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To: Philip Barlow Associate Commissioner

From: Sarah Schroeder

Date: March 31, 2014

Re: Premium Growth Assumptions and ACA Reforms -- GHMSI Surplus Review

In correspondence to Commissioner McPherson dated March 14, 2014, DC Appleseed Center for Law & Justice, Inc. asked Commissioner McPherson for certain information relating to R&A's analysis of the premium growth assumptions used in the Milliman stochastic modeling process and of the revisions R&A asked Milliman to make in the stochastic modeling process as a result of ACA reforms. Attached are two memoranda to R&A from FTI Consulting that provide a detailed analysis of these requests. Should the Commissioner decide to respond to Appleseed's requests, the attached memorandum provides the requested information.

If you have any additional questions, please don't hesitate to contact me.

FTI CONSULTING

MEMORANDUM

TO: **Rector and Associates**

FROM: **Jim Toole**

cc: Robert Stewart

DATE: September 12, 2013

RE: **ACA Reform and Surplus Requirements**

Background

Healthcare reform under the Affordable Care Act (ACA) will result in coverage changes, underwriting restrictions, and a broader base of individuals that will be purchasing health insurance. Reform presents opportunities and risks for insurers that will have to adapt to a very different environment.

The greatest impact of the ACA legislation is the expansion of health coverage in the individual and small group markets. Underwriting restrictions benefit those who have the greatest health risks and have the highest costs. The individual mandate requires that everyone purchase insurance or face a tax penalty, and federal subsidies will make it more affordable for the poor to purchase insurance. To implement these changes, the insurance landscape will be changing and costs will be shifted between demographic groups.

The new rules of the game introduce uncertainty and the potential for downside risks that should be considered when determining capital requirements of health insurers during the market transition. Milliman has added certain features to its capital model of GHMSI that reflect the impact of Health Care Reform. The potential risks, relevant issues, and suggested capital modeling impact for each of these items are discussed below. These can be broadly divided into impacts on rating adequacy and premium growth.

FTI Consulting has analyzed the reform assumptions in Milliman's model and independently considered the potential range of impacts reform may have on GHMSI's capital requirements. Based upon our analysis, FTI suggests modifications to the assumptions in the Milliman model and highlights our concerns as they relate to the impact of healthcare reform on surplus requirements going forward.

Approach

FTI has identified the following aspects of ACA reform that need to be considered in the context of GHMSI's surplus requirements:

ACA Modeled Items

- Premium Growth
- Medical Loss Ratio Requirement
- Increased Regulatory Oversight
- Coverage Changes

ACA Unmodeled Items

- Underwriting Restrictions
- Policyholder Behavioral Changes
- Coverage Mandate

In their 2011 report Milliman incorporated explicit assumptions for the medical loss ratio requirement, increased regulatory oversight, and coverage changes. The impact of these items was approximately $200 million in additional surplus requirements. For the remaining items, Milliman introduced a 100% RBC "catch-all" for the aggregate impact of other potential risks associated with ACA (approximately $100 million). Rather than adding on a flat RBC % amount, FTI has considered the impact of unmodelled items within the surplus model.

ACA Modeled Items

Premium Growth Assumption

See Memo on Premium Growth.

Medical Loss Ratio Requirements

The Affordable Care Act has introduced minimum loss ratio requirements to ensure plans provide value to enrollees. The amount paid for claims and quality improvement divided by earned premiums less taxes, licenses, and regulatory fees is known as the Medical Loss Ratio (MLR). MLRs of 80% for the small group and individual markets and 85% for the large group markets are required. Insurers that fail to meet these requirements must provide rebates to policyholders.

The medical loss ratio requirements force insurers to control expenses and limit the potential profitability of insurers. Only 20% of premium is available to pay for marketing, insurer administrative costs, agent's commissions, and contributions to surplus.

