare Suppl	-	-	-	-	-	-	-	-	-	-
Dental Only	0.0	(0.1)	(0.1)	(0.0)	(0.1)	(0.1)	(0.0)	0.1	(1.1)	(1.0)
FEHBP	(1.7)	2.4	10.3	3.5	(3.4)	(11.1)	0.9	0.4	(0.1)	0.2
Medicare	(11.9)	(6.4)	(7.6)	0.9	(5.6)	1.2	15.2	0.9	20.9	25.4
Medicaid	-	-	-	-	-	5.0	-	-	-	-
Other Health	-	-	-	-	-	-	-	-	-	-
Total	(1.1)	(9.5)	(11.1)	(14.4)	(7.3)	7.7	11.2	0.8	20.9	15.0

Table 2C. Underwriting Gain or (Loss) by Line of Business ($1,000,000) - HPIC

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Comprehensive	(0.3)	4.7	4.8	6.7	12.3	15.2	13.9	26.6	40.1	7.5
Medicare Suppl	-	-	-	-	-	-	-	-	-	-
Dental Only	0.1	0.0	(0.3)	0.3	0.3	0.7	0.5	0.3	0.4	0.3
FEHBP	-	-	-	-	-	-	0.0	(0.0)	0.0	0.0
Medicare	-	-	-	-	-	0.2	0.1	(0.1)	0.0	0.1
Medicaid	-	-	-	-	-	-	-	-	-	-
Other Health	0.9	3.9	4.3	0.8	(2.1)	(0.2)	4.1	0.9	6.9	5.6
Total	0.8	8.6	8.8	7.7	10.5	15.8	18.6	27.7	47.3	13.5

[105] Note 14(f) to 2012 NAIC financial statement.
[106] Note 14(h) to 2012 NAIC financial statement.

Table 3A. Underwriting Gain or (Loss) as a percentage of Revenue - HealthPartners, Inc.

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Comprehensive	1.1%	3.1%	0.5%	1.8%	1.7%	2.0%	1.8%	4.6%	8.3%	8.4%
Medicare Suppl	1.5%	0.6%	10.1%	16.2%	9.2%	27.5%	24.2%	18.3%	13.9%	19.2%
Dental Only	0.3%	-1.5%	-2.1%	-2.6%	-2.6%	-2.6%	-0.7%	2.5%	15.5%	12.8%
FEHBP	-9.4%	-5.8%	31.2%	14.3%	-50.0%	-7.1%	-	-	-	-
Medicare	21.6%	2.5%	11.2%	5.1%	4.5%	2.2%	-9.9%	-19.2%	-12.7%	-8.9%
Medicaid	-5.6%	-5.0%	-5.7%	-4.6%	0.1%	2.0%	3.6%	5.8%	2.8%	5.7%
Other Health	-	-	-	-	-	-	-	-	-	-
Total	1.9%	1.4%	1.0%	1.1%	1.6%	1.8%	2.0%	4.6%	6.8%	7.4%

Table 3B. Underwriting Gain or (Loss) as a percentage of Revenue - Group Health Plan, Inc.

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Comprehensive	4.5%	-1.6%	-3.9%	-4.3%	0.4%	2.6%	-1.0%	-0.1%	0.2%	-1.8%
Medicare Suppl	-	-	-	-	-	-	-	-	-	-
Dental Only	0.3%	-1.5%	-2.1%	-2.5%	-2.6%	-2.6%	-0.7%	2.5%	-3.1%	-2.7%
FEHBP	-2.6%	3.0%	11.3%	3.7%	-3.7%	-14.0%	1.1%	0.6%	-0.1%	0.5%
Medicare	-8.5%	-5.4%	-6.9%	1.9%	-18.9%	4.5%	5.6%	0.3%	6.1%	7.3%
Medicaid	-	-	-	-	-	5.1%	-	-	-	-
Other Health	-	-	-	-	-	-	-	-	-	-
Total	-0.2%	-1.7%	-2.0%	-2.5%	-1.3%	1.1%	1.3%	0.1%	2.2%	1.6%

Table 3C. Underwriting Gain or (Loss) as a percentage of Revenue - HPIC

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Comprehensive	-1.1%	12.7%	7.4%	4.9%	6.9%	5.3%	3.4%	4.3%	4.9%	0.9%
Medicare Suppl	-	-	-	-	-	-	-	-	-	-
Dental Only	2.4%	0.8%	-4.9%	3.9%	3.8%	6.1%	5.4%	2.6%	2.7%	2.4%
FEHBP	-	-	-	-	-	-	0.0%	-1.2%	0.3%	0.8%
Medicare	-	-	-	-	-	14.1%	6.5%	-194.8%	13.5%	14.5%
Medicaid	-	-	-	-	-	-	-	-	-	-
Other Health	7.7%	31.2%	39.9%	7.1%	-13.0%	-1.1%	15.1%	2.9%	18.2%	12.5%
Total	1.8%	15.6%	10.7%	5.0%	5.2%	4.9%	4.2%	4.2%	5.5%	1.5%

Taking into consideration investment income, capital gains and miscellaneous income, HPI reported a gain of $106 million for 2012. HPI experience was profitable in each of the ten years included in the analysis. Over the course of the ten year period HPI's pre-FIT income has ranged from a gain of $17 million in 2005 to a net profit of $106 million in 2012. GHI reported a gain of $20 million in 2012. GHI reported total losses of about $5 million in 2004 and 2005, but was profitable in all other years, with a highest profit of $27 million in 2011. HPIC reported pre-FIT profits of $16.4 million in 2012. HPIC was profitable in all ten years, with profits ranging from $1.6 million in 2003 to $49.7 million in 2011.

Table 4A. Net Income Before FIT ($1,000,000) - HealthPartners, Inc.

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Und. Gain	21.9	16.3	12.4	15.9	25.7	30.3	32.0	70.2	91.6	102.5
Net Inv. Income	2.5	3.2	4.6	6.6	8.9	7.5	3.5	3.1	2.6	3.0
Cap Gains	0.0	0.0	-0.4	-1.4	0.1	-2.5	0.5	1.0	0.3	0.9
Other	-	-	-	-	-	-	-	-	-	-
Net Pre-FITIncome	24.4	19.6	16.7	21.2	34.6	35.3	36.0	74.2	94.5	106.4

Table 4B. Net Income Before FIT ($1,000,000) - Group Health Plan, Inc.

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Und. Gain	-1.1	-9.5	-11.1	-14.4	-7.3	7.7	11.2	0.8	20.9	15.0
Net Inv. Income	5.4	4.8	6.8	17.1	12.3	11.3	6.6	4.7	7.1	3.1
Cap Gains	0.0	0.0	-0.7	-1.6	0.4	-11.8	1.1	3.0	-1.0	2.2
Other	-	-	-	-	-	-	-	-	-	-
Net Pre-FITIncome	4.3	-4.7	-5.0	1.2	5.5	7.1	18.9	8.5	27.0	20.3

Table 4C. Net Income Before FIT ($1,000,000) - HPIC

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Und. Gain	0.8	8.6	8.8	7.7	10.5	15.8	18.6	27.7	47.3	13.5
Net Inv. Income	0.8	0.7	1.1	1.9	2.6	2.7	2.1	2.3	2.3	2.6
Cap Gains	0.1	-0.1	-0.2	-0.1	0.0	-0.4	0.4	0.1	0.2	0.2
Other	-	-	-	-	-	-	-	-	-	-
Net Pre-FITIncome	1.6	9.3	9.7	9.5	13.2	18.1	21.0	30.1	49.7	16.4

HPI has built up capital reserves of approximately $709 million as of year-end 2012. The surplus has grown in each of the last nine years as compared to the year before, except for a modest decrease in 2008. Year to year growth in surplus has ranged from -$10 million (2008) to $119 million (2011). The surplus has more than doubled in the last four years. The compound growth in surplus has averaged 12% per year. HPI surplus includes the surplus of its subsidiaries GHI and HPIC and a portion of the surplus of its non-insurance subsidiaries.

GHI has built up capital reserves of approximately $99 million as of year-end 2012. The surplus declined in 2004 and 2005, and did not reach the 2003 level again until 2008. Overall, the compound annual growth over the ten-year period has averaged 3% per year.

HPIC has built up capital reserves of approximately $149 million as of year-end 2012. The surplus has grown in each of the last ten years. Overall, the compound annual growth over the ten-year period has averaged 33% per year.

HPI surplus, expressed as a percentage of revenue (SAPOR), has ranged from a low of 14.8% at year-end 2003 to a high of 51.4%, which was achieved at year-end 2012. SAPOR dropped by 1.9% in 2005, and did not reach the 2004 level again until 2009. It has since more than doubled. However, t should be noted that the surplus of HPI as of 2012 includes $248 million of GHI and HPIC surplus and an additional $102 million of surplus from non-insurance subsidiaries. Subtracting these from the total leaves a net HPI surplus of $359 million, reducing the equivalent SAPOR from 51.4% to 26.0%. That represents a more comparable basis with regard to the other Minnesota health plans.

GHI SAPOR was 10.2% in 2012. It has not varied more than a percent up or down from that level except in 2003 when it was higher and 2005 when it was lower. However, GHI revenue is misleading, in that it includes fee-based revenue related to self-insured claims for which GHI is not at risk. If the fee-based revenue were not included, GHI's surplus would represent 21.5% of the resulting net revenue in 2012.

HPIC SAPOR was 16.9% in 2012. SAPOR averaged around 30% from 2003-2005, but has ranged from 13% to 19% since.

Table 5A. Capital and Surplus Analysis ($1,000,000 or %) - HealthPartners, Inc.

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Surplus	167.3	264.9	275.1	297.0	344.7	335.4	386.6	497.4	616.9	709.1
Growth in Surplus		97.58	10.27	21.86	47.76	(9.33)	51.14	110.89	119.42	92.28
Growth Percentage		58.3%	3.9%	7.9%	16.1%	-2.7%	15.2%	28.7%	24.0%	15.0%
Suplus as % of Revenue	14.8%	23.3%	21.4%	20.3%	21.8%	20.4%	24.3%	32.7%	45.6%	51.4%

Table 5B. Capital and Surplus Analysis ($1,000,000 or %) - Group Health Plan, Inc.

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Surplus	75.7	58.1	44.4	60.2	61.2	75.8	79.4	85.5	98.7	98.8
Growth in Surplus		(17.59)	(13.71)	15.81	1.00	14.54	3.66	6.10	13.16	0.07
Growth Percentage		-23.2%	-23.6%	35.6%	1.7%	23.7%	4.8%	7.7%	15.4%	0.1%
Suplus as % of Revenue	15.6%	10.7%	7.9%	10.3%	10.6%	11.0%	9.4%	10.4%	10.6%	10.2%

Table 5C. Capital and Surplus Analysis ($1,000,000 or %) - HPIC

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Surplus	11.4	17.6	23.9	30.0	38.7	50.4	64.2	84.2	113.2	148.9
Growth in Surplus		6.15	6.35	6.11	8.65	11.75	13.74	20.04	28.99	35.65
Growth Percentage		53.8%	36.2%	25.6%	28.8%	30.4%	27.2%	31.2%	34.4%	31.5%
Suplus as % of Revenue	26.3%	31.7%	29.0%	19.3%	19.2%	15.7%	14.3%	12.7%	13.1%	16.9%

HPI Total Adjusted Capital[107], expressed as the ratio of reported surplus and the Authorized Control Level ("RBC" ratio) is 573% for year-end 2012. HPI's RBC ratio has varied over the ten year period, with a low of 446% (2009) and a high of 683% (2004). This ratio includes the capital and surplus and authorized control level surplus of the subsidiary insurers, GHI and HPIC. GHI's RBC ratio was 527% at year-end 2012, its lowest level since 2005. The range has been 393% (2005) to 726% (2003). HPIC's RBC ratio was 468% at year-end 2012. The range has been 365% (2010) to 607% (2005).

Another measure of the level of capital reserves expresses it as months of claims and expenses.[108] HPI's capital reserves have been equal to from 1.8 months to 6.7 months of claims and expenses during the last ten years, increasing almost every year. This is misleading, again because HPI capital reserves include $350 million of capital reserves of its subsidiaries. On a net basis, removing the capital reserves of the subsidiaries, HPI's 2012 remaining net reserves would represent 3.38 months of claims and expenses. GHI capital reserves have ranged from 0.9 months to 1.9 months of claims and expenses, but have been relatively stable at or near 1.2 months from 2006-2012. However, this is also misleading. If GHI's fee based revenue is removed from claims and expenses, its surplus would represent 2.67 months of the remaining net claims and expenses. HPIC capital reserves have been as high as 4.5 months claims and expenses (2004), but have ranged from 1.6 to 2.4 from 2006-2012, with a most recent year experience of 2.1 months.

[107] Total Adjusted Capital is a derived amount. It is the surplus reported in the annual statement with certain specified adjustments. In most instances they are the same.

[108] This measure of surplus differs slightly from the minimum reserve requirement that was in effect in Minnesota for the first two years of the ten year period under review.

Table 6A. Risk Based Capital Analysis ($1,000,000 or %) - HealthPartners, Inc.

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Surplus	167.3	264.9	275.1	297.0	344.7	335.4	386.6	497.4	616.9	709.1
Total Adjusted Capital	167.3	264.9	275.1	297.0	344.7	335.4	386.6	497.4	616.9	709.1
Authorized Control Level	33.5	38.8	44.2	51.2	54.9	56.8	86.6	101.4	110.1	123.7
RBC Ratio	499%	683%	623%	580%	628%	591%	446%	491%	561%	573%
MN Minimum Surplus	132.9	-	88.4	51.2	54.9	56.8	86.6	101.4	110.1	123.7
Surplus as % of MN Minimum Surplus	126%	-	311%	580%	628%	591%	446%	491%	561%	573%
Surplus as Months Claims & Expenses	1.8	2.8	2.6	2.5	2.7	2.5	3.0	4.1	5.9	6.7
Adj Surplus as Months Claims & Expenses	0.9	1.5	1.5	1.5	1.6	1.2	1.4	2.1	3.0	3.4

Table 6B. Risk Based Capital Analysis ($1,000,000 or %) - Group Health Plan, Inc.

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Surplus	75.7	58.1	44.4	60.2	61.2	75.8	79.4	85.5	98.7	98.8
Total Adjusted Capital	75.7	58.1	44.4	60.2	61.2	75.8	79.4	85.5	98.7	98.8
Authorized Control Level	10.4	11.5	11.3	10.0	9.0	9.3	14.3	14.9	17.5	18.8
RBC Ratio	726%	507%	393%	601%	680%	812%	557%	573%	565%	527%
MN Minimum Surplus	132.9	-	22.6	10.0	9.0	9.3	14.3	14.9	17.5	18.8
Surplus as % of MN Minimum Surplus	57%	-	196%	601%	680%	812%	557%	573%	565%	527%
Surplus as Months Claims & Expenses	1.9	1.3	0.9	1.2	1.3	1.3	1.1	1.2	1.3	1.2
Adj Surplus as Months Claims & Expenses	3.7	2.8	2.1	3.4	4.1	3.8	2.4	2.7	2.7	2.7

Table 6C. Risk Based Capital Analysis ($1,000,000 or %) - HPIC

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Surplus	11.4	17.6	23.9	30.0	38.7	50.4	64.2	84.2	113.2	148.9
Total Adjusted Capital	11.4	17.6	23.9	30.0	38.7	50.4	64.2	84.2	113.2	148.9
Authorized Control Level	3.1	3.2	3.9	6.3	8.2	12.5	17.3	23.1	29.4	31.8
RBC Ratio	371%	542%	607%	473%	470%	403%	371%	365%	385%	468%
MN Minimum Surplus	4.6	4.9	5.9	9.5	12.1	18.7	25.9	34.6	44.1	47.7
Surplus as % of MN Minimum Surplus	247%	361%	405%	316%	321%	269%	247%	243%	257%	312%
Surplus as Months Claims & Expenses	3.2	4.5	3.9	2.4	2.4	2.0	1.8	1.6	1.7	2.1

All three of the HealthPartners companies sell commercial Comprehensive business. GHI has consistently written about 25% of the total Comprehensive business of the three companies, while Comprehensive business has gradually declined at HPI and increased at HPIC. In 2003, HPIC wrote only 2.5% of the combined company comprehensive business, but by 2012 HPIC wrote more than HPI for the first time. All three companies also have significant Dental insurance blocks. The second largest line after Comprehensive for HPI is Medicaid and HPI reports very little Medicare. HPI has MSHO business that it includes in the Medicaid line. HPI had previously written a large block of Medicare business through 2008. For GHI the second largest line is Medicare, and they last reported Medicaid business in 2008. The Medicaid business they had in 2008 was 85% MSHO and the balance PMAP. For HPIC, the second largest

line of business is Stop Loss. GHI also reports about $48 million of FEHBP business, which has been gradually declining over the ten year period.

Comprehensive business had a 10 year average loss ratio of 87% at HPI, 97% at GHI and 80% at HPIC. In the most recent year, the loss ratio was 82% at HPI, 98% at GHI and 85% at HPIC.

GHI's Medicare line of business experienced a 10 year average loss ratio of 95.4%. For the most recent year the loss ratio was 85.0%, the lowest of the 10 years.

HPI's Medicaid line of business experienced an average loss ratio of 93.1% with results varying from 87.2% in 2012 to 98.1% in 2004. The reported loss ratio for 2012 is 87.2%.

Table 7A. Loss Ratio by Line of Business - HealthPartners, Inc.

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Comprehensive	89.3%	86.0%	88.7%	89.4%	88.6%	88.9%	88.9%	86.5%	81.7%	82.2%
Medicare Suppl	79.5%	81.1%	73.9%	70.2%	77.6%	59.5%	60.7%	65.6%	70.3%	64.7%
Dental Only	90.9%	91.3%	92.3%	94.4%	93.9%	94.1%	92.0%	82.2%	84.5%	75.0%
FEHBP	101.0%	97.1%	63.4%	77.4%	138.4%	100.0%	-	-	-	-
Medicare	70.9%	88.3%	81.3%	88.1%	88.2%	89.4%	105.3%	112.4%	94.3%	93.2%
Medicaid	99.3%	97.3%	98.1%	97.4%	93.2%	92.4%	89.9%	87.3%	89.8%	87.2%
Other Health	-	-	-	-	-	-	-	-	-	-
Total	89.2%	88.4%	89.2%	90.7%	89.6%	89.6%	89.4%	86.7%	84.2%	84.0%

Table 7B. Loss Ratio by Line of Business- Group Health Plan, Inc.

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Comprehensive	92.4%	98.0%	99.6%	101.4%	95.5%	92.5%	97.9%	97.1%	96.0%	98.1%
Medicare Suppl	-	-	-	-	-	-	-	-	-	-
Dental Only	95.0%	96.8%	97.5%	98.8%	97.9%	96.8%	95.6%	82.2%	92.1%	91.3%
FEHBP	93.5%	88.9%	81.4%	88.9%	95.9%	104.9%	91.3%	91.6%	91.7%	91.0%
Medicare	102.4%	100.0%	103.6%	93.8%	114.5%	91.3%	85.9%	91.0%	86.0%	85.0%
Medicaid	-	-	-	-	-	86.2%	-	-	-	-
Other Health	-	-	-	-	-	-	-	-	-	-
Total	95.5%	97.1%	97.4%	98.7%	96.6%	93.0%	93.3%	94.6%	91.9%	92.7%

Table 7C. Loss Ratio by Line of Business - HPIC

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Comprehensive	83.5%	72.2%	75.2%	80.6%	78.1%	79.9%	82.6%	81.8%	81.5%	85.3%
Medicare Suppl	-	-	-	-	-	-	-	-	-	-
Dental Only	82.7%	80.6%	85.2%	81.3%	81.4%	79.2%	81.0%	79.7%	80.5%	80.5%
FEHBP	-	-	-	-	-	-	85.6%	82.1%	81.7%	80.0%
Medicare	-	-	-	-	-	72.5%	89.7%	285.0%	82.9%	82.9%
Medicaid	-	-	-	-	-	-	-	-	-	-
Other Health	88.1%	51.8%	48.6%	78.7%	102.6%	85.3%	75.8%	87.7%	72.6%	78.1%
Total	84.7%	68.5%	72.5%	80.5%	80.2%	80.2%	82.1%	82.1%	81.1%	84.9%

The number of member months reported in the 2012 annual statement was approximately 2.9 million for HPI, 0.6 million for GHI, and 6.2 million for HPIC. HPIC member months are overstated because of double counting due to multiple products being sold to the same members, and because of relatively low premium stop loss insurance.

Table 8A. Member Months - HealthPartners, Inc.