While clearly a significant feature of the ACA legislation, the MLR requirement only has a minimal impact on the surplus requirements. It is unclear that the MLR rebates pose a significant enough a risk to even be included in the modeling process. MLR rebates are only paid during times of favorable experience. The better the loss experience, the higher the rebates will be. The surplus requirements are based on the capital necessary to sustain the

company during periods of stress. If there are poor underwriting results due to a trend miss or a catastrophe, rebates will not be issued.

There are some possibilities where the MLR rebates could impact surplus requirements, but these are rare. A large underwriting loss could occur in one region or line of business while another region or line has had favorable results and must therefore pay a rebate. Although this scenario is possible, given that trend and catastrophe losses between lines of business and locales are closely correlated, it is unlikely. Also, if it is known that one of the regions or lines is experiencing favorable loss ratios, then this experience will tend to offset the bad experience in the other lines. The greater concern is unfavorable results across all lines or all regions.

The MLR requirement also poses a solvency threat to insurers who cannot keep their long-term expense ratios in check. If the insurer's expenses minus investment income are consistently above 20% for the individual market or 15% for the group market, then the insurer will be losing money. This would lead to a slow deterioration in surplus that could eventually threaten the solvency of the company. While this is a risk, it does not present an immediate concern for a well managed insurer like GHMSI. An effectively managed insurer should be able to control expenses and meet the MLR regulation, while ineffective insurers who consistently cannot control expenses will struggle.

One criticism of Milliman's model is that the rebate calculations have been performed independently from the possibility of a catastrophe. If a catastrophe were to occur, then clearly loss ratios would be impacted and rebates would not be distributed. The Milliman methodology will tend to overstate the negative impact of the MLR rebate although it has little overall impact on the model.

While the medical loss ratio requirement does little to threaten the solvency of an already well-capitalized insurer, it does make it more difficult for an under-capitalized insurer to build surplus. If a catastrophe or large trend miss that significantly depleted surplus funds were to occur, GHMSI would be limited by the rebate provision as to how quickly they could rebuild their surplus. However, this is not the purpose of this exercise.

For this model, the impact of the MLR calculations is nearly a zero value. Given the negligible impact within this model, it is not inappropriate to continue including the MLR component. While the MLR rebates add to the intricacy of the modeling process, they have little impact on surplus requirements.

Increased Regulatory Oversight

Healthcare reform introduces new uncertainty to the insurance regulatory process. Companies are concerned about increased scrutiny and potential reduction of filed rates. Regulators are deciding how best to interpret and implement the laws as written. The Milliman model has assumed that regulatory oversight will increase with new barriers that lengthen the rate approval process and place limits on large rate increases. Within the model the increased regulatory requirements result in less responsive rates, worse underwriting results, and the need to hold greater capital.

The new law requires a process for reviewing increases to health plan premiums and requires that such rate increases be justified. In particular, rate increases above a certain threshold, currently 10%, regulatory reviews must be conducted. This new regulatory requirement will impact states that do not currently review rate increases. DISB already reviews rates before they are approved.

The Milliman model has made two significant regulatory change assumptions which impact surplus requirements:

- Increased Rate Review Time
- Rate Increase Restrictions

Increased Rate Review Time

Milliman has assumed that the regulatory review process will increase from 21 months to 24 months. This time marks the difference between the data used to create rates and midpoint when a rate increase would actually come into effect. The increase in regulatory time reduces the responsiveness of the rating adequacy and has a detrimental impact on the trend miss. If rates are inadequate, then they will remain inadequate for a longer period of time if regulatory approval times are longer.

After discussions with Regulators and Milliman, FTI notes that the filing of rates is being made earlier. Filings are required to be made by April or May to give regulators time to review rates both on and off the exchange. FTI in its ACA assumptions has included the increase of the 21 to 24 month lag time.

Rate Increase Restrictions

The Milliman model has assumed that there will be regulatory rate restrictions for increases above 10% and that only 65% of the amount over 10% will be approved. For example, if a 20% rate increase is filed, then only a 16.5% (10% + (20%-10%)*.65) will be allowed. The rating restriction has significant consequences. Since the surplus model is most sensitive to the times of poor underwriting results and high indicated rate increases, the premium restrictions have a greater effect on the required initial solvency requirements.