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Member Months (000)	4,243.4	4,005.7	4,056.7	4,156.8	3,997.2	4,050.1	3,620.7	3,354.8	2,905.8	2,860.1
Growth over Prior Year		-5.6%	1.3%	2.5%	-3.8%	1.3%	-10.6%	-7.3%	-13.4%	-1.6%
PMPM Revenue	266.37	284.27	316.74	351.16	396.36	405.04	439.35	452.88	465.30	482.23
Growth in PMPM Revenue		6.7%	11.4%	10.9%	12.9%	2.2%	8.5%	3.1%	2.7%	3.6%

Table 8B. Member Months - Group Health Plan, Inc.

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Member Months (000)	536.1	493.0	443.7	340.6	309.6	275.7	628.7	596.5	619.3	623.5
Growth over Prior Year		-8.0%	-10.0%	-23.2%	-9.1%	-10.9%	128.0%	-5.1%	3.8%	0.7%
PMPM Revenue	905.88	1,101.06	1,260.76	1,712.10	1,866.55	2,493.63	1,337.92	1,383.21	1,503.54	1,553.20
Growth in PMPM Revenue		21.5%	14.5%	35.8%	9.0%	33.6%	-46.3%	3.4%	8.7%	3.3%

Table 8C. Member Months - HPIC

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Member Months (000)	3,627.5	3,822.2	4,114.6	4,379.1	4,530.0	5,034.3	5,703.6	6,031.3	6,199.8	6,159.4
Growth over Prior Year		5.4%	7.7%	6.4%	3.4%	11.1%	13.3%	5.7%	2.8%	-0.7%
PMPM Revenue	11.97	14.50	20.02	35.53	44.57	63.64	78.44	110.02	138.95	142.99
Growth in PMPM Revenue		21.1%	38.1%	77.5%	25.4%	42.8%	23.2%	40.3%	26.3%	2.9%

The following paragraphs discuss expenses. It should be noted that expense trends may appear misleadingly high because some elements reported as expenses are outside the control of the company, including the 1% HMO premium tax, which started in 2004 and state assessments which have grown over the period.

HPI expenses[109] have varied over the ten year period, and have decreased in each of the last four years. Over the 10 year period, expenses averaged 8.9% of revenue, with a high of 10.2% in 2004 and a low of 8.2% in 2006. Expenses expressed on a PMPM basis have generally grown, although they are down 1.4% in the most recent year. The compound average annual PMPM increase is 6.5%.

GHI expenses have increased in seven of the last nine years, and are now more than twice as large as they were in 2003. They averaged 5.1% of revenue over the ten year period. The compound average annual pmpm expense increase is 8.3%.

HPIC expenses have increased sharply over the ten year period, as HPIC's business volume has increased, and its distribution of business has changed. In the 2009 – 2012 time frame they have averaged 13.6% of premium, which is also the current level. HPIC sells individual and small employer products which have higher administrative costs as a percent of premium revenue due to the lower premiums and lower benefits these customers purchase.

GHI supplies certain administrative services to HPI and is reimbursed in accordance with an administrative services agreement between the two companies. HPI paid GHI $77million and $79 million under this agreement for 2012 and 2011 respectively.

[109] The sum of Claim Adjustment Expenses and General Administrative Expenses

Table 9A. Claim Adjudication and Administrative Expenses - HealthPartners, Inc.

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Expenses (000,000)	100.2	116.1	126.3	120.0	138.8	139.7	136.0	131.5	122.4	118.8
Growth over Prior Year		15.8%	8.7%	-5.0%	15.7%	0.6%	-2.6%	-3.3%	-7.0%	-2.9%
Expense as % of Revenue	8.9%	10.2%	9.8%	8.2%	8.8%	8.5%	8.5%	8.7%	9.1%	8.6%
PMPM Expense	23.62	28.99	31.12	28.86	34.73	34.48	37.56	39.21	42.11	41.54

Table 9B. Claim Adjudication and Administrative Expenses - Group Health Plan, Inc.

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Expenses (000,000)	23.1	25.4	25.7	21.8	27.1	40.2	45.2	43.5	54.4	55.2
Growth over Prior Year		10.0%	1.1%	-15.2%	24.5%	48.4%	12.4%	-3.8%	25.1%	1.5%
Expense as % of Revenue	4.8%	4.7%	4.6%	3.7%	4.7%	5.8%	5.4%	5.3%	5.8%	5.7%
PMPM Expense	43.09	51.55	57.91	63.93	87.55	145.85	71.92	72.95	87.90	88.60
Growth in PMPM Expense		19.6%	12.3%	10.4%	36.9%	66.6%	-50.7%	1.4%	20.5%	0.8%

Table 9C. Claim Adjudication and Administrative Expenses - HPIC

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Expenses (000,000)	5.9	8.8	13.8	22.7	29.4	47.7	61.4	91.2	115.9	119.6
Growth over Prior Year		50.3%	56.7%	63.6%	30.0%	61.9%	28.8%	48.5%	27.1%	3.2%
Expense as % of Revenue	13.5%	15.9%	16.8%	14.6%	14.6%	14.9%	13.7%	13.7%	13.5%	13.6%
PMPM Expense	1.62	2.31	3.36	5.17	6.50	9.47	10.76	15.11	18.70	19.42
Growth in PMPM Expense		42.6%	45.6%	53.7%	25.7%	45.7%	13.7%	40.5%	23.7%	3.9%

For each accounting period the companies estimate their liability for claims incurred but not reported ("IBNR"). The IBNR is generally the largest liability reported on the company's balance sheet. For statutory accounting company management generally estimates this amount on a conservative basis by including a specified margin. This liability is required to be certified by an outside actuary annually in accordance with accepted actuarial standards consistently applied and fairly stated in accordance with sound actuarial principles, as filed with the Department of Commerce. The annual statement provides a test of the adequacy of the prior year reserve. An anticipated margin of 8-10% in the reconciled reserve is common and may generally be viewed as reasonable. However actual results from year to year will vary. Health plans maintain a margin in their IBNR reserve because the actual liability is not known at the time it is estimated and it is subject to variation. HealthPartners companies have generally reported very conservative liability amounts for their claim reserve. In the 2012 Annual Financial Statement, HPI, GHI and HPIC reported margins of 21%, 34% and 18%, respectively, of the reconciled 2011 claim reserve. For the most recent four years, HPI reported an average margin of 39% of the reconciled claim reserve. Excess margins in the claim reserve reduce the company's reported surplus.

Table 10A. Claim Reserve Reconciliation ($1,000,000 or %) - HealthPartners, Inc.

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Reported Prior Yr Reserve	49.5	77.8	74.0	88.1	108.7	116.4	108.8	113.3	105.6	96.2
Reconciled Reserve	50.8	71.8	75.9	86.6	93.1	101.7	84.7	91.0	82.3	79.3
Margin in Reserve	(1.3)	6.1	(2.0)	1.5	15.5	14.7	24.0	22.2	23.3	16.9
Margin as % of Reconciled Reserve	-2.6%	8.5%	-2.6%	1.7%	16.7%	14.5%	28.4%	24.4%	28.3%	21.3%
Margin as % of Surplus	-0.8%	2.3%	-0.7%	0.5%	4.5%	4.4%	6.2%	4.5%	3.8%	2.4%

Table 10B. Claim Reserve Reconciliation ($1,000,000 or %) - Group Health Plan, Inc.

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Reported Prior Yr Reserve	42.2	19.8	15.9	14.4	14.6	14.4	18.7	21.6	19.3	20.8
Reconciled Reserve	35.7	15.3	13.2	15.1	12.6	10.9	14.3	15.0	13.4	15.6
Margin in Reserve	6.5	4.5	2.7	(0.7)	2.0	3.5	4.4	6.6	5.9	5.3
Margin as % of Reconciled Reserve	18.2%	29.3%	20.3%	-4.4%	15.9%	31.6%	30.6%	43.8%	43.9%	34.0%
Margin as % of Surplus	8.6%	7.7%	6.0%	-1.1%	3.3%	4.6%	5.5%	7.7%	6.0%	5.3%

Table 10C. Claim Reserve Reconciliation ($1,000,000 or %) - HPIC

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Reported Prior Yr Reserve	11.4	11.0	9.3	12.9	21.6	24.2	32.1	41.7	71.5	84.9
Reconciled Reserve	5.4	4.9	5.0	11.2	15.7	19.8	34.2	36.0	52.8	72.3
Margin in Reserve	6.1	6.1	4.4	1.7	5.8	4.4	(2.1)	5.7	18.7	12.7
Margin as % of Reconciled Reserve	112.4%	123.4%	87.6%	14.7%	37.2%	22.1%	-6.1%	15.7%	35.4%	17.5%
Margin as % of Surplus	53.0%	34.7%	18.2%	5.5%	15.1%	8.7%	-3.2%	6.7%	16.5%	8.5%

At year-end 2012, approximately 47%, 58% and 74%, respectively, of the HPI, GHI and HPIC invested assets consisted of long term bonds. HPI reported 8% of its assets in common stocks, the first time they have reported common stock holdings since 2003. GHI held 12% of its assets in commons stocks. HPIC held no common stocks. Common stocks are valued at market and are relatively more volatile than other investments usually made by health plans. However, they offer the possibility of superior returns, which could ultimately make health premiums lower. They create a somewhat higher Authorized Control Level amount under the RBC formula, and therefore result in a lower RBC ratio for the same amount of capital reserves. The effect on the ratios of the HPI companies is not great, because their common stock portfolio is relatively small compared to other investments. In addition, 18% of GHI's assets are represented by company owned and occupied real estate. Neither of the other companies owns any real estate. The balance of their invested assets is virtually all in cash and cash equivalents.

Table 11A. Invested Assets by Type ($1,000,000) - HealthPartners, Inc.

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Bonds	106.0	109.7	98.8	82.6	91.8	92.1	114.7	113.1	195.6	180.6
Stocks - Preferred	-	-	-	-	-	-	-	-	-	-
Stocks - Common	25.7	-	-	-	-	-	-	-	-	30.3
Mortgage Loans- First	-	-	-	-	-	-	-	-	-	-
Mortgage Loans - Other	-	-	-	-	-	-	-	-	-	-
RE - Occupied	-	-	-	-	-	-	-	-	-	-
RE - For Income	-	-	-	-	-	-	-	-	-	-
RE Other	-	-	-	-	-	-	-	-	-	-
Cash & Equivalent	53.6	73.0	53.1	56.5	125.1	139.2	135.2	195.1	136.0	170.3
Other Invested Assets	-	-	-	20.0	20.0	-	-	9.8	8.3	6.6
Total Invested Assets	185.3	182.7	151.9	159.1	236.9	231.4	249.9	317.9	339.9	387.8

Table 11B. Invested Assets by Type ($1,000,000) - Group Health Plan, Inc.

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Bonds	149.4	162.4	167.6	160.9	168.2	164.7	188.0	188.1	221.1	232.7
Stocks - Preferred	-	-	-	-	-	-	-	-	-	-
Stocks - Common	26.2	23.3	23.4	30.8	22.8	20.0	28.2	35.4	39.5	47.8
Mortgage Loans- First	-	-	-	-	-	-	-	-	-	-
Mortgage Loans - Other	-	-	-	-	-	-	-	-	-	-
RE - Occupied	73.1	72.8	70.6	66.5	66.6	68.5	69.6	71.2	71.2	72.9
RE - For Income	-	-	-	-	-	-	-	-	-	-
RE Other	-	-	-	-	-	-	-	-	-	-
Cash & Equivalent	53.5	22.3	8.0	59.4	60.3	44.3	25.3	70.9	100.9	42.1
Other Invested Assets	-	-	-	-	-	-	-	3.0	3.6	5.3
Total Invested Assets	302.2	280.8	269.5	317.6	317.9	297.4	311.1	368.6	436.3	400.8

Table 11C. Invested Assets by Type ($1,000,000) - HPIC

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Bonds	18.6	22.7	30.7	38.8	40.0	51.3	77.1	115.5	183.7	190.7
Stocks - Preferred	-	-	-	-	-	-	-	-	-	-
Stocks - Common	-	0.0	0.0	0.0	0.0	0.0	-	-	-	-
Mortgage Loans- First	-	-	-	-	-	-	-	-	-	-
Mortgage Loans - Other	-	-	-	-	-	-	-	-	-	-
RE - Occupied	-	-	-	-	-	-	-	-	-	-
RE - For Income	-	-	-	-	-	-	-	-	-	-
RE Other	-	-	-	-	-	-	-	-	-	-
Cash & Equivalent	3.1	5.8	6.7	11.2	20.8	32.8	43.1	66.0	49.5	66.9
Other Invested Assets	0.0	-	-	-	-	-	-	-	-	-
Total Invested Assets	21.7	28.5	37.4	50.0	60.8	84.1	120.2	181.5	233.2	257.6

Table 12A. Invested Assets by Type (% of Total) - HealthPartners, Inc.

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Bonds	57%	60%	65%	52%	39%	40%	46%	36%	58%	47%
Stocks - Preferred	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Stocks - Common	14%	0%	0%	0%	0%	0%	0%	0%	0%	8%
Mortgage Loans- First	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Mortgage Loans - Other	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
RE - Occupied	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
RE - For Income	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
RE Other	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Cash & Equivalent	29%	40%	35%	36%	53%	60%	54%	61%	40%	44%
Other Invested Assets	0%	0%	0%	13%	8%	0%	0%	3%	2%	2%
Total Invested Assets	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Table 12B. Invested Assets by Type (% of Total) - Group Health Plan, Inc.

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Bonds	49%	58%	62%	51%	53%	55%	60%	51%	51%	58%
Stocks - Preferred	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Stocks - Common	9%	8%	9%	10%	7%	7%	9%	10%	9%	12%
Mortgage Loans- First	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Mortgage Loans - Other	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
RE - Occupied	24%	26%	26%	21%	21%	23%	22%	19%	16%	18%
RE - For Income	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
RE Other	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Cash & Equivalent	18%	8%	3%	19%	19%	15%	8%	19%	23%	11%
Other Invested Assets	0%	0%	0%	0%	0%	0%	0%	1%	1%	1%
Total Invested Assets	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Table 12C. Invested Assets by Type (% of Total) - HPIC

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Bonds	85%	80%	82%	78%	66%	61%	64%	64%	79%	74%
Stocks - Preferred	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Stocks - Common	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Mortgage Loans- First	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Mortgage Loans - Other	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
RE - Occupied	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
RE - For Income	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
RE Other	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Cash & Equivalent	14%	20%	18%	22%	34%	39%	36%	36%	21%	26%
Other Invested Assets	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Total Invested Assets	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Realized capital gains are reflected in the income statement (Statement of Revenue and Expenses). The change in unrealized capital gains is not reflected in the income statement but is a direct credit to the company's surplus account. The amounts of realized and unrealized capital gains are highly variable. 2012 was generally positive.

Table 13A. Capital Gains ($1,000,000) - HealthPartners, Inc.

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Realized Cap. Gains (Net of FIT)	-	-	(0.4)	(1.4)	0.1	(2.5)	0.5	1.0	0.3	0.9
Unrealized Cap. Gains	-	-	-	-	-	-	(0.8)	(0.0)	0.5	0.4

Table 13B. Capital Gains ($1,000,000) - Group Health Plan, Inc.

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Realized Cap. Gains (Net of FIT)	-	-	(0.7)	(1.6)	0.4	(11.8)	1.1	3.0	(1.0)	2.2
Unrealized Cap. Gains	-	-	-	(3.5)	(0.0)	(0.9)	0.9	1.2	0.1	1.9

Table 13C. Capital Gains ($1,000,000) - HPIC

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Realized Cap. Gains (Net of FIT)	0.1	(0.1)	(0.2)	(0.1)	0.0	(0.4)	0.4	0.1	0.2	0.2
Unrealized Cap. Gains	-	-	-	-	-	0.0	(0.1)	0.1	(0.1)	0.1

Itasca Medical Care

Itasca Medical Care (IMCare) iis a County Based Purchaser (CBP) operating in Itasca County MN.

IMCare currently has about $47 million in annual revenue. It serves approximately 6,300 members. IMCare writes only public program business, with approximately 74% in PMAP, 18% in MNCare and 8% in MSHO. IMCare has been a fully integrated ACO with 100% of capitation risk flowing to a network provider pool for the last three decades.

IMCare does not write ASO or ASC plans.

Table 1. Revenue by Line of Business ($1,000,000) – IMCare

	2012
Comprehensive	-
Medicare Suppl	-
Dental Only	-
FEHBP	-
Medicare	8.0
Medicaid	39.5
Other Health	-
Total	47.5

Based on annual statement lines of business, for 2012 IMCare reported an underwriting gain of $0.5 million in the Medicare line of business and an offsetting underwriting loss in the Medicaid line of business.

Table 2. Underwriting Gain or (Loss) by Line of Business ($1,000,000) - IMCare

	2012
Comprehensive	-
Medicare Suppl	-
Dental Only	-
FEHBP	-
Medicare	0.5
Medicaid	(0.5)
Other Health	-
Total	-

Table 3. Underwriting Gain or (Loss) as a percentage of Revenue - IMCare

	2012
Comprehensive	
Medicare Suppl	-
Dental Only	-
FEHBP	-
Medicare	6.2%
Medicaid	-1.3%
Other Health	-
Total	0.0%

IMCare reported $2.1 million of total net income in the last ten years. It reported net income of $3.0 million during that period for PMAP, $4.0 million for GAMC and $12.0 million for MSHO, with an offsetting total loss of $17.0 million for MNCare. For the most recent year, 2012, IMCare reported a net income of $16,000.

Table 4. Net Income Before FIT ($1,000,000) – IMCare

	2012
Und. Gain	0.0
Net Inv. Income	0.0
Cap Gains	0.0
Other	-
Net Pre-FITIncome	0.0

IMCare has built up capital reserves of approximately $4.8 million as of year-end 2012. The capital and surplus has been relatively stable in the last few years, although down about 10% as compared to 2008-2009. The yearend 2012 surplus is approximately 10.1% of IMCare's annual revenue.

Table 5. Capital and Surplus Analysis ($1,000,000 or %) - IMCare

	2012
Surplus	4.8
Growth in Surplus	4.79
Growth Percentage	-
Suplus as % of Revenue	10.1%

IMCare's Total Adjusted Capital[110], expressed as the ratio of reported surplus and the Authorized Control Level ("RBC" ratio) is 216% for year-end 2012. The RBC ratio has declined for each year since 2008, when the company's RBC ratio was 276%. As a capitated model, IMCare's ACL surplus is lower than other companies because capitated services are valued at a lower rate than services for which the insurer is wholly at risk.

[110] Total Adjusted Capital is a derived amount. It is the surplus reported in the annual statement with certain specified adjustments. In most instances they are the same.

Table 6. Risk Based Capital Analysis ($1,000,000 or %) - IMCare

	2008	2009	2010	2011	2012
Surplus	-	-	-	-	4.8
Total Adjusted Capital	5.3	5.3	4.7	4.8	4.8
Authorized Control Level	1.9	2.1	2.2	2.2	2.2
RBC Ratio	276%	257%	220%	214%	216%
MN Minimum Surplus	-	-	-	-	-
Surplus as % of MN Minimum Surplus	-	-	-	-	-
Surplus as Months Claims & Expenses	-	-	-	-	1.2

IMCare reported an overall loss ratio of 91.3% for 2012, reflecting a loss ratio of 85.1% and 92.5% for the Medicare and Medicaid lines respectively.

Table 7. Loss Ratio by Line of Business – IMCare

	2012
Comprehensive	-
Medicare Suppl	-
Dental Only	-
FEHBP	-
Medicare	85.1%
Medicaid	92.5%
Other Health	-
Total	91.3%

The number of member months reported in the annual statement has grown 10.6% since 2008 and 15.6% since 2003. The reported member months is at 75,800 for 2012.

Table 8. Member Months - IMCare

	2008	2009	2010	2011	2012
Member Months (000)	68.5	69.9	71.6	75.3	75.8
Growth over Prior Year	-	2.1%	2.4%	5.2%	0.6%
PMPM Revenue	-	-	-	627.36	626.28
Growth in PMPM Revenue	-	-	-	-	-0.2%

Total reported expenses for 2012 were $4.1 million. This is an increase of 9.3% over reported 2011 expenses. Per member per month expenses were 54.56 for 2012, an increase of 8.6% over 2011 pmpm expenses.

Table 9. Claim Adjudication and Administrative Expenses - IMCare

	2011	2012
Expenses (000,000)	3.8	4.1
Growth over Prior Year	-	9.3%
Expense as % of Revenue	8.0%	8.7%
PMPM Expense	50.24	54.56
Growth in PMPM Expense	-	8.6%

Based on the 2012 reconciliation of the 2011 IBNR reserve, IMCare had a shortfall in the reserve of $0.6 million. The shortfall of $0.6 million was 8.9% of the reconciled reserve amount and constitutes 11.9% of the company reported 2012 surplus.

Table 10. Claim Reserve Reconciliation ($1,000,000 or %) - IMCare

	2012
Reported Prior Yr Reserve	5.8
Reconciled Reserve	6.4
Margin in Reserve	(0.6)
Margin as % of Reconciled Reserve	-8.9%
Margin as % of Surplus	-11.9%

At yearend 2012, all of IMCare's invested assets consisted of cash and equivalent investments.

Table 11. Invested Assets by Type ($1,000,000) - IMCare

	2011	2012
Bonds	-	-
Stocks - Preferred	-	-
Stocks - Common	-	-
Mortgage Loans- First	-	-
Mortgage Loans - Other	-	-
RE - Occupied	-	-
RE - For Income	-	-
RE Other	-	-
Cash & Equivalent	11.1	9.7
Other Invested Assets	-	-
Total Invested Assets	11.1	9.7

Table 12. Invested Assets by Type (% of Total) - IMCare

	2011	2012
Bonds	0%	0%
Stocks - Preferred	0%	0%
Stocks - Common	0%	0%
Mortgage Loans- First	0%	0%
Mortgage Loans - Other	0%	0%
RE - Occupied	0%	0%
RE - For Income	0%	0%
RE Other	0%	0%
Cash & Equivalent	100%	100%
Other Invested Assets	0%	0%
Total Invested Assets	100%	100%

Table 13. Capital Gains ($1,000,000) – IMCare

	2012
Realized Cap. Gains (Net of FIT)	-
Unrealized Cap. Gains	-

Medica Profile

Medica Health Plans ("Medica") is a Minnesota licensed HMO. It and two other insurers, Medica Health Plans of Wisconsin and Medica Insurance Company ("MIC") are among companies controlled by the holding company, Medica Holding Company.

Medica currently has about $1.6 billion in annual revenue. For 2012, Medica reported 27.9% of its revenue as Comprehensive, 20.3% as Medicare, and 51.5% as Medicaid. It reported a very small amount of revenue as Medicare Supplement and as Dental. Medica's Comprehensive business has declined by about 7% annually, on average, from $883 million in 2003 to $445 million in 2012. However, it was in steep decline from 2003 through 2008 and has grown from $130 million at that point to the present level. Medica has experienced significant growth in its Medicare and Medicaid lines, with average annual revenue growth of 9.5% and 7.1 % respectively.

In its 2012 Minnesota Supplement, Medica reported 19.1% of total revenue as MSHO business, and included it in the Medicare line in the annual statement. Some other plans have reported this business as part of Medicaid. Medicaid also reported 1% of its revenue as Medicare Cost. It reported SNBC (MA Only) (10.9%) PMAP (34.3%) and MNCare (6.3%) as part of Medicaid in its NAIC statement.

Medica's affiliated company, MIC, has about $1.4 billion in annual revenue. For 2012, MIC reported 49% of revenue as Comprehensive, 48% as Medicare, and 3% as stop loss. MIC's Comprehensive business has been of about the same size since 2007, implying shrinkage in member months. Its Medicare business has been increasing every year, with the first Medicare business reported in 2004.

Reported revenue for Medica and MIC is impacted by a quota share reinsurance arrangement. Under the quota share arrangement Medica assumed $461 million of premium, $389 million of claims and $43.8 of administrative expenses. The quota share arrangement is subject to a retrospective rating arrangement under which Medica accrued a refund to MIC of $24.8 million. Associated with this quota share arrangement is a stop loss contract with MIC that limits Medica's risk to 110% of the premium.[111]

Table 1A. Revenue by Line of Business ($1,000,000) – Medica Health Plans

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Comprehensive	882.5	782.9	567.0	252.4	231.6	130.3	288.3	469.3	408.0	445.1
Medicare Suppl	16.2	13.9	9.4	4.2	2.6	2.2	2.2	1.5	1.1	1.0
Dental Only	0.9	0.8	0.7	0.4	0.4	0.5	3.2	3.0	3.2	3.7
FEHBP	-	-	-	-	-	4.2	5.5	8.1	6.1	0.6
Medicare	143.2	60.1	72.2	246.4	249.2	280.4	308.7	448.1	317.5	323.6
Medicaid	442.5	517.7	570.7	523.1	558.5	635.6	759.5	776.2	851.0	820.5
Other Health	-	-	-	-	-	-	-	-	-	-
Total	1,485.2	1,375.4	1,220.0	1,026.5	1,042.2	1,053.1	1,367.5	1,706.2	1,586.8	1,594.5

[111] Medica 2012 Annual Financial Statement, Notes to Financial Statements, Note 23.

Table 1B. Revenue by Line of Business ($1,000,000) – Medica Insurance Company

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Comprehensive	285.5	514.1	748.3	1,004.4	670.9	706.7	648.3	602.6	587.5	673.5
Medicare Suppl	-	-	-	-	-	-	-	-	-	-
Dental Only	-	-	-	-	-	-	-	-	-	-
FEHBP	-	-	-	-	-	0.0	0.1	0.3	-	-
Medicare	-	127.0	168.8	228.5	240.3	289.3	390.4	485.0	604.0	662.5
Medicaid	-	-	-	-	-	-	-	-	-	-
Other Health	21.1	19.6	18.9	19.9	20.4	26.1	26.0	29.1	38.7	45.0
Total	306.6	660.8	936.1	1,252.7	931.7	1,022.1	1,064.8	1,117.0	1,230.3	1,381.0

Medica reported $12 million of total net underwriting gains in the last ten years, with considerable variation by line of business and year. The Comprehensive business had a cumulative loss of $138.5 million. The Medicare business had $66.1 million of total net gains over the 10 year period, while the Medicaid business had total net gains of $70.7 million. The company experienced significant variability in the reported underwriting gains for both major lines of business. For the most recent year, 2012, Medica reported a net underwriting gain of $28.5 million. For 2012, 64% of the underwriting gain was derived from the Medicaid line and 45% was derived from the Medicare line. Net underwriting gains do not take into account investment earnings and realized capital gains.

MIC had a cumulative underwriting gain over the ten year period of $216 million. The ten year underwriting gain for the Medicare line was $217 million, while the Comprehensive line produced an underwriting loss of $67.1 million and the Other Health line showed a gain of $66.6 million. For the most recent year, 2012, MIC reported an underwriting loss of $3.7 million, due to a substantial decrease in profitability in all lines of business compared to the prior year.

Medica has entered into certain agreements with the State of Minnesota that impact the absolute amount of profitability of state contracts and will tend to smooth the company's underwriting gain[112]. In 2011 Medica agreed to limit its net underwriting gain on certain Medicaid products to 1% for the Medical Assistance (PMAP) and MinnesotaCare (MNCare) programs. In 2012 Medica agreed to share in the profits and losses of the "Special Needs Basic Care Non Medicare Advantage Special Needs Plan. Substantial payments have been made or accrued during 2011 and 2012 as a result of these agreements. This resulted in liabilities of approximately $25 million for 2011 and $8 million for 2012.

Table 2A. Underwriting Gain or (Loss) by Line of Business ($1,000,000) - Medica Health Plans

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Comprehensive	(21.9)	(23.2)	(40.0)	(21.2)	(14.2)	(10.6)	(6.0)	(1.9)	4.3	(3.9)
Medicare Suppl	2.8	3.0	1.5	0.0	(0.2)	0.1	0.2	(0.1)	0.1	0.3
Dental Only	1.0	0.8	0.7	0.4	0.4	0.5	0.5	0.9	0.9	0.8
FEHBP	-	-	-	-	-	0.0	(0.1)	(1.7)	0.5	0.4
Medicare	17.0	6.4	2.3	12.1	7.8	10.1	(3.8)	(3.9)	5.4	12.7
Medicaid	18.4	9.4	(0.1)	(42.9)	7.0	21.4	38.0	16.6	(15.3)	18.2
Other Health	-	-	-	-	-	-	-	-	-	-
Total	17.3	(3.5)	(35.6)	(51.5)	0.8	21.4	28.8	9.8	(3.9)	28.5

[112] 2012 Annual Statement, Note 1 p. 25.6, Notes to Financial Statements

Table 2B. Underwriting Gain or (Loss) by Line of Business ($1,000,000) - Medica Insurance Company

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Comprehensive	(8.0)	16.0	(26.6)	(6.5)	(9.8)	(22.8)	(2.2)	48.5	(18.8)	(36.9)
Medicare Suppl	-	-	-	-	-	-	-	-	-	-
Dental Only	-	-	-	-	-	-	-	-	-	-
FEHBP	-	-	-	-	-	-	(0.0)	(0.0)	(0.0)	(0.0)
Medicare	-	(1.2)	6.0	29.4	19.9	30.1	24.5	(3.0)	84.4	26.5
Medicaid	-	-	-	-	-	-	-	-	-	-
Other Health	21.1	(2.6)	10.8	5.4	2.2	3.2	(0.8)	8.0	12.5	6.7
Total	13.1	12.3	(9.7)	28.3	12.2	10.5	21.5	53.5	78.1	(3.7)

Table 3A. Underwriting Gain or (Loss) as a percentage of Revenue - Medica Health Plans

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Comprehensive	-2.5%	-3.0%	-7.1%	-8.4%	-6.1%	-8.1%	-2.1%	-0.4%	1.1%	-0.9%
Medicare Suppl	17.3%	21.8%	15.4%	0.5%	-7.0%	2.4%	11.1%	-4.4%	7.3%	29.3%
Dental Only	116.8%	100.0%	100.0%	100.0%	100.0%	100.0%	15.1%	28.5%	30.1%	21.3%
FEHBP	-	-	-	-	-	0.1%	-1.1%	-21.5%	9.0%	64.9%
Medicare	11.9%	10.7%	3.2%	4.9%	3.1%	3.6%	-1.2%	-0.9%	1.7%	3.9%
Medicaid	4.1%	1.8%	0.0%	-8.2%	1.3%	3.4%	5.0%	2.1%	-1.8%	2.2%
Other Health	-	-	-	-	-	-	-	-	-	-
Total	1.2%	-0.3%	-2.9%	-5.0%	0.1%	2.0%	2.1%	0.6%	-0.2%	1.8%

Table 3B. Underwriting Gain or (Loss) as a percentage of Revenue - Medica Insurance Company

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Comprehensive	-2.8%	3.1%	-3.6%	-0.6%	-1.5%	-3.2%	-0.3%	8.0%	-3.2%	-5.5%
Medicare Suppl	-	-	-	-	-	-	-	-	-	-
Dental Only	-	-	-	-	-	-	-	-	-	-
FEHBP	-	-	-	-	-	0.0%	-16.2%	-3.2%	-	-
Medicare	-	-0.9%	3.6%	12.9%	8.3%	10.4%	6.3%	-0.6%	14.0%	4.0%
Medicaid	-	-	-	-	-	-	-	-	-	-
Other Health	100.0%	-13.2%	57.3%	27.2%	10.5%	12.3%	-3.0%	27.6%	32.3%	14.9%
Total	4.3%	1.9%	-1.0%	2.3%	1.3%	1.0%	2.0%	4.8%	6.4%	-0.3%

Taking into consideration investment income, capital gains and miscellaneous income, Medica reported a gain of $44.5 million for 2012. Medica experience was profitable in each of the ten years included in the analysis except for 2006, when it reported a loss of $25.2 million. Over the course of the ten year period Medica's pre-FIT income has ranged from a loss of $25.2 million in 2006 to a net profit of $44.5 million in 2012. As a percentage of revenue, net profit has ranged from a loss of 2.5% (2006) to a profit of 3.6% (2009) with an average net profit margin over the ten year period of 1.6%. The 2012 net profit margin was 2.8% of revenue.

Medica reflected in its 2010, 2011 and 2012 financial statement a deficiency reserve of $12.9 million, $37.2 million and $12.4 million respectively. For each year the deficiency reserve reflects an anticipated inadequacy of premium for a block of business in a subsequent time period. The deficiency reserve results in the recognition of the premium inadequacy and charges it to the underwriting gain of the period in which the inadequacy is discovered, as is required by statutory accounting rules.

MIC reported 2012 net income before FIT of $4.9 million, a decrease of $82.7 million from the prior year, all of which is attributable to a decrease in underwriting gain.

Table 4A. Net Income Before FIT ($1,000,000) - Medica Health Plans

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Und. Gain	17.3	-3.5	-35.6	-51.5	0.8	21.4	28.8	9.8	-3.9	28.5
Net Inv. Income	19.3	20.8	21.5	22.6	26.3	17.6	19.6	14.9	10.6	11.9
Cap Gains	4.6	10.8	17.1	3.7	1.6	-27.7	1.2	4.5	8.0	4.1
Other	-	-	-	-	-	-	-	-	-	-
Net Pre-FITIncome	41.2	28.0	3.0	-25.2	28.7	11.4	49.6	29.3	14.7	44.5

Table 4B. Net Income Before FIT ($1,000,000) - Medica Insurance Company

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Und. Gain	13.1	12.3	-9.7	28.3	12.2	10.5	21.5	53.5	78.1	-3.7
Net Inv. Income	1.1	2.9	5.3	6.5	8.1	12.7	1.3	6.8	6.6	8.2
Cap Gains	0.2	0.6	0.0	-0.1	-0.2	-4.9	3.7	0.9	2.9	0.4
Other	-	-	-	-	-	-	-	-	-	-
Net Pre-FITIncome	14.3	15.8	-4.4	34.7	20.1	18.3	26.5	61.2	87.6	4.9

Medica has built up capital reserves of approximately $442 million as of year-end 2012. The compound growth in surplus has averaged 3.7% per year. Each of the most recent four years has shown an increase in Medica's surplus.

Medica's surplus, expressed as a percentage of revenue (SAPOR), has ranged from a low of 21.4% (2003) to a high of 30.7%, which was achieved at yearend 2007. SAPOR dropped by3.7% in 2009, but since then it has increased to the current level of 27.7%.

MIC has built up capital reserves of 455.3 million as of yearend 2012. Growth in MIC surplus is equivalent to a 17.5% compound growth rate. SAPOR as of yearend 2012 was 18.5% and averaged 16.3% over the ten year period ending with 2012.

Table 5A. Capital and Surplus Analysis ($1,000,000 or %) - Medica Health Plans

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Surplus	317.1	330.2	321.0	281.8	319.5	317.7	361.3	399.3	416.3	442.1
Growth in Surplus		13.08	(9.17)	(39.24)	37.75	(1.80)	43.57	38.06	16.99	25.74
Growth Percentage		4.1%	-2.8%	-12.2%	13.4%	-0.6%	13.7%	10.5%	4.3%	6.2%
Suplus as % of Revenue	21.4%	24.0%	26.3%	27.4%	30.7%	30.2%	26.4%	23.4%	26.2%	27.7%

Table 5B. Capital and Surplus Analysis ($1,000,000 or %) - Medica Insurance Company

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Surplus	60.0	70.6	118.9	142.3	159.9	174.3	196.9	190.7	248.6	255.3
Growth in Surplus		10.64	48.31	23.40	17.54	14.46	22.61	(6.26)	57.94	6.64
Growth Percentage		17.7%	68.4%	19.7%	12.3%	9.0%	13.0%	-3.2%	30.4%	2.7%
Suplus as % of Revenue	19.6%	10.7%	12.7%	11.4%	17.2%	17.1%	18.5%	17.1%	20.2%	18.5%

Medica's Total Adjusted Capital[113], expressed as the ratio of reported surplus and the Authorized Control Level ("RBC" ratio) is 773% for yearend 2012. Medica's RBC ratio has varied over the ten year period, with a low of 620% (2003) and a high of 881% (2008). Other measures of surplus can be considered:

[113] Total Adjusted Capital is a derived amount. It is the surplus reported in the annual statement with certain specified adjustments. In most instances they are the same.

Another measure of the level of Capital Reserves expresses it as months of claims and expenses.[114] Capital Reserves have been equal to from 2.6 months to 3.7 months of claims and expenses during the last ten years. This measure has varied from year-to-year and was 3.3 months at year end 2012.

MIC's RBC ratio has ranged from 299% (2004) to 608% (2011) over the ten year period. At yearend 2012 the company reported 516% as its RBC ratio. MIC's surplus, expressed as months of claims and expenses has ranged from 1.3 months (2004) to 2.6 months (2011) and was 2.2 months at yearend 2012.

Table 6A. Risk Based Capital Analysis ($1,000,000 or %) - Medica Health Plans

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Surplus	317.1	330.2	321.0	281.8	319.5	317.7	361.3	399.3	416.3	442.1
Total Adjusted Capital	317.1	330.2	321.0	281.8	319.5	317.7	361.3	399.3	416.3	442.1
Authorized Control Level	51.2	47.9	44.9	39.9	38.6	36.1	46.3	59.7	55.8	57.2
RBC Ratio	620%	689%	715%	706%	828%	881%	781%	668%	745%	773%
MN Minimum Surplus	122.3	47.9	44.9	79.9	77.2	72.1	109.0	109.0	-	114.4
Surplus as % of MN Minimum Surplus	259%	689%	715%	353%	414%	441%	331%	366%	-	386%
Surplus as Months Claims & Expenses	2.6	2.9	3.1	3.1	3.7	3.7	3.2	2.8	3.2	3.3

Table 6B. Risk Based Capital Analysis ($1,000,000 or %) - Medica Insurance Company

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Surplus	60.0	70.6	118.9	142.3	159.9	174.3	196.9	190.7	248.6	255.3
Total Adjusted Capital	60.0	70.6	118.9	142.3	159.9	174.3	196.9	190.7	248.6	255.3
Authorized Control Level	12.0	23.6	34.2	43.5	32.1	35.8	36.2	37.6	40.9	49.4
RBC Ratio	498%	299%	348%	327%	498%	487%	543%	507%	608%	516%
MN Minimum Surplus	12.0	23.6	-	87.0	64.2	71.7	72.5	75.3	81.8	98.9
Surplus as % of MN Minimum Surplus	498%	299%	-	164%	249%	243%	272%	253%	304%	258%
Surplus as Months Claims & Expenses	2.5	1.3	1.5	1.4	2.1	2.1	2.3	2.2	2.6	2.2

Medica actively markets Comprehensive Medical, Medicare Supplement, Dental Only, FEHBP, Medicare and Medicaid products. The Medicare Supplement, Dental Only and FEHBP lines have a very small amount of premium in comparison to the other lines of business.

Medica's Comprehensive product line experienced a generally declining loss ratio over the 10 year period. The average loss ratio for the ten year period was 92%, with an average for the most recent three years of 89.3%. The Medicare line of business experienced a somewhat increasing loss ratio over the 10 year period with an average loss ratio of 90.3%. For the most recent four years the loss ratio averaged 94.1%. The 2012 loss ratio was 91.4%. The Medicaid line of business experienced an average loss ratio of 91.5% with results varying from 88.1% in 2009 to 99.8% in 2006. The reported loss ratio for 2012 is 94.1%.

[114] This measure of surplus differs slightly from the minimum reserve requirement that was in effect in Minnesota for the first two years of the ten year period under review.

MIC markets Comprehensive Medical, Medicare and Stop Loss products. The Comprehensive product line experienced an average loss ratio over the ten year period of 84% and an average loss ratio of 79.6% over the most recent three years. The Medicare line experienced an average loss ratio over the 10 years of 81.6% and the Other Health line experienced a ten year average loss ratio of 61%.