Based upon Rector's discussions with regulators, insurance departments are able and willing to approve rate increases in a timely fashion as long as it is actuarially justified. If an insured begins to find themselves in a financially difficult situation, regulators will work expeditiously to approve needed rate increases. This would suggest that the rate increase restrictions are unfounded and should be removed from the model.

Coverage Changes

ACA coverage changes include unlimited benefits, coverage for dependents to age 26, and a pre-existing provision for children have been included within the Milliman model. These coverage provisions have been available since 2010 and are no longer a pricing concern. While Milliman has included these changes in the trend miss calculation, at this point they a normal part of the pricing landscape. FTI does not believe any separately identifiable risk component needs to be incorporated in the model for coverage changes. The impact of the coverage changes in the model are negligible in the Milliman Model.

ACA Unmodeled Items

Underwriting Restrictions

As part of the new health legislation, insurance companies will no longer be able to rate based on an individual's prior medical history. This will alter the individual and small group marketplace.

Insurers will have less knowledge and control of the health status of its members. Prior to reform some insurers had a competitive advantage based on their ability to underwrite and identify the best risks and price them accordingly. With the new underwriting restrictions, the pricing variables in these markets have changed. Insurers will be forced to change their pricing structures and could face anti-selection within this new marketplace.

In addition to the underwriting restrictions for pre-existing conditions, there will be limits on demographic variations in the rates. Insurers will no longer be able to vary rates by gender. Underwriting deviations by age will be restricted to a 3 to 1 maximum difference between the highest rates and the lowest rates. Also smoker to non-smoker rates will be able to vary up to 1 to 1.5. These new restrictions are a departure from the current practice and there is a potential for miss-pricing in the transition to the new system.

Current Policyholder Behavioral Changes

With the upcoming changes to the marketplace it is uncertain how consumers will respond. There are many questions that insurers face when offering coverage. How will the newly insured policyholders utilize healthcare? Will the currently insured policyholders seek to change coverage as premiums change? How will the underwriting limitations affect current blocks of business?

These behavioral characteristics are difficult to price for and may lead to rate inadequacies or excesses if not appropriately captured. The underwriting restrictions and policyholder behavioral changes are inter-related. The more changes made to the underwriting process the greater uncertainty there will be as to how policyholders respond.

FTI assumes that the underwriting restrictions and policyholder changes will increase the variability of the pricing in the individual and small group markets. The standard deviation of trends for those currently insured in the individual and small group market is assumed to increase by 20% to reflect this increase in variability.

Uninsured / Coverage Mandate

To ensure that that plans are not subject to anti-selection, an individual mandate has been introduced. Otherwise, healthy individuals would only purchase insurance as they became sick without the pre-existing conditions requirement. Under the ACA reforms, individuals are required to purchase health insurance or face a tax penalty. New exchanges for the individual marketplace are being introduced on a state level. It is expected that many who are currently uninsured will enter the markets through the exchange.

The introduction of this new population of insured in the individual market will be harder to price. These individuals do not have a history of insured experience, making it difficult to price accurately. FTI assumes that the variability of these uninsured risks is double the variability of risks in the current insured population.

Rating Adequacy and Fluctuation Assumption

The combined impact of the healthcare reform on the rating adequacy assumptions are shown for both the Milliman and FTI models in Table 1.