Table 7A. Loss Ratio by Line of Business - Medica Health Plans

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Comprehensive	89.0%	89.2%	93.5%	97.4%	94.4%	97.2%	91.0%	89.5%	87.9%	90.5%
Medicare Suppl	60.6%	57.5%	62.7%	79.3%	83.5%	82.7%	71.4%	85.5%	70.6%	59.8%
Dental Only	-16.8%	0.0%	0.0%	0.0%	0.0%	0.0%	84.8%	71.6%	70.0%	78.7%
FEHBP	-	-	-	-	-	91.9%	93.4%	120.3%	90.5%	35.1%
Medicare	76.7%	83.8%	91.3%	91.3%	92.7%	91.0%	96.0%	95.1%	94.0%	91.4%
Medicaid	91.2%	88.2%	92.3%	99.8%	91.0%	88.8%	88.1%	89.4%	92.6%	94.1%
Other Health	-	-	-	-	-	-	-	-	-	-
Total	88.1%	88.2%	92.5%	97.0%	92.1%	90.4%	90.5%	91.0%	91.6%	92.4%

Table 7B. Loss Ratio by Line of Business - Medica Insurance Company

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Comprehensive	87.2%	84.1%	90.0%	87.9%	83.6%	85.2%	82.4%	74.7%	77.5%	87.0%
Medicare Suppl	-	-	-	-	-	-	-	-	-	-
Dental Only	-	-	-	-	-	-	-	-	-	-
FEHBP	-	-	-	-	-	100.0%	116.2%	103.2%	-	-
Medicare	-	85.0%	82.3%	77.1%	79.6%	78.6%	80.8%	88.0%	80.1%	82.8%
Medicaid	-	-	-	-	-	-	-	-	-	-
Other Health	0.0%	98.3%	27.2%	57.6%	72.3%	71.6%	87.7%	62.6%	60.2%	72.8%
Total	81.2%	84.7%	87.3%	85.5%	82.3%	83.0%	82.0%	80.1%	78.2%	84.5%

For Medica, the number of member months reported in the 2012 annual statement has decreased 72% over the number reported in the 2003 annual statement. The member months have decreased from 5.8 million in 2003 to 1.7 million in 2012. Based on a review of the revenue growth by line of business, it appears that the decrease in member months is attributable to the shrinkage of the Comprehensive Medical business. PMPM revenue per member month increased by 15.9% per year over the 10 year period. The annual PMPM revenue increases have shown significant swings, with a 30% and 31% increases in 2006 and 2012 respectively. A change in the mix of business is a contributor to the growth in pmpm revenue.

MIC member months increased from 3.8 million to 5.0 million, a 30% increase. MIC's pmpm revenue showed a compound growth rate of 14.8%.

Table 8A. Member Months - Medica Health Plans

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Member Months (000)	5,832.3	4,815.7	3,831.2	2,485.4	2,262.5	1,983.6	2,091.7	2,379.5	2,156.0	1,653.8
Growth over Prior Year		-17.4%	-20.4%	-35.1%	-9.0%	-12.3%	5.4%	13.8%	-9.4%	-23.3%
PMPM Revenue	254.65	285.60	318.44	413.01	460.65	530.91	653.79	717.04	736.02	964.13
Growth in PMPM Revenue		12.2%	11.5%	29.7%	11.5%	15.3%	23.1%	9.7%	2.6%	31.0%

Table 8B. Member Months - Medica Insurance Company

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Member Months (000)	3,827.8	5,179.9	5,269.0	4,935.4	4,826.6	4,716.1	4,418.8	4,181.3	4,374.8	4,984.4
Growth over Prior Year		35.3%	1.7%	-6.3%	-2.2%	-2.3%	-6.3%	-5.4%	4.6%	13.9%
PMPM Revenue	80.11	127.56	177.66	253.83	193.03	216.73	240.98	267.15	281.22	277.07
Growth in PMPM Revenue		59.2%	39.3%	42.9%	-24.0%	12.3%	11.2%	10.9%	5.3%	-1.5%

Medica's expenses[115] have decreased significantly over the 10 years subject to review. The decrease is attributed to the decrease in member months (See Table 8). Expenses expressed on a PMPM basis display a strong growth pattern. The average annual PMPM expense increase is 10.8%. Annual expense growth, measured on a PMPM basis, has ranged from a high of 30.4% (2012) to small decreases reported in 2005, 2006 and 2011.

MIC's expenses have increased from $44.6 million in 2003 to $209.5 million in 2012. On a pmpm basis, expenses have increased at a 15.3% compound growth rate. In comparison, revenues have grown by at a 18.2% compound growth rate.

Medica and MIC have administrative services agreements with United HealthCare Services (UHC). The services provided by UHC are described as system dependent billing, enrollment, claims processing and accounting functions. The management fee paid to UHC is computes as a fixed pmpm amount. For 2012 Medica incurred expenses related to this agreement of $14.5 million, a portion of which is contingent on performance[116]. Similarly, for 2012 MIC incurred expenses related to this agreement of $44.4 million.

Medica is reimbursed by affiliates for administrative services that are provided in accordance with written agreements. Reimbursements for 2012 totaled $86.3 million of which $46.1 million was attributed to MIC[117].

During 2012 and 2011 Medica recorded charitable contributions of $10.0 million each year to the Medica Foundation and the Medica Research Institute. Charitable contributions are recorded as General Administrative Expenses.[118]

Table 9A. Claim Adjudication and Administrative Expenses - Medica Health Plans

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Expenses (000,000)	170.9	165.7	127.0	81.9	81.7	80.2	101.3	130.5	116.8	116.8
Growth over Prior Year		-3.0%	-23.3%	-35.5%	-0.3%	-1.9%	26.4%	28.8%	-10.5%	0.0%
Expense as % of Revenue	11.5%	12.0%	10.4%	8.0%	7.8%	7.6%	7.4%	7.6%	7.4%	7.3%
PMPM Expense	29.30	34.41	33.15	32.96	36.10	40.41	48.44	54.85	54.15	70.62
Growth in PMPM Expense		17.4%	-3.6%	-0.6%	9.5%	11.9%	19.9%	13.2%	-1.3%	30.4%

[115] The sum of Claim Adjustment Expenses and General Administrative Expenses
[116] Medica and MIC 2012 Financial Statements, Notes to Financial Statements, Note 1
[117] 2012 Financial Statement, Notes to Financial Statements, Note 10
[118] 2012 Annual Statement, Page 14 Line 2503 and Notes to Annual Statements, Note 10

Table 9B. Claim Adjudication and Administrative Expenses - Medica Insurance Company

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Expenses (000,000)	44.6	88.9	128.3	153.6	152.7	163.6	170.6	161.7	189.1	209.5
Growth over Prior Year		99.2%	44.3%	19.7%	-0.6%	7.1%	4.3%	-5.3%	17.0%	10.8%
Expense as % of Revenue	14.6%	13.5%	13.7%	12.3%	16.4%	16.0%	16.0%	14.5%	15.4%	15.2%
PMPM Expense	11.66	17.16	24.35	31.12	31.64	34.69	38.61	38.66	43.23	42.04
Growth in PMPM Expense		47.2%	41.9%	27.8%	1.7%	9.7%	11.3%	0.1%	11.8%	-2.8%

For each accounting period the company estimates its liability for claims incurred but not reported ("IBNR"). The IBNR is generally the largest liability reported on the company's balance sheet. For statutory accounting company management generally estimates this amount on a conservative basis by including a specified margin. The annual statement provides a test of the adequacy of the prior year reserve. An anticipated margin of 8-10% in the reconciled reserve is common and may generally be viewed as reasonable. However actual results from year to year will vary. Health Plans maintain a margin in their IBNR reserve because the actual liability is not known at the time it is estimated and it is subject to variation. Not much can be concluded from the adequacy and/or margin in any one year's reconciliation.

Medica's margin in the claim reserve, expressed as a percentage of the reconciled reserve has ranged from as high as 42.5% (2002 yearend claim reserve) to as low as 1.9% (2006 yearend claim reserve). In its 2012 Annual Financial Statement, Medica reported a margin of 14.1% of the reconciled 2011 claim reserve.

MIC's margin in the claim reserve, expressed as a percentage of the reconciled reserve has ranged from as high as 67% (2002 yearend claim reserve) to shortfall of 3.6%% (2006 yearend claim reserve). In its 2012 Annual Financial Statement, MIC reported a margin of 26.1% of the reconciled 2011 claim reserve.

Excessive margins in the claim reserve reduce the company's reported surplus. For many of the years included in our analysis Medica and MIC tended to report margins in their reported liability for IBNR in excess of what might be reasonably expected.

The margin determined to be in the claim reserve can be compared to the company reported surplus level. Excessive margins in claim reserves understate the company's surplus position.

Table 10A. Claim Reserve Reconciliation ($1,000,000 or %) - Medica Health Plans

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Reported Prior Yr Reserve	199.4	185.0	141.3	123.0	117.4	121.8	122.9	161.4	178.0	169.4
Reconciled Reserve	139.9	159.9	114.2	120.7	94.2	99.7	106.7	137.1	130.8	148.5
Margin in Reserve	59.5	25.1	27.1	2.3	23.2	22.1	16.1	24.3	47.1	21.0
Margin as % of Reconciled Reserve	42.5%	15.7%	23.8%	1.9%	24.6%	22.2%	15.1%	17.8%	36.0%	14.1%
Margin as % of Surplus	18.8%	7.6%	8.5%	0.8%	7.3%	7.0%	4.5%	6.1%	11.3%	4.7%

Table 10B. Claim Reserve Reconciliation ($1,000,000 or %) - Medica Insurance Company

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Reported Prior Yr Reserve	36.8	39.6	78.9	105.8	98.8	81.1	93.7	93.2	96.9	102.0
Reconciled Reserve	22.1	26.6	54.2	88.5	102.4	62.0	76.9	82.4	73.0	80.9
Margin in Reserve	14.8	13.1	24.6	17.3	(3.7)	19.1	16.7	10.9	24.0	21.1
Margin as % of Reconciled Reserve	66.9%	49.3%	45.4%	19.5%	-3.6%	30.8%	21.7%	13.2%	32.8%	26.1%
Margin as % of Surplus	24.6%	18.5%	20.7%	12.2%	-2.3%	11.0%	8.5%	5.7%	9.6%	8.3%

At year-end 2012, approximately 60% of Medica's invested assets consisted of long term bonds. The value of company occupied real estate increased significantly during 2012, to $91.8 million (17% of invested assets). Medica maintains a significant share of investments in cash and cash equivalents. At yearend 2012 cash and cash equivalents amounted to 23% of total invested assets.

At year-end 2012, approximately 73% of MIC invested assets consisted of long term bonds with the balance consisting of cash and cash equivalents.

Table 11A. Invested Assets by Type ($1,000,000) - Medica Health Plans

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Bonds	422.1	427.2	359.9	283.3	296.7	253.8	224.9	197.9	277.7	326.0
Stocks - Preferred	-	-	0.8	1.7	1.5	2.7	2.2	1.4	0.9	0.7
Stocks - Common	107.7	97.1	51.7	36.7	38.8	0.0	-	-	-	-
Mortgage Loans- First	-	-	-	-	-	-	-	-	-	-
Mortgage Loans - Other	-	-	-	-	-	-	-	-	-	-
RE - Occupied	-	8.6	9.7	9.2	8.5	7.8	7.5	6.9	6.2	91.8
RE - For Income	1.0	-	-	-	-	-	-	-	-	-
RE Other	-	-	-	-	-	-	-	-	-	-
Cash & Equivalent	94.2	46.8	21.4	98.8	107.9	138.8	174.0	343.0	307.8	125.1
Other Invested Assets	5.0	2.6	51.3	50.1	50.1	50.1	50.2	0.0	0.0	0.4
Total Invested Assets	630.0	582.4	494.8	479.9	503.5	453.2	458.9	549.3	592.7	544.0

Table 11B. Invested Assets by Type ($1,000,000) - Medica Insurance Company

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Bonds	51.1	75.6	131.2	186.9	192.1	271.4	284.7	294.8	311.8	375.1
Stocks - Preferred	-	-	-	-	-	-	-	-	-	-
Stocks - Common	-	-	-	-	-	-	-	-	-	-
Mortgage Loans- First	-	-	-	-	-	-	-	-	-	-
Mortgage Loans - Other	-	-	-	-	-	-	-	-	-	-
RE - Occupied	-	-	-	-	-	-	-	-	-	-
RE - For Income	-	-	-	-	-	-	-	-	-	-
RE Other	-	-	-	-	-	-	-	-	-	-
Cash & Equivalent	51.5	58.8	103.3	60.0	145.8	75.5	139.3	67.4	98.3	141.4
Other Invested Assets	-	-	-	-	-	-	-	-	-	0.0
Total Invested Assets	102.6	134.5	234.5	247.0	337.9	346.9	424.0	362.2	410.2	516.5

Table 12A. Invested Assets by Type (% of Total) - Medica Health Plans

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Bonds	67%	73%	73%	59%	59%	56%	49%	36%	47%	60%
Stocks - Preferred	0%	0%	0%	0%	0%	1%	0%	0%	0%	0%
Stocks - Common	17%	17%	10%	8%	8%	0%	0%	0%	0%	0%
Mortgage Loans- First	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Mortgage Loans - Other	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
RE - Occupied	0%	1%	2%	2%	2%	2%	2%	1%	1%	17%
RE - For Income	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
RE Other	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Cash & Equivalent	15%	8%	4%	21%	21%	31%	38%	62%	52%	23%
Other Invested Assets	1%	0%	10%	10%	10%	11%	11%	0%	0%	0%
Total Invested Assets	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Table 12B. Invested Assets by Type (% of Total) - Medica Insurance Company

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Bonds	50%	56%	56%	76%	57%	78%	67%	81%	76%	73%
Stocks - Preferred	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Stocks - Common	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Mortgage Loans- First	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Mortgage Loans - Other	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
RE - Occupied	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
RE - For Income	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
RE Other	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Cash & Equivalent	50%	44%	44%	24%	43%	22%	33%	19%	24%	27%
Other Invested Assets	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Total Invested Assets	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Realized capital gains are reflected in the income statement (Statement of Revenue and Expenses). The change in unrealized capital gains is not reflected in the income statement but is a direct credit to the company's surplus account. The amounts of realized and unrealized capital gains are highly variable, with 2008 showing a large negative swing for realized and unrealized capital gains for both Medica and MIC. Realized and unrealized capital gains contributed $4.5 million to Medica's 2012 year end surplus.

Table 13A. Capital Gains ($1,000,000) - Medica Health Plans

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Realized Cap. Gains (Net of FIT)	4.6	10.8	17.1	3.7	1.6	(27.7)	1.2	4.5	8.0	4.1
Unrealized Cap. Gains	28.4	1.9	(14.9)	0.1	0.7	(9.4)	(0.3)	0.2	(0.1)	0.1

Table 13B. Capital Gains ($1,000,000) - Medica Insurance Company

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Realized Cap. Gains (Net of FIT)	0.2	0.6	(0.0)	(0.1)	(0.2)	(4.9)	3.7	0.9	2.9	0.4
Unrealized Cap. Gains	-	-	-	-	-	-	-	-	-	-

PreferredOne Profile

PreferredOne Community Health Plan (PCHP) is a not-for-profit tax-exempt Minnesota HMO. It was organized as a nonprofit community integrated service network in 1994 and was certified to operate as an HMO in 1999. It is controlled by two hospital systems (Fairview Health Services and North Memorial Health Care) and a physician group, PreferredOne Physician Associates. Administrative services are provided to PCHP by PreferredOne Administrative Services, Inc. (PAS). PAS is 50% owned by Fairview Health Services and 25% each by North Memorial Health Services and PreferredOne Physician Health Services. PAS in turn owns 100% of PreferredOne Insurance Company (PIC). PAS and PIC are for-profit entities.[119]

PCHP reported about $62.9 million in 2012 annual revenue. All of PCHP's business is commercial comprehensive medical insurance. PIC reported approximately $144.8 million in 2012 annual revenue. Approximately 93% of PIC's business in 2012 was commercial comprehensive medical insurance, while the remaining 7% was reported as other health, and represents stop loss business written on self-insured customers of PAS. PIC first reported Other Health (stop loss) business in the 2004 annual statement, and first reported commercial comprehensive medical business in the 2006 statement.

Chapter 62D.04 Subd. 5 requires that an HMO, as a condition of receiving and retaining its certificate of authority, "participate in the medical assistance, general assistance medical care, and MinnesotaCare programs". The Minnesota Department of Human Services (DHS) has not required PCHP to submit proposals for the provision of health care services to Medical Assistance and MinnesotaCare enrollees in various counties, in exchange for PCHP's willingness to make its network available to other entities participating in the procurement process.

Table 1a. Revenue by Line of Business ($1,000,000) – PCHP

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Comprehensive	101.0	120.6	125.0	134.8	153.2	157.0	136.1	138.1	103.8	62.9

Table 1b. Revenue by Line of Business ($1,000,000) – PIC

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Comprehensive	-	-	-	0.2	2.5	13.5	72.1	95.4	109.7	134.7
Other Health	-	0.2	1.2	2.0	3.3	4.7	7.6	8.4	9.5	10.2
Total	-	0.2	1.2	2.2	5.8	18.2	79.7	103.8	119.2	144.8

PCHP has reported a total of $20.3 million of total net underwriting losses in the last ten years, with losses in each of the last nine years consecutively. PIC has also reported underwriting losses in several years for commercial comprehensive business, although the total is a $1.3 million net underwriting gain. They have reported a total of $8.3 million of net underwriting gains for stop loss business since 2004.

Table 2a. Underwriting Gain or (Loss) by Line of Business ($1,000,000) – PCHP

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Comprehensive	3.6	(0.8)	(1.6)	(6.0)	(5.3)	(3.7)	(3.8)	(1.2)	(0.0)	(1.5)

[119] 2012 Annual Statement, Schedule Y Part 1 & Part 1A

Table 2b. Underwriting Gain or (Loss) by Line of Business ($1,000,000) – PIC

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Comprehensive	-	-	-	(0.0)	0.4	1.3	0.5	(0.1)	(0.8)	(0.1)
Other Health	-	(0.1)	(0.3)	0.1	(0.3)	0.8	1.3	1.2	2.2	3.4
Total	-	(0.1)	(0.3)	0.1	0.2	2.0	1.8	1.2	1.4	3.3

Table 3a. Underwriting Gain or (Loss) as a percentage of Revenue – PCHP

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Comprehensive	3.6%	-0.6%	-1.3%	-4.5%	-3.5%	-2.4%	-2.8%	-0.8%	0.0%	-2.4%

Table 3b. Underwriting Gain or (Loss) as a percentage of Revenue – PIC

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Comprehensive				-1.9%	17.6%	9.4%	0.7%	-0.1%	-0.7%	-0.1%
Other Health	-	-67.1%	-27.8%	6.5%	-8.1%	16.0%	17.2%	14.8%	23.3%	33.2%
Total	-	-67.1%	-27.8%	5.6%	2.8%	11.1%	2.3%	1.1%	1.2%	2.3%

Taking into consideration investment income, realized capital gains and miscellaneous income, PCHP reported a net loss of $0.8 million for 2012, While PIC reported a net gain of $4.6 million. PCHP Is exempt from Federal income tax, while PIC is taxable.

Table 4a. Net Income Before FIT ($1,000,000) – PCHP

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Und. Gain	3.6	-0.8	-1.6	-6.0	-5.3	-3.7	-3.8	-1.2	0.0	-1.5
Net Inv. Income	1.0	1.1	1.6	1.7	1.7	1.5	0.9	0.6	0.7	0.3
Cap Gains	0.3	0.1	0.6	0.1	1.5	-2.1	0.8	1.0	0.5	0.4
Other	-	-	-	-	-	-	-	-	-	-
Net Pre-FIT Income	4.9	0.4	0.7	-4.2	-2.1	-4.3	-2.1	0.4	1.2	-0.8

Table 4b. Net Income Before FIT ($1,000,000) – PIC

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Und. Gain	0.0	-0.1	-0.3	0.1	0.2	2.0	1.8	1.2	1.4	3.3
Net Inv. Income	0.0	0.0	0.1	0.2	0.3	0.4	0.7	0.8	0.8	1.1
Cap Gains	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.3	0.2
Other	-	-	-	-	-	-	-	-	-	-
Net Pre-FITIncome	0.0	-0.1	-0.2	0.3	0.4	2.4	2.7	2.0	2.5	4.6

PCHP has capital reserves of approximately $10.2 million as of year-end 2012. The surplus has decreased gradually from its highest level of $26.5 million in 2005. PCHP included $6.7 million of contributed capital in its capital reserves as of 2005, but has reduced contributed capital by $2 million in each of 2006, 2009 and 2011 to the current level of $0.7 million. PIC reported capital reserves of $30.5 million in 2012, and has grown in surplus each year since 2004.

In the last ten years, PCHP's surplus, expressed as a percentage of revenue (SAPOR), has ranged from a low of 8.4% to a high of 25.1%, which was achieved at year-end 2003. In 2012 it was 16.2%. PIC's SAPOR was very high in the early years of this decade, when it had little to no revenue to measure against. In recent year the ratio has decreased as PIC has written more business, and now stands at 21.0%.

Table 5a. Capital and Surplus Analysis ($1,000,000 or %) - PCHP

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Surplus	25.3	26.0	26.5	22.0	19.1	14.7	11.4	11.9	10.6	10.2
Growth in Surplus		0.70	0.49	(4.53)	(2.85)	(4.42)	(3.29)	0.53	(1.40)	(0.36)
Growth Percentage		2.7%	1.9%	-17.1%	-13.0%	-23.1%	-22.4%	4.6%	-11.7%	-3.4%
Surplus as % of Revenue	25.1%	21.6%	21.2%	16.3%	12.5%	9.4%	8.4%	8.7%	10.2%	16.2%

Table 5b. Capital and Surplus Analysis ($1,000,000 or %) - PIC

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Surplus	3.0	2.9	4.8	5.0	5.3	11.8	19.6	21.7	26.3	30.5
Growth in Surplus		(0.06)	1.86	0.22	0.29	6.49	7.79	2.13	4.60	4.12
Growth Percentage		-2.0%	63.2%	4.7%	5.8%	121.8%	65.9%	10.9%	21.1%	15.6%
Suplus as % of Revenue	-	1801.3%	388.2%	224.2%	91.9%	64.8%	24.6%	20.9%	22.1%	21.0%

PCHP Total Adjusted Capital[120], expressed as the ratio of reported surplus and the Authorized Control Level (ACL), the RBC ratio, is 357%% for year-end 2012. This is the highest level since 2006. PIC's RBC ratio was 472%. The ratio observed in the years 2003-2006 was not meaningful as PIC was just starting operations and did not have a large amount of business.

Another measure of the level of Capital Reserves expresses it as months of claims and expenses.[121] PCHP Capital Reserves have been equal to from 1.8 months to 2.5 months of claims and expenses during the last ten years. PIC Capital Reserves were 2.6 months in the last year. They were not particularly meaningful prior to the last few years because PIC did not have much business compared to minimum required surplus. This measure has varied from year-to-year and was 1.9 months at year-end 2012.This measure has varied from year-to-year and was 1.9 months at year-end 2012.

Table 6a. Risk Based Capital Analysis ($1,000,000 or %) – PCHP

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Surplus	25.3	26.0	26.5	22.0	19.1	14.7	11.4	11.9	10.6	10.2
Authorized Control Level	3.9	4.7	5.0	5.7	6.1	6.2	5.4	5.4	4.2	2.9
RBC Ratio	643%	551%	528%	386%	311%	239%	213%	223%	252%	357%
Surplus as Months Claims & Expenses	3.1	2.6	2.5	1.9	1.4	1.1	1.0	1.0	1.2	1.9

Table 6b. Risk Based Capital Analysis ($1,000,000 or %) – PIC

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Surplus	3.0	2.9	4.8	5.0	5.3	11.8	19.6	21.7	26.3	30.5
Authorized Control Level	0.0	0.0	0.2	0.6	1.0	1.3	4.0	4.9	5.6	6.4
RBC Ratio	*	*	*	*	540%	930%	493%	444%	472%	472%
Surplus as Months Claims & Expenses	*	*	*	*	11.4	8.7	3.0	2.5	2.7	2.6

[120] Total Adjusted Capital is a derived amount. It is the surplus reported in the annual statement with certain specified adjustments. In most instances they are the same.
[121] This was the measure of surplus in effect in Minnesota for the first two years of the ten year period under review.

PCHP has had a loss ratio of at least 85% in every year since 2005, and was at 89.5% in the most recent year. PIC has had loss ratios on comprehensive business of approximately 85% in the last four years. The loss ratio on stop loss business has been generally decreasing, and was at 47.4% in 2012.

Table 7a. Loss Ratio by Line of Business - PCHP

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Comprehensive	82.1%	84.4%	85.4%	90.6%	87.9%	87.2%	88.2%	86.9%	87.1%	89.5%

Table 7b. Loss Ratio by Line of Business - PIC

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Comprehensive	-	-	-	61.3%	52.1%	73.3%	85.0%	85.4%	85.9%	85.0%
Other Health	-	147.3%	112.7%	80.1%	94.1%	70.8%	67.9%	70.3%	57.3%	47.4%
Total	-	147.3%	112.7%	78.1%	76.2%	72.6%	83.4%	84.2%	83.6%	82.4%

The number of member months reported in the PCHP 2012 annual statement was lower than it had been in any of the preceding years in our study period. PIC, on the other hand, has had increasing member months in each year. Many of them are likely to be associated with the lower average premium stop loss business, leading to the lower average PMPM revenue for PIC than for PCHP.

Table 8a. Member Months – PCHP

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Member Months (000)	491.2	562.1	567.0	590.0	634.8	610.3	491.1	475.9	336.7	205.5
Growth over Prior Year		14.4%	0.9%	4.0%	7.6%	-3.9%	-19.5%	-3.1%	-29.3%	-39.0%
PMPM Revenue	205.71	214.46	220.41	228.50	241.30	257.26	277.05	290.15	308.36	306.10
Growth in PMPM Revenue		4.3%	2.8%	3.7%	5.6%	6.6%	7.7%	4.7%	6.3%	-0.7%

Table 8b. Member Months – PIC

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Member Months (000)	-	15.9	67.3	90.2	138.5	220.9	565.7	674.2	893.5	966.6
Growth over Prior Year		-	322.7%	34.0%	53.6%	59.5%	156.1%	19.2%	32.5%	8.2%
PMPM Revenue	-	10.28	18.42	24.90	41.86	82.49	140.91	153.96	133.38	149.85
Growth in PMPM Revenue		-	79.2%	35.2%	68.1%	97.1%	70.8%	9.3%	-13.4%	12.4%

PCHP expenses[122] have trended generally down, consistent with the pattern of decreasing revenue. On a PMPM basis, they have been relatively flat in the last five years, while declining gradually to the current level of 12.9% of revenue. PIC Expenses have been increasing along with the increasing revenue, but have been constant as a percent of revenue in the last several years, representing 14.6% of revenue in 2012. On a PMPM basis, the expenses are relatively lower than for PCHP, reflecting the lower premium, lower expense PMPM stop loss business.

[122] The sum of Claim Adjustment Expenses and General Administrative Expenses

Table 9a. Claim Adjudication and Administrative Expenses – PCHP

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Expenses (000,000)	14.5	19.6	19.9	18.7	23.8	23.8	19.8	19.3	13.4	8.1
Growth over Prior Year		35.2%	1.6%	-5.9%	27.1%	0.1%	-16.6%	-2.8%	-30.6%	-39.2%
Expense as % of Revenue	14.3%	16.2%	15.9%	13.9%	15.5%	15.1%	14.6%	14.0%	12.9%	12.9%
PMPM Expense	29.44	34.79	35.04	31.68	37.43	38.96	40.37	40.48	39.71	39.59
Growth in PMPM Expense		18.2%	0.7%	-9.6%	18.2%	4.1%	3.6%	0.3%	-1.9%	-0.3%

Table 9b. Claim Adjudication and Administrative Expenses – PIC

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Expenses (000,000)	0.0	0.0	0.2	0.4	1.2	3.0	11.4	15.3	17.8	21.1
Growth over Prior Year		1114.7%	482.2%	95.2%	225.6%	150.3%	282.1%	33.8%	16.4%	18.8%
Expense as % of Revenue	-	19.7%	15.1%	16.3%	20.6%	16.4%	14.3%	14.7%	14.9%	14.6%
PMPM Expense	-	2.03	2.79	4.06	8.61	13.52	20.17	22.64	19.88	21.83
Growth in PMPM Expense		-	37.7%	45.7%	112.0%	56.9%	49.2%	12.3%	-12.2%	9.8%

For each accounting period the company estimates its liability for claims incurred but not reported ("IBNR"). The IBNR is generally the largest liability reported on the company's balance sheet. For statutory accounting company management generally estimates this amount on a conservative basis by including a specified margin. The annual statement provides a test of the adequacy of the prior year reserve. An anticipated margin of 8-10% in the reconciled reserve is common and may generally be viewed as reasonable. However actual results from year to year will vary. Health Plans maintain a margin in their IBNR reserve because the actual liability is not known at the time it is estimated and it is subject to variation. Not much can be concluded from the adequacy and/or margin in any one year's reconciliation. The average margin for both PCHP and PIC has been within what we think of as normal ranges, with both companies ranging from a small unfavorable reconciliation to a double digit positive percent reconciliation, depending on the year. In 2012, both companies were in the range of 14-15% positive.

Excess margins in the incurred but not reported (IBNR) unpaid claim liability reduce the company's reported surplus. In our review of PCHP and PIC, we did not encounter evidence of IBNR margins greater than those typical for other companies.

Table 10a. Claim Reserve Reconciliation ($1,000,000 or %) - PCHP

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Reported Prior Yr Reserve	8.7	11.0	12.2	13.4	15.4	16.1	14.7	12.0	13.5	9.0
Reconciled Reserve	6.9	11.4	12.5	14.3	14.8	15.9	14.1	11.2	13.8	7.9
Margin in Reserve	1.8	(0.5)	(0.3)	(0.9)	0.5	0.2	0.6	0.8	(0.3)	1.1
Margin as % of Reconciled Reserve	26.3%	-4.0%	-2.1%	-6.0%	3.7%	1.0%	4.3%	7.3%	-2.4%	14.1%
Margin as % of Surplus	7.1%	-1.7%	-1.0%	-3.9%	2.8%	1.1%	5.4%	6.8%	-3.1%	10.9%

Table 10b. Claim Reserve Reconciliation ($1,000,000 or %) - PIC

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Reported Prior Yr Reserve	-	-	0.2	0.3	0.7	1.6	4.3	8.0	10.9	14.2
Reconciled Reserve	-	-	0.2	0.3	0.7	1.2	3.0	8.2	10.5	12.4
Margin in Reserve	-	-	0.0	0.0	0.0	0.4	1.3	(0.2)	0.4	1.8
Margin as % of Reconciled Reserve	-	-	2.0%	11.9%	0.3%	32.5%	43.3%	-2.9%	3.4%	14.6%
Margin as % of Surplus	0.0%	0.0%	0.1%	0.6%	0.0%	3.3%	6.7%	-1.1%	1.4%	5.9%

At year-end 2012, approximately 60-70% of each company's invested assets consisted of long term bonds. For each company, approximately 20% of the invested assets are in common stocks. Common stocks are valued at market and are relatively more volatile than other investments usually made by health plans. However, they offer the possibility of superior returns, which could ultimately make health premiums lower. They create a somewhat higher Authorized Control Level amount under the RBC formula, and therefore result in a lower RBC ratio for the same amount of capital reserves. The effect on PCHP and PIC is not great, because the underwriting risk component of RBC is so much larger. If all the common stock investments were made in bonds instead, the effect on RBC would be approximately 0.4% for PCHP and 1.2% for PIC.

PCHP maintains approximately 20% of investments in cash and cash equivalents, while PIC has approximately 10% of its investments in cash and cash equivalents.

Table 11a. Invested Assets by Type ($1,000,000) - PCHP

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Bonds	31.4	34.2	29.8	30.4	30.3	25.1	18.9	18.0	15.3	9.8
Stocks - Common	3.7	5.2	8.6	9.3	7.7	6.1	3.6	7.1	4.9	2.9
Cash & Equivalent	5.4	5.4	8.2	(1.0)	1.4	0.1	3.7	4.3	1.4	3.0
Total Invested Assets	40.5	45.1	46.5	38.7	39.3	31.3	26.2	29.3	21.5	15.7

Table 11b. Invested Assets by Type ($1,000,000) – PIC

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Bonds	1.9	1.4	4.7	5.4	6.6	8.8	23.8	25.3	33.4	34.3
Stocks - Common	-	-	-	-	-	1.3	4.3	7.6	8.8	10.3
Cash & Equivalent	1.1	1.8	0.3	0.7	0.6	7.6	2.8	4.0	2.0	5.7
Total Invested Assets	3.0	3.2	5.0	6.0	7.3	17.7	31.0	36.8	44.2	50.3

Table 12a. Invested Assets by Type (% of Total) - PCHP

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Bonds	78%	76%	64%	79%	77%	80%	72%	61%	71%	62%
Stocks - Common	9%	12%	18%	24%	19%	19%	14%	24%	23%	19%
Cash & Equivalent	13%	12%	18%	-3%	4%	0%	14%	15%	6%	19%
Total Invested Assets	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Table 12b. Invested Assets by Type (% of Total) - PIC

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Bonds	64%	44%	95%	89%	91%	50%	77%	69%	76%	68%
Stocks - Common	0%	0%	0%	0%	0%	7%	14%	21%	20%	21%
Cash & Equivalent	36%	56%	5%	11%	9%	43%	9%	11%	5%	11%
Total Invested Assets	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Realized capital gains are reflected in the income statement (Statement of Revenue and Expenses). The change in unrealized capital gains is not reflected in the income statement but is a direct credit to the company's surplus account. The amounts of realized and unrealized capital gains are highly variable, with 2011 showing some unrealized capital losses and 2012 showing positive amounts for both realized and unrealized capital gains.

Table 13a. Capital Gains ($1,000,000) - PCHP

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Realized Cap. Gains (Net of FIT)	0.3	0.1	0.6	0.1	1.5	(2.1)	0.8	1.0	0.5	0.4
Unrealized Cap. Gains	0.7	0.4	(0.2)	0.6	(0.9)	(0.8)	0.9	0.0	(0.6)	0.4

Table 13b. Capital Gains ($1,000,000) - PIC

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Realized Cap. Gains (Net of FIT)	-	-	0.0	-	(0.0)	0.0	0.1	0.0	0.3	0.2
Unrealized Cap. Gains	-	-	-	-	-	(0.1)	0.7	0.5	(0.3)	0.8

PrimeWest Health Profile

PrimeWest Health ("PrimeWest") is a County Based Purchaser (CBP) that is currently operating in thirteen rural counties. PrimeWest was created on December 1, 1998 in accordance with Minnesota statutes. PrimeWest began offering coverage for public healthcare programs July 1, 2003. The participating member counties are Beltrami, Big Stone, Clearwater, Douglas, Grant, Hubbard, McLeod, Meeker, Pipestone, Pope, Renville, Stevens and Traverse.

Prime West currently has about $180 million in annual revenue. It serves approximately 24,000 members. PrimeWest writes only public program business, with approximately 56% in PMAP, 5% in MNCare and 39% in MSHO and SNBC.

Table 1. Revenue by Line of Business ($1,000,000) - PrimeWest

	2012
Comprehensive	-
Medicare Suppl	-
Dental Only	-
FEHBP	-
Medicare	57.8
Medicaid	125.2
Other Health	0.2
Total	183.2

PrimeWest reported $38.1 million of total net income in the last ten years. It reported net income of $58 million during that period for PMAP, with offsetting losses in GAMC, MNCare and MSHO/SNBC. For the most recent year, 2012, PrimeWest reported a net income of $4.9million.

Table 2. Underwriting Gain or (Loss) by Line of Business ($1,000,000) - PrimeWest

	2012
Comprehensive	-
Medicare Suppl	-
Dental Only	-
FEHBP	-
Medicare	(3.9)
Medicaid	8.5
Other Health	0.2
Total	4.8

Table 3. Underwriting Gain or (Loss) as a percentage of Revenue - PrimeWest

	2012
Comprehensive	
Medicare Suppl	-
Dental Only	-
FEHBP	-
Medicare	-6.8%
Medicaid	6.8%
Other Health	116.2%
Total	2.6%

Table 4. Net Income Before FIT ($1,000,000) - PrimeWest

	2011	2012
Und. Gain	11.3	4.8
Net Inv. Income	0.0	0.1
Cap Gains	-0.1	0.0
Other	-	(0.0)
Net Pre-FITIncome	11.2	4.9

PrimeWest has built up capital reserves of approximately $41 million as of year-end 2012. The capital and surplus has grown rapidly since 2009, when it was approximately $11 million. Of the total capital and surplus, $3.5 million is contributed capital from three of the member counties.

Table 5. Capital and Surplus Analysis ($1,000,000 or %) - PrimeWest

	2012
Surplus	41.2
Growth in Surplus	41.15
Growth Percentage	-
Suplus as % of Revenue	22.5%

PrimeWest Total Adjusted Capital[123], expressed as the ratio of reported surplus and the Authorized Control Level ("RBC" ratio) is 614% for year-end 2012. That is the highest ratio PrimeWest has reported. Minnesota Statutes Section 256B.692 specifies that County-Based Purchasing (CBP) organizations are subject to the fiscal solvency requirements under the provisions of chapter 62D as applicable to health maintenance organizations. This statute provides timetables and specifications for phased-in progression to minimum net worth levels under chapter 62D. Under the requirements of Chapter256B.692, 100% of the RBC requirements under Chapter 62D are effective for CBPs on January 1, 2013. Prior to January 1, 2013, a CBP organization could have also demonstrated its ability to cover any losses by satisfying the net worth requirements of Chapter 62N.

[123] Total Adjusted Capital is a derived amount. It is the surplus reported in the annual statement with certain specified adjustments. In most instances they are the same.

Table 6. Risk Based Capital Analysis ($1,000,000 or %) - PrimeWest

	2008	2009	2010	2011	2012
Surplus	-	-	-	-	41.2
Total Adjusted Capital	12.3	11.8	24.7	36.2	41.2
Authorized Control Level	4.7	5.7	5.6	6.1	6.7
RBC Ratio	262%	209%	438%	590%	614%
MN Minimum Surplus	-	-	-	-	12.5
Surplus as % of MN Minimum Surplus	-	-	-	-	328%
Surplus as Months Claims & Expenses	-	-	-	-	2.8

PrimeWest experienced loss ratios of 99.7% and 82.4% in 2012 for its Medicare and Medicaid lines of business respectively. Its overall loss ratio for 2012 was 87.7%.

Table 7. Loss Ratio by Line of Business – PrimeWest

	2012
Comprehensive	-
Medicare Suppl	-
Dental Only	-
FEHBP	-
Medicare	99.7%
Medicaid	82.4%
Other Health	-32.9%
Total	87.7%

The number of member months reported in the annual statement has grown slightly over the last few years, and is at 288,000 for 2012.

Table 8. Member Months – PrimeWest

	2011	2012
Member Months (000)	268.3	287.5
Growth over Prior Year	5.8%	7.1%
PMPM Revenue	649.60	637.48
Growth in PMPM Revenue	-	-1.9%

For 2012, PrimeWest's expenses were 9.6% of revenue.

Table 9. Claim Adjudication and Administrative Expenses - PrimeWest

	2011	2012
Expenses (000,000)	17.0	17.6
Growth over Prior Year	-	3.7%
Expense as % of Revenue	9.8%	9.6%
PMPM Expense	63.43	61.36
Growth in PMPM Expense	-	-3.3%

Based on the 2012 reconciliation of the 2011 IBNR reserve, PrimeWest included a margin of $3.4 million, or 21% of the reconciled reserve in its year-end reported IBNR.

Table 10. Claim Reserve Reconciliation ($1,000,000 or %) - PrimeWest

	2012
Reported Prior Yr Reserve	19.3
Reconciled Reserve	15.9
Margin in Reserve	3.4
Margin as % of Reconciled Reserve	21.1%
Margin as % of Surplus	8.2%

At yearend 2012, approximately 12% of PrimeWest's invested assets consisted of long term bonds, 6% was company occupied real estate, and the balance was in cash and equivalent investments.

Table 11. Invested Assets by Type ($1,000,000) - PrimeWest

	2011	2012
Bonds	-	7.3
Stocks - Preferred	-	-
Stocks - Common	-	-
Mortgage Loans- First	-	-
Mortgage Loans - Other	-	-
RE - Occupied	3.5	3.4
RE - For Income	-	-
RE Other	-	-
Cash & Equivalent	41.6	48.2
Other Invested Assets	-	-
Total Invested Assets	45.1	58.9

Table 12. Invested Assets by Type (% of Total) - PrimeWest

	2011	2012
Bonds	0%	12%
Stocks - Preferred	0%	0%
Stocks - Common	0%	0%
Mortgage Loans- First	0%	0%
Mortgage Loans - Other	0%	0%
RE - Occupied	8%	6%
RE - For Income	0%	0%
RE Other	0%	0%
Cash & Equivalent	92%	82%
Other Invested Assets	0%	0%
Total Invested Assets	100%	100%

Table 13. Capital Gains ($1,000,000) – PrimeWest

	2011	2012
Realized Cap. Gains (Net of FIT)	(0.1)	0.0
Unrealized Cap. Gains	-	-

South Country Health Alliance Profile

South Country Health Alliance (South Country) is a County Based Purchasing Plan (CBP) providing healthcare coverage in twelve rural counties, Brown, Dodge, Freeborn, Goodhue, Kanabec, Morrison, Sibley, Steele, Todd, Wabasha, Wadena and Waseca. South Country is based in Owatonna. South Country began enrolling members in 2001.

South Country currently has about $176 million in annual revenue. It serves approximately 23,000 members. Membership declined approximately 28% from 2010 to 2012. During that time, three counties withdrew as members of South Country. South Country writes only public program business, with approximately 55% of its revenue from PMAP, 3% from MNCare and 42% from MSHO and SNBC. Revenue is not proportional to membership because of large differences in PMPM revenue among the products. For 2012, $31 million of revenue was reported in the Medicare line of business and the balance was reported in the Medicaid line of business.