Table 1: Rating Adequacy and Fluctuation

Surplus Change as a % of Non-FEP Insured Premium			
	Milliman		FTI
Probability	2-Year Deviation	3-Year Deviation	2.5 Year Deviation
3.0%	26.0%	31.1%	30.1%
6.8%	20.9%	24.6%	24.1%
7.6%	17.4%	20.3%	20.2%
6.7%	15.0%	17.4%	17.5%
12.2%	12.2%	14.1%	14.6%
27.4%	6.8%	7.4%	9.3%
12.2%	0.6%	-0.2%	3.4%
6.7%	-3.0%	-4.7%	-0.3%
7.6%	-6.6%	-9.3%	-3.6%
6.8%	-12.1%	-16.1%	-9.3%
3.0%	-20.6%	-26.7%	-18.2%

FTI CONSULTING

MEMORANDUM

TO: **Rector and Associates**

FROM: **Jim Toole**

cc: Robert Stewart

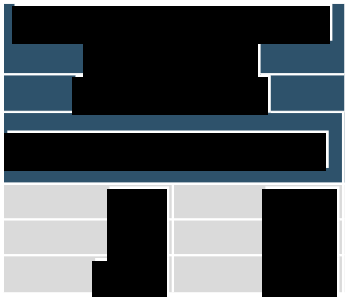
DATE: **May 16, 2013**

RE: **Premium Growth Assumption**

Executive Summary

Estimates of GHMSI's premium growth assumptions have differed widely between parties concerned with GHMSI's capital and surplus. As of 4/19/2013, Milliman has proposed an annual premium growth range with the following probabilities:

Table 1



[redacted] These figures can be compared to Milliman's previous reports which included deterministic growth rate scenarios of 12% and 14% in their December 4, 2008 report and 7% and 11% in their May 31, 2011 report. On the other hand, Appleseed actuary Mark Shaw recommended in 1/18/2013 correspondence a premium growth assumption of between 2% and 6%.

FTI Consulting believes that the proposed Milliman range of [redacted] is not unreasonable overall, but suggests this assumption be split into Non-FEP and FEP components.

Background

Insurers need capital and surplus to back the underwriting risk they face. In the Health Risk Based Capital formula, the NAIC has tied underwriting risk to premium which serves as a proxy for the exposure. For each type of business, a factor is multiplied by premium and a claims ratio to reflect the underwriting portion of the RBC-ACL. For instance Comprehensive Medical and Hospital coverage premium factors range from 15% to 9% depending on the premium

volume written. The 2012 underwriting risk factor for GHMSI is 9.1% and 85.6% for the claims ratio factor[1]. For FEPBP business a factor of 2% is applied to only premium with no claims ratio factor.

Given the importance of premium in measuring underwriting risk, accurately estimating the premium growth is critical to modeling capital requirements. For determining an estimate of future premium growth, GHMSI's historical experience should be used as a guidepost and expert opinion should be incorporated for aspects not captured within the history. The historical experience should be adjusted for atypical activity that is not expected to continue in the projection period. This includes activities like one-time mergers and structural reinsurance changes. Also, given the upcoming implementation of ACA health reforms there are some known changes that will impact premium that are not captured in GHMSI's experience. Adjustments should be made to the premium growth assumption for the expected impact of ACA.

Historical Growth – All Lines

Below is a chart examining the historical growth in net earned premium for all lines of business for GHMSI including FEP. In addition to GHMSI's own direct business, a portion of GHMSI's affiliates has been added. An assumed ownership percentage of 50% has been the applied to all years to reflect the current business structure. GHMSI only owned 40% of CFBC for 2002 through 2010. Changes to the ownership structure obscure other premium growth trends so a constant assumed ownership percentage has been presented. Also, it should be noted that in 2008 GHMSI entered into a reinsurance agreement with CFMI which resulted in a one-time change in the population covered. The 2008 Annual % Change in premium is the lowest value in the past ten years due to this reinsurance change. 2008 is an outlier due to the reinsurance change and should be excluded from future projections.

The table below shows the earned premium of GHMSI and its affiliates and the annual premium growth year over year.