South Country does not write ASO or ASC plans. South Country's revenue as shown here is capitation revenue less reinsurance premiums.

Table 1. Revenue by Line of Business ($1,000,000) - South Country

	2012
Comprehensive	-
Medicare Suppl	-
Dental Only	-
FEHBP	-
Medicare	31.0
Medicaid	145.3
Other Health	-
Total	176.3

For 2012 South Country reported an underwriting loss of $7.7 million for the Medicare line and an underwriting gain of $11.7 million for the Medicaid line, for a net underwriting gain of $4.0 million.

Table 2. Underwriting Gain or (Loss) by Line of Business ($1,000,000) - South Country

	2012
Comprehensive	-
Medicare Suppl	-
Dental Only	-
FEHBP	-
Medicare	(7.7)
Medicaid	11.7
Other Health	-
Total	4.0

Table 3. Underwriting Gain or (Loss) as a percentage of Revenue - South Country

	2012
Comprehensive	
Medicare Suppl	-
Dental Only	-
FEHBP	-
Medicare	-24.9%
Medicaid	8.1%
Other Health	-
Total	2.3%

South Country reported $11.9 million of total net income in the last ten years. It reported net income of $16.5 million during that period for PMAP, a loss of $11.2 million and a loss of $14.1 million for GAMC and MNCare respectively and net income of $21.7 million for MSHO and SNBC. For the most recent year, 2012, South Country reported net income of approximately $4.0 million.

Table 4. Net Income Before FIT ($1,000,000) - South Country

	2011	2012
Und. Gain	4.3	4.0
Net Inv. Income	0.0	0.0
Cap Gains	0.0	0.0
Other	-	-
Net Pre-FITIncome	4.3	4.0

South Country has capital reserves of approximately $17.8 million as of year-end 2012. The capital and surplus has grown by 57% since 2008, when it was $11.3 million. Of the total capital and surplus $11.1 million was contributed by member counties. The yearend 2012 surplus is 10% of South Country's annual revenue.

Table 5. Capital and Surplus Analysis ($1,000,000 or %) - South Country

	2009	2010	2011	2012
Surplus	8.3	14.2	13.9	17.8
Growth in Surplus	(3.00)	5.83	(0.23)	3.87
Growth Percentage	-26.4%	70.0%	-1.6%	27.8%
Suplus as % of Revenue	4.1%	6.8%	8.0%	10.1%

South Country's Total Adjusted Capital[124], expressed as the ratio of reported surplus and the Authorized Control Level ("RBC" ratio) is 269% for year-end 2012. That is the highest ratio of the 2008 through 2012 period.

As of yearend 2012, South Country's surplus was equal to 1.2 months of claims and expenses.

Table 6. Risk Based Capital Analysis ($1,000,000 or %) - South Country

	2008	2009	2010	2011	2012
Surplus	-	-	-	13.9	17.8
Total Adjusted Capital	11.3	8.3	14.2	13.9	17.8
Authorized Control Level	7.0	7.8	7.6	6.6	6.6
RBC Ratio	162%	107%	186%	212%	269%
MN Minimum Surplus	-	-	-	-	-
Surplus as % of MN Minimum Surplus	-	-	-	-	-
Surplus as Months Claims & Expenses	-	-	-	1.0	1.2

South Country experienced an 89% loss ratio for 2012, which represents the combination of a 117.8% and 82.8% loss ratio for Medicare and Medicaid respectively.

Table 7. Loss Ratio by Line of Business - South Country

	2012
Comprehensive	-
Medicare Suppl	-
Dental Only	-
FEHBP	-
Medicare	117.8%
Medicaid	82.8%
Other Health	-
Total	89.0%

The number of member months reported in the annual statement has decreased from 322,000 in 2008 to 280,000 in 2012, a decrease of 13%.

Table 8. Member Months - South Country

	2008	2009	2010	2011	2012
Member Months (000)	321.9	361.7	387.2	302.0	279.8
Growth over Prior Year	-	12.4%	7.0%	-22.0%	-7.4%
PMPM Revenue	-	-	-	577.56	629.97
Growth in PMPM Revenue	-	-	-	-	9.1%

[124] Total Adjusted Capital is a derived amount. It is the surplus reported in the annual statement with certain specified adjustments. In most instances they are the same.

South Country's expenses for 2012 were $15.4 million, which equals 8.7% of revenue and $55 PMPM.

Table 9. Claim Adjudication and Administrative Expenses - South Country

	2011	2012
Expenses (000,000)	15.6	15.4
Growth over Prior Year	-	-1.6%
Expense as % of Revenue	9.0%	8.7%
PMPM Expense	51.79	55.00
Growth in PMPM Expense	-	6.2%

The 2012 reconciliation of the 2011 IBNR reserve showed that the reserve developed a margin of $1.6 million or 9% of the reconciled reserve.

Table 10. Claim Reserve Reconciliation ($1,000,000 or %) - South Country

	2012
Reported Prior Yr Reserve	19.3
Reconciled Reserve	17.7
Margin in Reserve	1.6
Margin as % of Reconciled Reserve	9.0%
Margin as % of Surplus	8.9%

At yearend 2012, all of South Country's invested assets consisted of cash and equivalent investments.

Table 11. Invested Assets by Type ($1,000,000) - South Country

	2011	2012
Bonds	-	-
Stocks - Preferred	-	-
Stocks - Common	-	-
Mortgage Loans- First	-	-
Mortgage Loans - Other	-	-
RE - Occupied	-	-
RE - For Income	-	-
RE Other	-	-
Cash & Equivalent	23.2	26.9
Other Invested Assets	-	-
Total Invested Assets	23.2	26.9

Table 12. Invested Assets by Type (% of Total) - South Country

	2011	2012
Bonds	0%	0%
Stocks - Preferred	0%	0%
Stocks - Common	0%	0%
Mortgage Loans- First	0%	0%
Mortgage Loans - Other	0%	0%
RE - Occupied	0%	0%
RE - For Income	0%	0%
RE Other	0%	0%
Cash & Equivalent	100%	100%
Other Invested Assets	0%	0%
Total Invested Assets	100%	100%

Table 13. Capital Gains ($1,000,000) - South Country

	2012
Realized Cap. Gains (Net of FIT)	-
Unrealized Cap. Gains	-

UCare Profile

UCare Minnesota ("UCare") is a not-for-profit tax-exempt Minnesota HMO. UCare has a wholly-owned subsidiary, UCare Health, Inc. ("UCare Health") which shares its Board of Directors and management. UCare Health is a non-profit service insurance corporation licensed to do business in Wisconsin. It became licensed in 2012 as a foreign insurer in Minnesota.[125]

UCare currently has about $2.2 billion in annual revenue. For 2012, UCare reported 38.6% of its revenue as Medicare, 61.4% as Medicaid and a very small amount of revenue as Medicare Supplement. UCare does not have any commercial Comprehensive Medical business. UCare has experienced significant growth in its Medicare and Medicaid lines, with average annual revenue growth of 17% and 18 % respectively.

UCare reported 38.6% of total revenue as Medicare, all in Medicare Advantage products. It reported its MSHO business (12.4% of total revenue) and SNBC (MA Only) (7.0%) as part of the Medicaid line in its NAIC statement. Some other companies report this business as part of the Medicare line in their annual NAIC statements. It also reported its PMAP business (32.9%) and MNCare business (6.6%) as part of the Medicaid line in the NAIC statement. It reported Medicare Supplement and MSC+ together as "Other" (2.5%) in the Minnesota Supplement Report #1.

UCare administers two ASO plans for independent organizations[126]. UCare does not write any ASC plans.[127]

Table 1. Revenue by Line of Business ($1,000,000) - UCare

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Comprehensive	-	-	-	-	-	-	-	-	-	-
Medicare Suppl	2.1	1.9	1.7	0.9	0.7	0.6	0.5	0.4	0.4	0.3
Dental Only	-	-	-	-	-	-	-	-	-	-
FEHBP	-	-	-	-	-	-	-	-	-	-
Medicare	208.4	230.7	263.4	332.1	389.6	436.0	589.0	696.8	776.1	861.1
Medicaid	329.6	376.7	440.5	557.3	625.3	715.7	871.8	907.0	966.0	1,368.2
Other Health	-	-	-	-	-	-	-	-	-	-
Total	540.1	609.3	705.6	890.4	1,015.6	1,152.2	1,461.3	1,604.3	1,742.5	2,229.5

UCare reported $274.4 million of total net underwriting gains in the last ten years, with considerable variation by line of business and year. The Medicare business had $60.4 million of total net underwriting gains over the 10 year period, while the Medicaid business had total net underwriting gains of $213.7 million. The company experienced significant variability in the reported net underwriting gains for both major lines of business. For the most recent year, 2012, UCare reported a net underwriting gain of $62.8 million. For 2012, 85.2% of the underwriting gain was derived from the Medicaid line and 16.5% was derived from the Medicare line, offset by net underwriting losses (1.7%) from Other Health and the

[125] 2012 Annual Statement, Schedule Y Part 1 & Part 1A
[126] 2912 Note 18 to Financial Statements
[127] 2012 Annual Statement, Note 13A&B, Notes to Financial Statements

Medicare Supplement line. Net underwriting gains do not take into account investment earnings and realized capital gains.

The net underwriting gain, expressed as a percentage of revenue, has ranged from 0.1% in 2008 to 6.9% in 2004. Over the ten year period it has averaged 2.7%. The net underwriting gain for 2012 was 2.8% of revenue (1.2% for Medicare and 3.9% for Medicaid). Over the ten year period the Medicare line of business averaged 1.8% and the Medicaid line of business averaged 3.3%.

UCare has entered into certain agreements with the State of Minnesota that impact the absolute amount of profitability of state contracts and will tend to smooth the company's net underwriting gain[128]. In 2011 UCare agreed to limit its net underwriting gain on certain Medicaid products to 1% of revenue for the Medical Assistance (PMAP) and MinnesotaCare (MNCare) programs. In 2012 UCare agreed to share in the aggregate gain or loss of the "Special Needs Basic Care Non Medicare Advantage Special Needs Plan. Significant payments have been made or accrued during 2011 and 2012 as a result of these agreements.

Table 2. Underwriting Gain or (Loss) by Line of Business ($1,000,000) - UCare

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Comprehensive	-	-	-	-	-	-	-	-	-	-
Medicare Suppl	(1.5)	0.3	(0.2)	0.5	0.1	(0.0)	0.1	0.1	0.1	(0.0)
Dental Only	-	-	-	-	-	-	-	-	-	-
FEHBP	-	-	-	-	-	-	-	-	-	-
Medicare	9.8	13.0	2.1	7.2	4.6	1.1	0.8	1.0	10.5	10.3
Medicaid	22.9	28.6	9.9	11.3	9.2	(0.3)	26.9	45.3	6.3	53.5
Other Health	0.5	0.3	0.3	0.3	0.0	0.1	0.1	0.1	(0.1)	(1.1)
Total	31.8	42.3	12.1	19.3	14.0	0.9	27.9	46.5	16.8	62.7

Table 3. Underwriting Gain or (Loss) as a percentage of Revenue - UCare

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Comprehensive										
Medicare Suppl	-70.6%	15.8%	-10.3%	55.5%	14.0%	-0.2%	23.1%	29.3%	22.4%	-0.7%
Dental Only	-	-	-	-	-	-	-	-	-	-
FEHBP	-	-	-	-	-	-	-	-	-	-
Medicare	4.7%	5.6%	0.8%	2.2%	1.2%	0.2%	0.1%	0.1%	1.3%	1.2%
Medicaid	7.0%	7.6%	2.3%	2.0%	1.5%	0.0%	3.1%	5.0%	0.7%	3.9%
Other Health	-	-	-	-	-	-	-	-	-	-
Total	5.9%	6.9%	1.7%	2.2%	1.4%	0.1%	1.9%	2.9%	1.0%	2.8%

Taking into consideration investment income, realized capital gains and miscellaneous income, UCare reported a net income of $70.7 million for 2012. UCare experience was profitable in each of the ten years included in the analysis. Over the course of the ten year period, UCare's pre-FIT net income has ranged from a gain of $3.2 million in 2008 to a net profit of $70.7 million in 2012. As a percentage of revenue, net profit has ranged from 0.3% (2008) to 7.5% (2005) with an average net income over the ten year period of approximately 3.1%. The 2012 net income was 3.2% of revenue. UCare is exempt from Federal income tax.

[128] 2012 Annual Statement, Note 24, Notes to Financial Statements

Table 4. Net Income Before FIT ($1,000,000) - UCare

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Und. Gain	31.8	42.3	12.1	19.3	14.0	0.9	27.9	46.5	16.9	62.8
Net Inv. Income	2.7	3.4	7.8	14.7	18.3	4.4	10.7	7.8	7.5	5.7
Cap Gains	0.1	0.0	-0.1	-0.2	-0.4	-2.1	-1.0	6.8	9.7	2.4
Other	-	-	-	-	-	-	(0.1)	(0.1)	(0.2)	(0.2)
Net Pre-FITIncome	34.6	45.7	19.9	33.8	31.9	3.2	37.5	61.0	33.9	70.7

UCare has capital reserves of approximately $387.7 million as of year-end 2012. The surplus has grown in each of the last nine years as compared to the year before. Year to year growth in surplus has ranged from $5 million (2008) to $66 million (2012). The compound growth in surplus has averaged approximately 20% per year, consistent with the average growth in UCare revenue. The lowest increase was 2.5%, which was realized in 2008 due to relatively poor underwriting results compounded by reduced investment earnings. The largest percentage increase in surplus occurred in 2004 with an increase of 59% from the relatively low level of surplus in 2003.

The company's surplus, expressed as a percentage of revenue (SAPOR), has ranged from a low of 13.8% to a high of 19.6%, which was achieved at yearend 2007. SAPOR decreased from this level in subsequent years and is currently 17.4%.

Table 5. Capital and Surplus Analysis ($1,000,000 or %) - UCare

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Surplus	74.7	118.8	137.6	169.9	198.9	203.8	246.1	308.4	321.9	387.7
Growth in Surplus		44.06	18.76	32.39	28.90	4.98	42.31	62.24	13.56	65.80
Growth Percentage		58.9%	15.8%	23.5%	17.0%	2.5%	20.8%	25.3%	4.4%	20.4%
Suplus as % of Revenue	13.8%	19.5%	19.5%	19.1%	19.6%	17.7%	16.8%	19.2%	18.5%	17.4%

UCare Total Adjusted Capital[129], expressed as the ratio of reported surplus and the Authorized Control Level (ACL), the RBC ratio, is 476%% for yearend 2012. UCare's RBC ratio has varied over the ten year period, with a low of 405% (2003) and a high of 582% (2004). Other measures of surplus can be considered:

- UCare calculates and reports its minimum statutory surplus in its Annual Statement. For 2003 and 2004 the calculation was largely based on incurred claims, claim adjustment expenses and administrative expenses as state law set the minimum required based on the number of months expenses in reserves. For 2005 and later years the minimum statutory surplus level is reported as 200% of the Authorized Control Level consistent with the change in state law setting the minimum based on the NAIC's risk based capital formula.. UCare's surplus as a function of the minimum statutory surplus ranged from 177% (2003) to 291% (2004) and was 238% at yearend 2012.
- Another measure of the level of Capital Reserves expresses it as months of claims and expenses.[130] Capital Reserves have been equal to from 1.8 months to 2.5 months of claims and

[129] Total Adjusted Capital is a derived amount. It is the surplus reported in the annual statement with certain specified adjustments. In most instances they are the same.
[130] This measure of surplus differs slightly from the minimum reserve requirement that was in effect in Minnesota for the first two years of the ten year period under review.

expenses during the last ten years. This measure has varied from year-to-year and was 2.1 months at year end 2012.

UCare Health is a Wisconsin domiciled non-profit service insurance corporation that became licensed in Minnesota during 2012 and is wholly owned by UCare. UCare has made investments in UCare Health. During 2011 UCare made a cash contribution of $2.5 million to UCare Health. During 2012 UCare purchased a surplus note of $10 million. As of year-end 2012, UCare owned $13 million of UCare Health surplus notes. The total cost of UCare's investments in UCare Health is $29 million. This investment is assigned a Fair Value of $14.7 million, $13 million of which are the above referenced surplus notes. The surplus notes are accounted for as nonadmitted assets, leaving $1.7 million as an admitted asset and counting as part of UCare's surplus position. UCare Health RBC also contributes to UCare's RBC, increasing the ACL for UCare by approximately $3 million.

Table 6. Risk Based Capital Analysis ($1,000,000 or %) - UCare

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Surplus	74.7	118.8	137.6	169.9	198.9	203.8	246.1	308.4	321.9	387.7
Total Adjusted Capital	74.7	118.8	137.6	169.9	198.9	203.8	246.1	308.4	321.9	387.7
Authorized Control Level	18.4	20.4	24.9	31.2	35.3	41.9	53.2	58.1	61.4	81.5
RBC Ratio	405%	582%	553%	545%	564%	487%	462%	531%	524%	476%
MN Minimum Surplus	42.2	40.8	49.8	62.3	70.5	83.7	106.5	116.2	122.8	163.0
Surplus as % of MN Minimum Surplus	177%	291%	276%	273%	282%	243%	231%	265%	262%	238%
Surplus as Months Claims & Expenses	1.8	2.5	2.4	2.3	2.4	2.1	2.1	2.4	2.2	2.1

UCare's Medicare Supplement, Medicare Advantage and Medicaid products are open to new enrollment, while its Medicare Supplement business is closed. As a result, in comparison to the other lines of business, its volume of Medicare Supplement business is very small (see Table 1 of the UCare profile).

The Medicare Supplement product line experienced a generally declining loss ratio over the 10 year period. The average loss ratio for the ten year period was 87.1%, with the lowest loss ratios realized in the most recent two years, as losses in the product have been covered by the provision of a premium deficiency reserves established when the product was closed in 2005.

The Medicare line of business experienced a somewhat increasing loss ratio over the 10 year period with an average loss ratio of 90.8%. For the most recent five years the loss ratios were in the low nineties, with a 2012 loss ratio of 92.4%.

The Medicaid line of business experienced an average loss ratio of 89.0% with results varying from 85.1% in 2004 to 93.7% in 2008. The reported loss ratio for 2012 is 88.8%.

Table 7. Loss Ratio by Line of Business - UCare

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Comprehensive	-	-	-	-	-	-	-	-	-	-
Medicare Suppl	88.8%	87.2%	106.4%	91.6%	91.8%	94.5%	90.0%	81.5%	63.1%	76.5%
Dental Only	-	-	-	-	-	-	-	-	-	-
FEHBP	-	-	-	-	-	-	-	-	-	-
Medicare	88.8%	87.0%	90.2%	89.0%	89.4%	92.3%	93.0%	93.4%	92.3%	92.4%
Medicaid	86.3%	85.1%	90.0%	90.2%	90.4%	93.7%	89.8%	86.9%	89.0%	88.8%
Other Health	-	-	-	-	-	-	-	-	-	-
Total	87.1%	85.8%	90.1%	89.7%	90.0%	93.2%	91.1%	89.7%	90.5%	90.2%

The number of member months reported in the 2012 annual statement has increased 163% over the number reported in the 2003 annual statement. The member months have increased from 1.3 million in 2003 to 3.4 million in 2012. Based on a review of the revenue growth by line of business, it appears that the growth was generally equally spread over the Medicare and Medicaid lines of business. PMPM revenue per member month increased by 5.1% per year over the 10 year period. The annual PMPM revenue increases have varied over the ten year period, with 21.5% increase in 2006 and decreases in the most recent three years. However, the PMPM revenue by product line varies greatly between Medicare and Medicaid. In 2012, revenue PMPM for the Medicaid line of business was $578 as compared to revenue PMPM for the Medicare line of business of $842. As a result, the change in overall revenue PMPM reflects changes over time in product mix. Increases in 2006 through 2008 reflect UCare's growing ratio of Medicare with recent declines reflect an increasing Medicaid enrollment proportion.

Table 8. Member Months - UCare

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Member Months (000)	1,286.3	1,346.0	1,417.2	1,471.3	1,485.6	1,636.0	1,974.9	2,284.2	2,569.9	3,389.2
Growth over Prior Year		4.6%	5.3%	3.8%	1.0%	10.1%	20.7%	15.7%	12.5%	31.9%
PMPM Revenue	419.93	452.72	497.89	605.16	683.62	704.30	739.94	702.34	678.07	657.84
Growth in PMPM Revenue		7.8%	10.0%	21.5%	13.0%	3.0%	5.1%	-5.1%	-3.5%	-3.0%

UCare expenses[131] have increased each year except for 2008, when the company reported a decrease of 11%. Over the 10 year period, expenses averaged 7.6% of revenue, with a high of 8.6% in 2007 and a low of 6.7% in 2008. Expenses expressed on a PMPM basis have grown since 2003. The average annual PMPM increase is 6.7% and equates to a compound growth rate of 5.4% per year. Annual expense growth, measured on a PMPM basis, has ranged from a high of 22.7% (2005) to a low of negative 20.6% in 2012.

UCare supplies all administrative services to UCare Health in accordance with an administrative services agreement between the two companies. UCare charged UCare Health $10.1 million and $9.9 million under this agreement for 2012 and 2011 respectively[132].

[131] The sum of Claim Adjustment Expenses and General Administrative Expenses
[132] 2012 Annual Statement, Notes to Annual Statement, Note 10

During 2012 UCare recorded charitable contributions of $12.0 million. Charitable contributions are recorded as General Administrative Expenses.[133] Similarly, UCare recorded charitable contributions of $7.8 million for 2011.

During 2011 UCare made a voluntary contribution to the State of Minnesota of $30 million. This contribution was recorded as a General Administrative Expense. This voluntary contribution is the primary factor for the 2011 increase in expenses. Excluding this voluntary contribution, the decrease in PMPM expenses for 2012 compared to 2011 would have been 31%

Table 9. Claim Adjudication and Administrative Expenses - UCare

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Expenses (000,000)	36.6	44.5	57.5	72.7	87.3	77.7	101.5	119.2	148.8	155.7
Growth over Prior Year		21.7%	29.2%	26.3%	20.2%	-11.0%	30.6%	17.4%	24.8%	4.7%
Expense as % of Revenue	6.8%	7.3%	8.2%	8.2%	8.6%	6.7%	6.9%	7.4%	8.5%	7.0%
PMPM Expense	28.44	33.08	40.60	49.39	58.78	47.49	51.39	52.18	57.90	45.95
Growth in PMPM Expense		16.3%	22.7%	21.6%	19.0%	-19.2%	8.2%	1.5%	11.0%	-20.6%

For each accounting period the company estimates its liability for claims incurred but not reported ("IBNR"). The IBNR is generally the largest liability reported on the company's balance sheet. For statutory accounting company management generally estimates this amount on a conservative basis by including a specified margin. The annual statement provides a test of the adequacy of the prior year reserve. An anticipated margin of 8-10% in the reconciled reserve is common and may generally be viewed as reasonable. However actual results from year to year will vary. Health Plans maintain a margin in their IBNR reserve because the actual liability is not known at the time it is estimated and it is subject to variation. Not much can be concluded from the adequacy and/or margin in any one year's reconciliation. UCare's margin in the claim reserve, expressed as a percentage of the reconciled reserve has ranged from as high as 41% (2002 yearend claim reserve) to as low as 12% (2006 yearend claim reserve). In its 2012 Annual Financial Statement, UCare reported a margin of 16.7% of the reconciled 2011 claim reserve.

Excess margins in the incurred but not reported (IBNR) unpaid claim liability reduce the company's reported surplus. For each of the years included in our analysis UCare consistently reported margins in its reported liability for IBNR greater than typical margins we see from other companies.

Table 10. Claim Reserve Reconciliation ($1,000,000 or %) - UCare

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Reported Prior Yr Reserve	87.4	86.7	95.8	93.7	134.5	144.5	179.8	195.1	185.6	227.8
Reconciled Reserve	61.9	68.7	79.5	74.4	120.5	119.5	147.8	162.4	143.4	195.1
Margin in Reserve	25.5	18.1	16.4	19.3	14.0	25.1	32.1	32.7	42.1	32.6
Margin as % of Reconciled Reserve	41.1%	26.3%	20.6%	26.0%	11.6%	21.0%	21.7%	20.1%	29.4%	16.7%
Margin as % of Surplus	34.1%	15.2%	11.9%	11.4%	7.0%	12.3%	13.0%	10.6%	13.1%	8.4%

At year-end 2012, approximately 60% of the company's invested assets consisted of long term bonds. The percentage of UCare's invested assets that are in common stocks has ranged from 0% to 12% and is

[133] 2012 Annual Statement, Page 14 Line 2501 and Notes to Annual Statements, Note 10

currently at 6%. Common stocks are valued at market and are relatively more volatile than other investments usually made by health plans. However, they offer the possibility of superior returns, which could ultimately make health premiums lower. They create a somewhat higher Authorized Control Level amount under the RBC formula, and therefore result in a lower RBC ratio for the same amount of capital reserves. The effect on UCare is not great, because UCare's common stock portfolio is relatively small compared to other investments.

UCare maintains a significant share of investments in cash and cash equivalents. At recent yearends cash and cash equivalents have amounted to 28-34% of total invested assets.

Table 11. Invested Assets by Type ($1,000,000) - UCare

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Bonds	64.6	98.9	139.9	170.8	208.7	219.7	280.9	323.1	349.1	395.2
Stocks - Preferred	-	-	-	-	-	-	-	-	-	-
Stocks - Common	-	-	-	25.0	47.7	38.2	26.3	32.9	33.1	38.6
Mortgage Loans- First	-	-	-	-	-	-	-	-	-	-
Mortgage Loans - Other	-	-	-	-	-	-	-	-	-	-
RE - Occupied	-	-	-	-	-	-	-	-	-	-
RE - For Income	-	-	-	-	-	-	-	-	-	-
RE Other	-	-	-	-	-	-	-	-	-	-
Cash & Equivalent	137.2	135.7	116.3	151.6	124.8	117.7	142.6	145.1	165.3	229.1
Other Invested Assets	-	-	-	-	4.2	2.4	3.1	8.8	0.5	1.7
Total Invested Assets	201.8	234.6	256.1	347.4	385.4	378.0	452.9	510.0	548.0	664.7

Table 12. Invested Assets by Type (% of Total) - UCare

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Bonds	32%	42%	55%	49%	54%	58%	62%	63%	64%	59%
Stocks - Preferred	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Stocks - Common	0%	0%	0%	7%	12%	10%	6%	6%	6%	6%
Mortgage Loans- First	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Mortgage Loans - Other	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
RE - Occupied	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
RE - For Income	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
RE Other	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Cash & Equivalent	68%	58%	45%	44%	32%	31%	31%	28%	30%	34%
Other Invested Assets	0%	0%	0%	0%	1%	1%	1%	2%	0%	0%
Total Invested Assets	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Realized capital gains are reflected in the income statement (Statement of Revenue and Expenses). The change in unrealized capital gains is not reflected in the income statement but is a direct credit to the company's surplus account. The amounts of realized and unrealized capital gains are highly variable, with 2011 showing large unrealized capital losses and 2012 showing positive amounts for both realized and unrealized capital gains.

Table 13. Capital Gains ($1,000,000) - UCare

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Realized Cap. Gains (Net of FIT)	0.1	0.0	(0.1)	(0.2)	(0.4)	(2.1)	(1.0)	6.8	9.7	2.4
Unrealized Cap. Gains	-	-	-	-	-	-	6.1	(0.2)	(13.2)	4.7

Appendix E. Extended description of RBC calculation

Annually each insurer is required file a financial statement, prepared in accordance with statutory accounting principles (SAP), with the state regulator and the NAIC. This requirement applies to HMOs, health service plans and insurance companies. Included in the annual statement is a Risk Based Capital Analysis[134]. This analysis is intended to show the relationship of the insurer's surplus position to a calculated amount that takes into consideration various risk factors. The calculated values in the annual statement are the "Total Adjusted Capital" (TAC) and the "Authorized Control Level Risk Based Capital" (ACL). The ratio of the TAC and the ACL is the Risk Based Capital (RBC) ratio.

In addition to the requirements for reporting the RBC analysis in the annual statement, the state of Minnesota requires the annual submission of a comprehensive RBC report on or before April 1 to the NAIC and the Commissioner. This requirement is detailed in Minnesota Statutes, Chapter 60A.50 for health organizations[135] and Chapter 60A.60 for life/health insurance companies and casualty companies.

Total Adjusted Capital is based on the company's reported surplus and in many instances is equal to the company's reported surplus. The Authorized Control Level Risk Based Capital represents is 50% of a computed value based on a formula and factors that are specified by the NAIC and that taking into consideration the company risk profile. The ratio of these two is the number that is typically used by insurance regulators to assess solvency adequacy.

The RBC formula is focused on solvency. The purpose of the RBC formula is to determine the minimum amount of capital for an insurer below which the regulator must intervene in order to protect the interests of the insured members. The intervention taken will vary, depending on the RBC ratio.

The cited statutes state that the calculation must follow a formula specified by the NAIC.

The RBC formula is complex. An insurer's capital and surplus is evaluated relative to the minimum for statutory solvency by the RBC ratio. The RBC formula takes into consideration the following five major categories of risk, referred to in the RBC formula as H0 through H4:

- H0: Asset risk of affiliates
- H1: Other asset risk
- H2: Underwriting risk
- H3: Credit Risk
- H4: General business risk.

A brief discussion of the five categories of risk follows.

[134] The Risk Based Capital Analysis is contained in the Five Year Historical Data page
[135] Organizations licensed under Chapter 62C or Chapter 62D

Asset risk related to affiliates (H0 risk): The H0 risk component differentiates between those affiliates that are themselves subject to an RBC calculation and others. For those affiliates subject to an RBC calculation, the RBC result of the affiliate becomes the basis of its contribution to the H0 risk. For other affiliates, contribution to this component is the asset value multiplied by a percentage factor indicated in the calculation instructions.

The Other Asset Risk Component (H1 risk) includes all non-affiliate assets. These assets consist primarily of various categories of invested assets (e.g., stocks, bonds, etc.) and furniture and equipment. Bonds are carried in the statutory statement at amortized value (except in the case of a default). That is, bonds are not "marked to market" for statutory statement purposes, as they are for GAAP accounting. Therefore differences between book and market value of bonds do not affect earnings or surplus in statutory accounting. The statement value of bonds effectively assumes that they will be held to maturity. Bonds are split into seven different risk classifications which are based on the designations assigned by the NAIC Securities Valuations Office. U.S. government bonds and those guaranteed by the U.S government are considered to be risk free and do not contribute to the RBC calculation. For all other bond categories the statement value is multiplied by a factor which ranges from 0.3% for the least risky to 30% for bonds in default. That is, a $1000 face amount corporate bond characterized as "least risky" would contribute $3 to the H1 component calculated value, while a similar bond that was in default would contribute $300 to the calculation. A similar process is in place for preferred stocks. Mortgage loans are generally subject to a 5% factor. Owned real estate is generally subject to a 10% factor. Furniture, equipment (including EDP equipment), and software are generally subject to a 10% factor. Common stocks are generally carried at market value in the statutory statement and the RBC factor is 15%.

The category "other assets" includes equity investments that are not publicly traded. These investments, including partnership interests, are listed in the annual statement in Schedule BA. Schedule BA assets are subjected to a 20% RBC factor

In addition to the description of various elements of the H1 component listed above, there are additional calculations for certain off balance sheet transactions, derivatives and other less common categories.

The following table provides an overview of the RBC factors for the most common investment types:

Table 1. Asset Risk Factors

Asset Type	% Factor*
Bonds — U.S. Guaranteed	0.0%
Bonds — High quality	0.3%
Real Estate	10.0%
Common Stocks	15.0%
Mortgages	10.0%
Schedule BA Equity	20.0%

* Applied to statement value

The sum of the investments times the relevant factors becomes the total H1 component.

The investment strategy for each company will result in a risk profile that will drive the amount of the H1 component. As the risk profile of the investment portfolio increases, the H1 component of the RBC formula will increase. Thus, to a limited extent, an insurer can manage its RBC ratio by changing its investment strategy.

For a health insurer the Underwriting Risk Component (H2 Risk) of the RBC formula) is generally the largest contributor to the RBC calculation. Health insurers, unlike life insurers, make few long-term guarantees, but they are exposed to risk because volume of claims paid may be different from that which is expected. This may be due to changes in the block of business, changes in medical care trend, cost projection errors, or random variation. The H2 calculation takes into account the level of incurred claims for various types of coverage, the protection provided by reinsurance, the risk of rate guarantees beyond 12 months, and the reduction of risk provided by premium stabilization funds and provider arrangements, such as capitation and “withholds.”

The Credit Risk Component (H3 Risk) takes into account the risk of recovering receivable amounts from creditors. The H3 risk considers the collection risk of:

- Amounts due from reinsurers and affiliates,
- Amounts due from providers under risk arrangements,
- Investment income receivables,
- Pharmaceutical rebate receivables and similar amounts.

The General Business Risk Component (H4 Risk) recognizes such risks as:

- Unanticipated fluctuations in administrative expenses,
- Unanticipated fluctuations in the cost of administering ASC and ASO contracts,

- Guaranty fund assessments[136] and
- Excessive growth.

The RBC formula recognizes that it is unlikely that adverse experience for each type of event considered for H1 through H4 risk will occur simultaneously. A covariance formula adjusts the combined effect of the H1 through H4 risks so that the combination of the risk components is less than the sum of them. The formula assumes that the H1 through H4 risks are uncorrelated. The H0 risk is added to the combined result of the H1 through H4 risk, reflecting the assumption that the H0 risk is highly correlated with the overall risk of the company (i.e. if the company experiences severe financial problems the affiliates would also be adversely affected.) The process described in this paragraph is summarized in the following formula:

RBC = H0 + Square Root of (H12+H22+H32+H42)

The ACL is calculated as 50% of the RBC amount calculated by the formula. If the company's TAC amount is less than the ACL, the regulator is required to act for the purpose of protecting insureds.

The Total Adjusted Capital (TAC) and the Authorized Control Level (ACL) amounts are included in the Five Year Historical Data[137] page of the statutory financial statement filed by insurers. The ratio of these two items is used by regulators as an indicator of the financial health of an insurer and is generally referred to as the "RBC ratio."

The filing company may be subject to certain action by its regulator, as stated in the statute, based on the ratio of the TAC and the ACL Amount, usually referred to as the RBC ratio. In addition to ACL, the following three other categories of action are defined in the regulation:

- The Company Action Level RBC is 200% of ACL
- The Regulatory Action Level RBC is 150% of ACL
- The Mandatory Control Level RBC is 70% of ACL.

If the company's TAC amount is greater than or equal to the Regulatory Action Level but less than the Company Action Level, the company may be required to prepare and submit to the regulator a plan (an "RBC Plan), including assumptions and projections, that contains proposed actions that will allow the company to achieve a TAC level equal to or greater than the Company Action Level.

If the company's TAC amount is greater than or equal to the ACL and less than the Regulatory Action Level:

- The company is required to submit an RBC Plan to the regulator,
- The regulator is required to perform an examination of the company, including a review of the RBC Plan and

[136] While this is part of the RBC formula, it is not relevant for Minnesota HMOs, which are not subject to guarantee fund assessments.
[137] Page 28 of the 2012 statutory financial statement.

- The regulator is required to issue an order specifying the corrective actions to be taken by the company (a "Corrective Order").

If the TAC amount is greater than or equal to the Mandatory Control level but less than the ACL, the regulator may take the same action as specified in the prior paragraph or may take other action allowed and as specified in the statute. If the TAC amount is less than the Mandatory Control Level, the regulator is directed to place the company under regulatory control[138] as allowed by provisions of the Chapter under which the company was organized.

Regulatory intervention is required if the Total Adjusted Capital amount is less than 200% of the Authorized Control Level. This suggests that a TAC amount equal to 200% of the Authorized Control Level defines a floor for a company's capital and surplus under ordinary conditions. In practice it would be desirable for a company to establish a goal for a ratio that is in excess of this amount in order to provide reasonable assurance that the company does not become subject to regulatory action due to ordinary fluctuations in its business.

The profile section for each of the insurers in this report includes data that shows for each year in the 10 year study period the level of surplus, TAC and ACL reported and the RBC ratio. For BCBS and for each of the HMOs except for Sanford, the HMOs included in this study the RBC ratio at year-end 2012 is significantly above the 200% level. Table 1 below indicates the TAC amount, the ACL amount and the RBC ratio at year end 2012 for these insurers.

Table 2. 2012 RBC Development ($1,000,000)

Company	Reported TAC	Reported ACL	Ratio
BCBSM	827.5	117.6	703%
Blue Plus	359.6	38.2	942%
Group Health	98.8	18.8	527%
Health Partners Inc	709.1	123.7	573%
Medica	442.1	57.2	773%
Metropolitan	24.7	4.8	515%
PreferredOne	10.2	2.9	357%
Sanford	0.7	0.5	125%
Ucare	387.7	81.5	476%
Itasca Medical	4.8	2.2	216%
Prime West Health	41.2	6.7	614%
South Country Health	17.8	6.6	269%

Over the ten year timeframe of this analysis Blue Plus, Health Partners and UCare experienced significant growth in the level of TAC. During 2008 several companies experienced significant realized and unrealized investment losses and which were greater than their underwriting gains. In particular, BCBSM and Blue Plus experienced substantial investment losses due to their investments in common

[138] The regulator may delay such action by up to ninety days.

stocks. As of year-end 2007, common stocks constituted 28% and 22% respectively of their invested assets. Metropolitan's TAC experienced a decline of approximately 40% at year-end 2008. BCBSM and Blue Plus have established a significant level of deficiency reserves for year-end 2010 through 2012. As of year-end 2012 BCBSM and Blue Plus held deficiency reserves of $77.6 million and $51.5 million respectively[139].

Table 3. Total Adjusted Capital – TAC ($1,000,000)

Company	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
BCBSM	609.2	692.6	693.9	715.3	648.3	520.2	631.9	762.8	793.7	827.5
Blue Plus	96.3	130.3	162.5	210.2	234.8	200.8	250.9	317.6	357.2	359.6
Group Health	75.7	58.1	44.4	60.2	61.2	75.8	79.4	85.5	98.7	98.8
Health Partners Inc	167.3	264.9	275.1	297.0	344.7	335.4	386.6	497.4	616.9	709.1
Medica	317.1	330.2	321.0	281.8	319.5	317.7	361.3	399.3	416.3	442.1
Metropolitan	-	-	12.6	10.4	12.2	4.8	8.1	10.6	19.0	24.7
PreferredOne	25.3	26.0	26.5	22.0	19.1	14.7	11.4	11.9	10.6	10.2
Sanford	1.0	1.5	1.9	2.2	2.4	2.0	1.7	1.3	1.3	0.7
Ucare	74.7	118.8	137.6	169.9	198.9	203.8	246.1	308.4	321.9	387.7
Itasca Medical	*	*	*	*	*	5.3	5.3	4.7	4.8	4.8
Prime West Health	*	*	*	*	*	12.3	11.8	24.7	36.2	41.2
South Country Health	*	*	*	*	*	11.3	8.3	14.2	13.9	17.8

Each of the carriers displayed significant variation in its RBC ratio over the ten year period ending with 2012.

Table 4. Risk Based Capital Ratio (%)

Company	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
BCBSM	819%	811%	753%	666%	596%	489%	583%	718%	757%	703%
Blue Plus	418%	656%	758%	729%	751%	595%	703%	865%	924%	942%
Group Health	726%	507%	393%	601%	680%	812%	557%	573%	565%	527%
Health Partners Inc	499%	683%	623%	580%	628%	591%	446%	491%	561%	573%
Medica	620%	689%	715%	706%	828%	881%	781%	668%	745%	773%
Metropolitan			313%	214%	232%	71%	136%	177%	284%	515%
PreferredOne	643%	551%	528%	386%	311%	239%	213%	223%	252%	357%
Sanford	238%	725%	1020%	1019%	1133%	953%	670%	398%	446%	125%
Ucare	405%	582%	553%	545%	564%	487%	462%	531%	524%	476%
Itasca Medical	*	*	*	*	*	276%	257%	220%	214%	216%
Prime West Health	*	*	*	*	*	262%	209%	438%	590%	614%
South Country Health	*	*	*	*	*	162%	107%	186%	212%	269%

The calculation of the ACL amount is done based on instructions provided by the NAIC and the results of this calculation are reported to the NAIC and to state regulators. The filed RBC report is confidential and

[139] SAP requires that an insurer currently recognize the amount of premium inadequacy in future periods for a block of business.

there was no access to RBC reports for the purposes of analysis. However, based on the NAIC instructions provided for the calculation of the ACL amounts, a reasonable estimate for the H0–H4 amounts was developed based on each company's 2012 annual statement data.[140] The results of this analysis are indicated below:

Table 5. 2012 Modeled ACL ($1,000,000)

Company	Reported ACL	Modeled ACL	Modeled as % of Reported
BCBSM	117.6	123.5	105%
Blue Plus	38.2	37.9	99%
Group Health	18.8	17.6	94%
Health Partners Inc	123.7	122.9	99%
Medica	57.2	57.2	100%
Metropolitan	4.8	4.8	100%
PreferredOne	2.9	2.9	100%
Sanford	0.5	0.6	101%
Ucare	81.5	78.0	96%

[140] Certain elements of the calculation are based on data that is contained in company records and that is not separately identified the annual statutory financial statement. In such instances reasonable estimates were made.