Table 2

	2003	2004	2005	2006	2007
GHMSI EARNED PREMIUM	1,891.19	2,032.74	2,257.44	2,457.59	2,828.48
CFBC + AFFILIATES EARNED PREMIUM	878.77	1,062.22	1,303.14	1,421.78	1,591.32
ASSUMED OWNERSHIP	50%	50%	50%	50%	50%
GHMSI AND AFFILIATES	2,330.58	2,563.85	2,909.01	3,168.48	3,624.14
ANNUAL % CHANGE	12.4%	10.0%	13.5%	8.9%	14.4%

	2008	2009	2010	2011	2012
GHMSI EARNED PREMIUM	2,757.51	2,890.87	2,917.43	3,059.42	3,165.92
CFBC + AFFILIATES EARNED PREMIUM	1,747.82	1,878.52	1,992.68	2,006.71	2,163.65
ASSUMED OWNERSHIP	50%	50%	50%	50%	50%
GHMSI AND AFFILIATES	3,631.42	3,830.13	3,913.77	4,062.77	4,247.75
ANNUAL % CHANGE	0.2%	5.5%	2.2%	3.8%	4.6%

Source: Earned Premium figures from Statutory Annual Statements 2003-2012

[1] Group Hospitalization and Medical Insurance Company- Health Risk Based Capital for the Year ending December 31, 2012 (Page XR012): Experience Fluctuation Risk, Underwriting Risk Factor

There has been variation of 2.2% to 14.4% annual premium growth from 2003 – 2012 (excluding the 2008 outlier). It should be noted that during the period 2003-2007 the premium growth was higher than the period from 2009 to 2012. Examining an all year average excluding 2008 a growth rate of 8.4% has been calculated. This value is strikingly different than the 4.0% in the most recent four years as seen in the chart below.

Table 3

% ANNUAL PREMIUM CHANGE	
AVERAGE ALL YEARS	7.5%
AVERAGE ALL YEARS EX 2008	8.4%
AVERAGE LAST 4 YEARS	4.0%

Future Premium Growth

To effectively project future premiums, we need to identify and understand the factors that change premium. Premium can be driven by three interrelated factors.

- First, the number of enrollees who are insured can change. This could be due to an insurer capturing a larger portion of the market or a growing health insurance marketplace.
- Second, the average premium per customer may need to be increased to reflect rising insurance cost per member (PMPM). The healthcare cost trend has been increasing reflecting price inflation, deductible leveraging, utilization, technology advances, cost shifting from governmental plans.
- Third, benefit reductions and employee cost shifting either due to plan design changes or changing to lower cost plans tend to move the average PMPM cost downward.

Each of these items should be examined for GHMSI in turn.

The number of enrolled members in GHMSI and Carefirst has fluctuated up and down during the historical period. Between 2009 – 2012, GHMSI has lost membership with significant percentage membership declines in 2009 and 2010. As a result of this membership decline, premium growth has stalled at a pace slower than medical inflation. On a forward going basis, it is unclear if it is appropriate to assume a continuing decline in GHMSI's enrolled members. It is expected that natural population growth will slightly expand the marketplace. If GHMSI is able to maintain its market share, then slow but steady membership gains should be assumed.

Table 4

	2003	2004	2005	2006	2007
GHMSI Aggregate Enrollment	710,923	737,769	756,919	810,150	846,805
% Change		3.8%	2.6%	7.0%	4.5%
Carefirst Aggregate Enrollment	370,326	405,576	446,347	450,060	656,623
% Change		9.5%	10.1%	0.8%	45.9%
GHMSI + 50% Carefirst	896,086	940,557	980,093	1,035,180	1,175,117
% Change		5.0%	4.2%	5.6%	13.5%

	2008	2009	2010	2011	2012
GHMSI Aggregate Enrollment	928,875	861,753	796,147	815,218	803,048
% Change	9.7%	-7.2%	-7.6%	2.4%	-1.5%
Carefirst Aggregate Enrollment	566,437	533,181	517,324	535,143	553,437
% Change	-13.7%	-5.9%	-3.0%	3.4%	3.4%
GHMSI + 50% Carefirst	1,212,094	1,128,344	1,054,809	1,082,790	1,079,767
% Change	3.1%	-6.9%	-6.5%	2.7%	-0.3%