Appendix F. Summary of Stakeholder Comments

Stakeholder Interviews

MN Capital Reserves Project – List of Interviews outside of MN State Government

Health Plans

Blue Cross Blue Shield of MN, Blue Plus
- Nancy Nelson: VP, Chief Actuary
- Scott Keefer, VP for Policy and Legislative Affairs
- Denise Bergevin, VP, finance and Corporate Controller

Health Partners, Group Health, HPIC
- Dave Dziuk, Senior VP and CFO
- Kevin Brandt, Director of Corporate Financial Reporting and Tax.

Medica
- Geoff Barsh, VP Public Policy and Govt Relations
- Mary Quist, Finance

PreferredOne
- Mike Umland, CFO
- Jon Carlson, Director of Accounting

UCare
- Beth Monsrud, Senior VP, CFO
- Mark Traynor, Senior VP, General Counsel
- Ghita Worcester, Senior VP, Public Affairs and Marketing

Academic Representative

University of Minnesota, School of Public Health
- Jon Christianson, PhD, Faculty Division of Health Policy and Management

Consumer Representative

Minnesota Citizen's Federation
- Buddy Robinson, Staff Director

TakeAction MN

Liz Doyle, Associate Director

Halleland Habicht PA

Michael Scandrett, Consultant

Call also included: John Klein (Cirdan), CFO of Prime West, actuarial service to IMCare; Brett Skyles, Executive Director, Itasca, IMCare; Brian Hicks, CFO, South Country

County-Based Purchasers

Prime West

Jim Przybilla, CEO

Provider/ACO

Fairview

Dan Fromm, CFO

State Regulators and Related

Colorado

Liz Leif, Consultant familiar with CO environment

Massachusetts

Kevin Beagan, Deputy Commissioner, Division of Insurance

Oregon

Laura Cali, Insurance Commissioner

Pennsylvania

Joel Ario, former Insurance Commissioner

Sharon Woda, former consultant to Insurance Department on Surplus Regulation of Blues

Rhode Island

Chris Koller, Former Health Insurance Commissioner, now President of Milbank Memorial Fund

Washington

Lichiou Lee, Health Actuary

We also received written responses from Metropolitan Health Plan and from Sanford Health Plans, as well as supplementary written responses from several of the insurers.

Summary of Stakeholder Comments

HMOS and affiliated insurance companies, including BCBSMN, Inc.:

1. **Should there be a maximum surplus level for HMOs?**
    a. Responses ranged from acceptance of a surplus limit if it is calculated and managed appropriately to strong disagreement, to a statement that a cap is not needed, to refusal to state a position.
    b. Plans disagreed with respect to whether a maximum, if placed on HMOs, also had to be placed on insurance companies.
    c. Placing a cap on multi-line insurance companies is far more complex than a maximum for just health insurance companies
    d. Some expressed acceptance of a limit on surplus for HMOs but not for insurance companies.

2. **Items that should inform and impact surplus requirements, other than the standard:**
    a. Corporate size
    b. Corporate structure
    c. Medicaid bidding process in MN
    d. Medicaid payment withholds
    e. Uncertain Medicaid payment levels prior to the January 1 start date of a new contract
    f. ACA implementation and ICD 10 are recent, major initiatives requiring capital
    g. Geographic area served
    h. Proportion of members represented by state public program businesses
    i. Accuracy of risk adjustment in new exchange marketplace
    j. Impact of Medicaid expansion
    k. Organizational form: non-profits need higher levels of surplus than for profit companies as they depend more heavily on retained earnings for capital requirements than do for profit companies.
    l. Anticipated elimination of the Medicare Cost program and thus the probable shifts in enrollment towardsl Medicare Advantage products in the state
    m. Liabilities from non-insurance subsidiaries are not considered in the RBC formula and yet have to be taken into account by the parent company.
    n. Company expansion, both in state and out of state – both new members in existing products and new product offerings
    o. The timing of MLR rebates, risk adjustments, and finalizing of premium rates requires funds on hand.
    p. Non-profits use surplus to support the community in ways that impact the health of the community

q. Uncertainty of new members' expected morbidity. For example, previously uninsured purchasing coverage via MNsure may be higher or lower risk than existing populations.
r. Providers do not at this point accept much insurance risk, or downside risk, in MN – most provider contracts are shared savings – so the issue of much risk being borne by providers rather than insurers, is not a key concern at this point.
s. Some companies have more low income members than others. Research shows that low income individuals generally have poorer health status, and thus greater healthcare needs, than those with higher incomes.
t. IT investments will continue to require capital

3. Issues to consider if setting/implementing a maximum surplus level:

a. Take a long term, rather than short term approach to both determining the maximum level itself – that is, a company needs to be at the maximum level for longer than just one point in time, e.g., 2 years or more --and the means of managing to get below the maximum– that is, giving companies a particular amount of time – e.g., two or three years – to manage surplus levels to below the maximum.
b. Be prospective, not retrospective.
c. Have the health plan work with the Department of Commerce to develop a plan for managing surplus down to an acceptable level, similar to the process used if a plan falls below accepted surplus levels.
d. Carriers integrated with providers have different – usually greater – capital needs than other carriers.
e. Credit ratings and bond covenants can necessitate various levels of surplus. Bond rating agencies may require a specific surplus level which might be above any state mandated maximum
f. Carriers expressed differing opinions in their support of using marketplace intiaitives – e.g., premium rebates, premium holidays, premium reductions, etc. –to manage down surplus levels. . Some supported such as being the easiest and most direct means of returning surplus; others saw it as inappropriately disrupting the market
g. Any give-back of funds should be to another non-profit, community benefit, or to the state – not to subscribers. (This point came up because several of the respondents were concerned about potential market destabilization if a well-capitalized insurer were to use its excess reserves to support premium decreases, thereby becoming more competitive than the other carriers could match.)
h. All the insurers agreed that it would not be appropriate to determine and manage product-specific reserves, because reserves exist for the benefit of the entire company, and because it would be less efficient use of capital to require

each line of business to maintain separate reserve. For example, if one line of business suffered losses, the entire company can remain solvent because of its overall reserve level.

i. There was a concern that a limit on capital reserves might encourage excess administrative spending or increased provider payments as a way for a company to use up "excess" surplus.

4. If there is a maximum, what type of measure should be used?

a. Most carriers felt RBC is a better means of measuring surplus requirements than months of claims
b. Some felt that months of claims – as previously used in Minnesota – while not ideal is easier for people to understand and thus is a better regulatory measure.

5. What might that maximum level be?

a. For those carriers willing to offer a maximum, various levels were mentioned:
    i. More than 800% RBC, more diverse responses were received from UCare
    ii. 3-4 months of expenses, which can be translated for each company into an RBC level

6. Potential Consequences of the Implementation of a Maximum level

a. Carriers might move products out of the HMO to the insurance company
b. Carriers might change corporate structure
c. Value of the non-profit MN HMO environment could deteriorate if companies move members out of HMOs and into insurance companies

7. Reasons to not implement a maximum surplus level

a. MN is a sufficiently competitive market
b. Not much likelihood of an insolvency in MN, while at the same time MN RBC levels are currently at the national average
c. The uncertainty of the ACA implementation – both Medicaid expansion and the impact of new enrollees – make this a poor time to implement a cap even if it might be appropriate at another time
d. Minimum loss ratio requirements under the ACA help to manage profit levels
e. Current political pressure to keep Medicaid margins low should resolve concerns about state programs contributing to excess reserve levels

8. Other concerns about a maximum level

a. It can be difficult to explain what appears to be an excess surplus level increasing even while a company is experiencing losses.
b. It may be appropriate to treat paid-in-capital differently from surplus accumulated from earnings.

c. Complexities of surplus and RBC are difficult to explain: for instance, surplus and RBC can rise even when carriers are experiencing losses.

County-Based Purchasers:

1. **Should there be a maximum surplus level for HMOs?**
   a. Support a cap.
   b. Currently, for at least one CBP, reserves are managed through payments to provider stakeholders.

2. **Items that impact surplus requirements, other than the standard**
   a. Mix of state and commercial programs
   b. "Program" or "political/legislative" risk with state programs – these aren't captured by RBC formula
   c. Growth can decrease RBC levels

3. **Issues to consider if setting/implementing a maximum surplus level:**
   a. Needs to be a means of separating surplus generated by public programs from that generated by commercial products
   b. Any perceived excess surplus in CBPs now goes to support community programs that have a positive impact on health care costs. This is what should happen should carriers go above a maximum surplus – funds shouldn't go back to subscribers.
   c. Need to develop a list of appropriate uses for excess surplus
   d. Have a range, over time, rather than a hard and fast cap
   e. Require RBC to be above maximum level for at least two years before action is taken
   f. Require greater transparency re: contributions to capital from specific products
   g. Flexibility required to not interfere with other program requirements – e.g., Medicare, NAIC or SAO accounting
   h. Geographic area served – rural or urban
   i. Provider payment models

4. **If there is a maximum, what type of measure should be used?**
   a. RBC

5. **What might that maximum level be?**
   a. 500-600% RBC

6. **Other concerns about a maximum level**

a. Continue to be cognizant of concerns if RBC is too low – allow carriers to rebuild RBC by keeping gains even if the state program has a maximum profit margin requirement

Consumers

1. **Should there be a maximum surplus level for HMOs?**
   a. Definitely should be a maximum reserve level for the HMOs
   b. Competition doesn't limit reserves in MN
   c. Non-profits in particular should be subject to a maximum level
   d. Caps would prevent potential for subsidies across product lines as some data suggests may currently exist.

2. **Issues to consider if setting/implementing a maximum surplus level:**
   a. Transparency – the data used in the RBC calculation is not public
   b. Be aware of means of impacting surplus levels – e.g., re-classifying assets from admitted to non-admitted; transferring assets to affiliates; calculations for Premium Deficiency Reserves, etc.
   c. Require consolidated financial statements quarterly so state can better monitor corporate-wide financials
   d. Excess surplus accumulated from public programs needs to go back to the state, and any federal share needs to go back to the federal government. For state programs, this could be accomplished by segregating these excess funds and drawing them down over time.
   e. Any legal questions re: the institution of a maximum limit and/or a requirement to use any excess surplus funds in a given way need to be addressed for implementation of a limit
   f. Any investment gains from public programs would need to be considered when calculating surplus associated with public programs
   g. Expense allocations need to be examined
   h. State needs to conduct audits to determine actual profits and expenses of state programs over past
   i. Consider reserve levels as Department of Commerce approves commercial rates and DHS approves Medicaid rates
   j. If state contracts do not put a carrier at risk, should a carrier need reserves to support this product? If state contracts are actually cost plus, the carrier should not need reserves.
   k. Source of funding from "excess" reserves might have been from the federal government programs.

3. **If there is a maximum, what type of measure should be used?**
   a. RBC.

4. **What might that maximum level be?**
    a. 400% RBC more than adequate, though anything above NAIC monitoring level of 200% should be safe.
    b. CBPs have lower RBC levels than the HMOs. HMOs should be able to manage with the same RBC level as the CBPs.

5. **Other concerns/issues about a maximum level**
    a. As carriers approach the maximum they may be incented to spend funds or take other actions simply to prevent reaching that level.

Academics and Providers

1. **Should there be a maximum reserve level for HMOs?**
    a. Movement from capitated arrangements to FFS resulted in higher need for reserves.
    b. Competition serves to limit reserves in MN, as does provider scrutiny during rate negotiations
    c. MLR implementation will make it harder for plans to increase reserve levels going forward
    d. Non-profits should have maximum reserve levels as they get a number of advantages.
    e. Since organizations can always manage around any maximum, there is no real need for one or value in having one.
    f. Payment reform will reduce the insurance risk carriers hold; high reserves may create unnecessary duplication in care improvement practices.

2. **Items that impact reserve levels other than the standard**
    a. Changing provider contracts – e.g., moving toward more total cost of care contracts, and contracts where providers take downside risk – will change the need for carriers to have as much in reserves
    b. Large reserve levels have slowed the transfer of insurance risk to providers
    c. Administrative services only (ASO or ASC) contracts require less reserves as well, and carriers are moving commercial business in this direction.

3. **Issues to Consider if setting/implementing a maximum surplus level**
    a. Once carriers have reserves they should be able to use them as they choose, even if the funds are from state programs.
    b. Difficult to increase transparency in Minnesota due to power – both economic and political – of carriers
    c. Any market disruption due to carriers drawing down excess reserves can impact care management programs – as members change carriers they potentially could change providers as well

d. Rather than decrease current levels of reserves, move to limit growth going forward
e. “operational risk” is transferring from carriers to providers
f. As providers accept more downside risk in the future, might insurers need lower reserves?
g. Can expect more provider/payer consolidation going forward
h. The movement from insured to ASO/ASC business also moderates a plan’s need for reserves.
i. Detailed surplus limit requirements (e.g., on investments, expense allocations, etc.) generate detailed audit requirements. Such a limit is not practical.
j. Product-specific limits will yield better results, as any overall limit can be managed around.
k. Limits may not be very workable because they are hard to audit.

Appendix G. IBNR Analysis

Health insurers are required to hold a liability for unpaid claims in their annual financial statements. Since the amount of unpaid claims is not known at the time of the statement, they use actuarial methods, most commonly what is known as the development method, to estimate the liability. That is, they use past experience to predict what claims that have already occurred will be presented for payment after the end of the fiscal year. Because the estimate relies on projections and judgment, it will invariably be difficult for it to be precisely accurate. However, claims are generally presented relatively quickly, and the true amount of the liability is mostly known by the time of the following year financial statement.

Health insurers report on the reconciliation of the prior year liability as part of the Underwriting and Investment Exhibit Part 2B of the annual statement. Normally, the insurers build a margin into their estimates, because it is undesirable for the estimates to prove to be inadequate. However, any margin reduces the reported income, and also reduces reported surplus. Results generally vary from year to year, but a typical margin built in by health insurers that the actuarial team is familiar with is in the range of 8-10%. Results of any one year are not particularly meaningful, because of the inherent variation, so one year with a reconciled margin of zero, or of 20% is not dispositive. However, a continuing pattern of negative margin, or a continuing pattern of margins well in excess of standard levels, might demand some inquiry as to the methods being used to develop the IBNR estimate, and some evaluation as to whether they should be changed.

It should be noted that the calculation of IBNR is generally performed by and certified by a qualified actuary, and reviewed and examined by state regulators. We do not mean to imply that the IBNR calculated by the insurers is incorrect or inappropriate.

While excess margin in any one year reduces surplus, it is reconciled in the following year, so there is no accumulated impact of margin. However, if a high level of margin is maintained in all years then surplus may be systematically under-reported. We analyzed the reconciliation of IBNR reported by the Minnesota HMOs, by BCBSM and by the domiciled affiliated insurers, and found that margin levels in the 2003-2011 IBNR as revealed by subsequent year analysis on average for all of the HMOs ranged from 7.2% to 26.2% of the reconciled IBNR claims by year. On a weighted average over nine years, HMOs had an average margin of 17.9%, insurers an average margin of 21.8% and BCBSM an average margin of 5.1%.

By company, the results were variable. The relatively highest average margins were revealed in the reports of the HealthPartners companies, the Medica companies, Metropolitan Health Plan and UCare.

In total, the reconciled IBNR reserves released margin in subsequent years ranging from $56 million to $214 million. In the most recent reconciliation, the margin in the 2011 IBNR was revealed by subsequent events to be $130 million. There is no published information currently available to show the amount of margin in the 2012 IBNR. That will be published in the 2013 financial statements of the insurers.

If the insurers had maintained a margin not to exceed 10% in their IBNR, 2011 surplus would have been reported $37 million higher than it was for HMOs, and $19 million higher for insurers. BCBSM would have been unaffected. This is highly theoretical since the amount of the margin was not known or knowable at the time the statements were prepared. Nevertheless, since the level of margin does affect reported surplus, and because the average pattern over time indicates a relatively high level of margin, it can be estimated that in any given year, surplus is understated for at least some carriers. The following table shows the additional surplus that would have been reported by companies in each year if the margin in the IBNR were no more than 10%. Note that this is not really possible, since the amount of the IBNR is not known until the following year. However, if companies were encouraged not to include margin higher than 10% in their estimates, presumably over time the level of surplus would be more fully reported.

Table 1. Revealed Margin in IBNR Reconciliation ($000,000)

Company	2003	2004	2005	2006	2007	2008	2009	2010	2011
BCBS	20	14	10	10	17	19	32	34	0
Blue Plus	30	12	5	14	14	5	15	12	11
Group Health	4	3	(1)	2	3	4	7	6	5
HealthPartners, Inc	6	(2)	1	16	15	24	22	23	17
HPIC	6	4	2	6	4	(2)	6	19	13
Medica	25	27	2	23	22	16	24	47	21
Medica Ins Co	13	25	17	(4)	19	17	11	24	21
MHP	-	-	-	-	-	3	4	6	6
PrefOne	(0)	(0)	(1)	1	0	1	1	(0)	1
PrefOne Ins	-	0	0	0	0	1	(0)	0	2
Sanford	(0)	(0)	0	0	(0)	0	0	0	(0)
UCare	18	16	19	14	25	32	33	42	33
Total	$ 122	$ 100	$ 56	$ 81	$ 120	$ 121	$ 154	$ 214	$ 130

Table 2 below compares the revealed margin in the subsequent year to the reconciled actual amount of the IBNR claims as determined in the following year. Table 3 below shows what the amount of excess IBNR liability that would be released (and reported instead as surplus) if the margin in IBNR were no larger than 10% for any one company. The total would be approximately $56 million.

Table 2. Revealed Margin as a Percent of Reconciled IBNR

Company	2003	2004	2005	2006	2007	2008	2009	2010	2011
BCBS	9.0%	4.9%	3.3%	3.2%	5.1%	5.6%	8.1%	8.6%	0.0%
Blue Plus	50.5%	18.2%	8.5%	17.1%	16.6%	4.5%	12.6%	9.8%	8.5%
Group Health	29.3%	20.3%	-4.4%	15.9%	31.6%	30.6%	43.8%	43.9%	34.0%
HealthPartners, Inc	8.5%	-2.6%	1.7%	16.7%	14.5%	28.4%	24.4%	28.3%	21.3%
HPIC	123.4%	87.6%	14.7%	37.2%	22.1%	-6.1%	15.7%	35.4%	17.5%
Medica	15.7%	23.8%	1.9%	24.6%	22.2%	15.1%	17.8%	36.0%	14.1%
Medica Ins Co	49.3%	45.4%	19.5%	-3.6%	30.8%	21.7%	13.2%	32.8%	26.1%
MHP						19.9%	40.5%	56.4%	35.9%
PrefOne	-4.0%	-2.1%	-6.0%	3.7%	1.0%	4.3%	7.3%	-2.4%	14.1%
PrefOne Ins		2.0%	11.9%	0.3%	32.5%	43.3%	-2.9%	3.4%	14.6%
Sanford	-1.8%	-14.2%	29.3%	51.7%	-29.8%	11.2%	30.1%	6.0%	-1.8%
UCare	26.3%	20.6%	26.0%	11.6%	21.0%	21.7%	20.1%	29.4%	16.7%
Total	19.1%	14.0%	7.2%	9.6%	14.2%	12.7%	14.4%	20.3%	10.7%

Table 3. Margin in IBNR in excess of 10% of reconciled reserve, by company ($000,000)

Company	2003	2004	2005	2006	2007	2008	2009	2010	2011
BCBS	-	-	-	-	-	-	-	-	-
Blue Plus	24	6	-	6	5	-	3	-	-
Group Health	3	1	-	1	2	3	5	5	4
HealthPartners, Inc	-	-	-	6	5	16	13	15	9
HPIC	6	4	1	4	2	-	2	13	5
Medica	9	16	-	14	12	5	11	34	6
Medica Ins Co	10	19	8	-	13	9	3	17	13
MHP	-	-	-	-	-	2	3	5	4
PrefOne	-	-	-	-	-	-	-	-	0
PrefOne Ins	-	-	0	-	0	1	-	-	1
Sanford	-	-	0	0	-	0	0	-	-
UCare	11	8	12	2	13	17	16	28	13
Total	$ 63	$ 54	$ 21	$ 33	$ 53	$ 53	$ 56	$ 117	$ 56