Source: Enrollment by product type figures from Statutory Annual Statements 2003-2012

The annual per member cost of insurance has been increasing due to medical inflation. Nationally industry medical costs have been rising per insured. A study “Medical Cost Trend: Behind the Numbers 2013” by PWC suggests that projected 2013 trends will be flat at 7.5%. [redacted] Furthermore, deductible leveraging tends to shift the increasing medical costs more onto insurers. A key assumption to this model is a baseline 8% medical cost trend. Premiums must be increased to keep pace with these rising costs.

With the increasing cost of insurance, many policyholders have opted for less coverage in exchange for reduced premiums. Some plans have altered their benefit design to reduce premiums. Many insureds have chosen to migrate from higher cost insurance plans with rich benefits to lower cost plans with fewer benefits. High Deductible insurance plans have become more common and grown in membership for many insurance providers. The shift in covered benefits has limited the premium increases, and has been cited by GHMSI management as one of the drivers in the recent period of slow premium growth. They also suggest the plans have reached a point of diminishing returns with respect to benefit reductions and cost shifting.

ACA

The impact of the ACA legislation needs to be considered when projecting premium growth. It is expected that ACA will have a substantial impact on the individual insurance marketplace due to the individual mandate and the introduction of insurance exchanges. Many currently uninsured people are expected to be covered in the individual insurance markets in 2014 through the exchanges. Per the research report “The Cost of the Future Newly Insured under the Affordable Care Act (ACA)” sponsored by the Society of Actuaries, both the size of the individual insured market and the average cost per member is expected to increase substantially. According to this study, the size of the non-group market is expected to more

than double nationally from 11.9 million to 25.6 million as citizens enroll in the exchanges in 2014.

Table 5

State	% Uninsured Pre-ACA	Size of Non-Group Pre-ACA	Size of Non-Group Post-ACA	% Change in Non-Group	Average Non-Group PMPM Pre-ACA	Average Non-Group PMPM Post-ACA	% Change in Non-Group PMPM	Total ACA % Change
District of Columbia	12.3%	25,343	41,271	63%	$ 348	$ 528	51.9%	147%
Maryland	13.1%	184,809	386,491	109%	$ 284	$ 473	66.6%	248%
Virginia	15.1%	328,880	628,457	91%	$ 306	$ 393	28.4%	145%
DC, MD, VA	NA	539,032	1,056,219	96%	$ 300	$ 428	42.3%	179%
National	16.6%	11,931,125	25,618,984	115%	$ 314	$ 413	31.5%	182%

Source: "The Cost of the Future Newly Insured Under the Affordable Care Act (ACA)"

It is assumed that the ACA legislation will change the landscape of the individual market in 2014. For the FTI model a 180% premium increase relative to Non-FEP Premium has been selected in 2014 reflecting a doubling in the number of members and a 40% increase in non-group PMPM cost (Table 5). For the high and low assumptions, the % change in the non-group market has varied from 50% to 150% to reflect the uncertainty in the market volume and GHMSI's market share. The percentage change in the PMPM cost has been selected to increase from 30% and 50% respectively.

Table 6

	% Change in Non Group Market	% Change in Non-Group PMPM	Total % Impact
Selected ACA Impact	100%	40%	180%
High ACA Impact	150%	50%	275%
Low ACA Impact	50%	30%	95%

The individual market is small compared to GHMSI's group business. The individual business made up only 7.7% of non-FEP earned premium in 2012. A 180% increase in premium in the individual markets is expected to increase the proportion of individual business as a % of total Non-FEP premium to 13.8% (Table 7).

Table 7

	GHMSI + 50% CareFirst							
		Earned Premium (1,000s)			Including FEP		Excluding FEP	
	Total ACA % Impact	Total	Non-FEP	Individual	Individual % of Total	ACA Impact on Total	Individual % of Non-FEP	ACA Impact on Non-FEP
Base ACA Impact	180%	4,442,821	2,567,193	196,740	4.4%	8.0%	7.7%	13.8%
High ACA Impact	275%	4,442,821	2,567,193	196,740	4.4%	12.2%	7.7%	21.1%
Low ACA Impact	95%	4,442,821	2,567,193	196,740	4.4%	4.2%	7.7%	7.3%

FTI Premium Growth Assumptions

Incorporating the ACA changes of 2014 into our three year projection model we obtain the following table of outcomes (Table 8). The FEP vs. Non-FEP premium differences are greater in the light of the impact of ACA.

Table 8

Central

	Non-FEP				FEP			
	2013	2014	2015	3 Year Ave	2013	2014	2015	3 Year Ave
Base Medical Trend	7.5%	7.5%	7.5%	7.5%	7.5%	7.5%	7.5%	7.5%
Market and Benefit Trends*	-0.2%	-0.2%	-0.2%	-0.2%	-0.2%	-0.2%	-0.2%	-0.2%
ACA impact**	0.0%	13.8%	0.0%	4.6%	0.0%	0.0%	0.0%	0.0%
Total	7.5%	22.3%	7.5%	12.4%	7.5%	7.5%	7.5%	7.5%

High

	Non-FEP				FEP			
	2013	2014	2015	3 Year Ave	2013	2014	2015	3 Year Ave
Base Medical Trend	8.5%	8.5%	8.5%	8.5%	8.5%	8.3%	8.3%	8.4%
Market and Benefit Trends*	1.3%	1.3%	1.3%	1.3%	-0.2%	-0.2%	-0.2%	-0.2%
ACA impact**	0.0%	21.1%	0.0%	7.0%	0.0%	0.0%	0.0%	0.0%
Total	8.5%	31.4%	8.5%	16.1%	8.5%	8.3%	8.3%	8.4%

Low

	Non-FEP				FEP			
	2013	2014	2015	3 Year Ave	2013	2014	2015	3 Year Ave
Base Medical Trend	6.5%	6.5%	6.5%	6.5%	6.5%	6.5%	6.5%	6.5%
Market and Benefit Trends*	-1.7%	-1.7%	-1.7%	-1.7%	-0.2%	-0.2%	-0.2%	-0.2%
ACA impact**	0.0%	7.3%	0.0%	2.4%	0.0%	0.0%	0.0%	0.0%
Total	6.5%	14.3%	6.5%	9.1%	6.5%	6.5%	6.5%	6.5%

Notes:
* Market and Benefit Trends includes GHMSI's market share growth, marketplace growth due to demographic changes, benefit changes, plan migration, and deductible leveraging
** ACA Growth assumptions based on the following:
Central: Individual marketplace will grow 180% in 2014
High: Individual marketplace will grow 270% in 2014
Low: Individual marketplace will grow 90% in 2014

Comparison to Milliman

In aggregate the FTI premium growth assumptions are not significantly different than the most recent Milliman assumptions. The FTI combined FEP and Non-FEP growth rate has been shown below for comparison to the Milliman assumptions. The FTI central rate is slightly higher and the variance of the premium assumption is less.

Table 9

FTI Annual Premium Growth Rates		[redacted]
FEP + Non-FEP		[redacted]
Growth Rate	Probability	[redacted]
8.0%	25.0%	[redacted]
10.4%	50.0%	[redacted]
12.8%	25.0%	[redacted]

While Table 9 shows differences on a combined basis, determining separate assumptions for FEP and Non-FEP is significant.

Premium Growth Rate Conclusion

Based upon the Central, High and Low assumptions FTI suggest the following simplified average annual premium growth assumptions.

FTI Annual Premium Growth Rates			
Non-FEP		FEP	
Growth Rate	Probability	Growth Rate	Probability
9.1%	25.0%	6.5%	25.0%
12.4%	50.0%	7.5%	50.0%
16.1%	25.0%	8.4%	25.0%