

Washington, D.C. Department of Insurance, Securities and Banking

CareFirst Hearing on Group Hospitalization and Medical Services, Inc, Surplus

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The Lewin Group (Lewin) is a premier national health and human services consulting firm which has delivered objective analyses and strategic counsel to public agencies, non-profit organizations, and private companies across the United States since 1970. The value we place on accuracy, independence and objectivity is reflected in the trust our clients place in The Lewin Group. As a subsidiary of Ingenix and its parent UnitedHealth Group, The Lewin Group safeguards its integrity by maintaining separate business and technical practices, while operating under editorial independence. We have delivered objective analysis and insight to 39 states and the District of Columbia on issues related to Medicaid, health insurance coverage, health reform, long term care and other related issues. We also have extensive experience working with private payers and federal agencies, including the Centers for Medicare and Medicaid Services (CMS), and the Department of Defense (DOD) on a wide range of health and human services priorities. Finally, we have conducted projects on behalf of the District of Columbia (DC), such as our work in assisting the DC Department of Health on DC Alliance, a public program aimed at providing insurance coverage for DC residents not qualifying for Medicaid. We have several other projects currently underway in the District that are assisting both private and public organizations in improving children's access to health care and education.

With regards to the issue at hand, Lewin has extensive experience in evaluating and analyzing insurer surplus. We assisted the Pennsylvania General Assembly's Legislative Finance and Budget Committee in reviewing the surplus levels and community benefit activities of the four Blue Cross Blue Shield (BCBS) plans operating in Pennsylvania. This assessment included a review of the Determination and Order issued by the Pennsylvania Insurance Department which implemented target surplus ranges for the BCBS plans operating in that state. We have worked on behalf of the insurance commissioners in Rhode Island and Washington to assist and provide expert guidance in evaluating options for regulating surplus. We have also worked on behalf of several private health plans, primarily BCBS plans, which have required our assistance in either addressing regulator concerns about surplus or in establishing internal surplus targets. Our experience working for both regulators and insurers provides us with a unique perspective on how to evaluate surplus as well as policy options for regulating surplus.

I am here to explain Lewin's findings regarding some questions that GHMSI asked us to comment on as well as comment on treatment of surplus limits in other states and conclusions from the work we did for the Commonwealth of Pennsylvania.

Before diving in, it is important to define both surplus and Risk Based Capital (RBC). Surplus is generally defined as an insurer's retained earnings or funds on hand to protect the company and its customers against adverse business conditions and support investment needs. Since surplus amounts do not provide perspective on a health plan's risk profile and organizational structure, state regulators commonly use RBC to assess an insurer's level of risk.

RBC is a measure generally used by regulators to establish the minimum amount of capital appropriate for a health plan to support its overall business operations during a period of adverse conditions. In DC, if RBC drops below 200% an insurer is required to present a plan to the DC DISB for improving its surplus. BCBS plans have similar, but more stringent RBC requirements imposed by the Blue Cross Blue Shield Association (BCBSA). The BCBSA requirements generally call for a licensee to maintain an RBC ratio of at least 375% as a threshold below which additional reporting and monitoring with regard to surplus levels is required. The 375% level to maintain good standing within the BCBSA is important to keep the trust and confidence of employers and subscribers who place a premium on the financial stability of their vendors and insurers.

The Lewin Group's Findings Regarding GHMSI

I will now discuss Lewin's findings regarding CareFirst's DC affiliate, Group Hospitalization and Medical Services, Inc (GHMSI). Lewin was retained by CareFirst to perform an independent assessment of the RBC suggested by Milliman for GHMSI. Lewin produced a report with findings in response to three key questions. Those questions are:

- Question 1: Is the approach used and range of RBC set forth by the Milliman report appropriate?
- Question 2: Is RBC an appropriate mechanism for assessing upper limits of insurers' surplus?
- Question 3: Is the concept of attributing "excess" surplus to a geographic area reasonable?

To answer these questions, Lewin relied on several sources of information to conduct this assessment. First, we relied on our experience in having conducted similar analyses on behalf of states and other health insurers. Second, we used statutory financial statements as the basis for much of our review of GHMSI's financial condition. Finally, we used publicly available reports and documents, such as Milliman's December 4, 2008 report to CareFirst executives and the documents publicly available on the DC

Department of Insurance, Securities, and Banking (DC DISB) website. We did not perform extensive modeling or GHMSI-specific research for our analysis, but we did carefully review Milliman's report and do independent testing with our own models and tools to verify that Milliman's outputs were in a reasonable range.

Our findings from our review are as follows:

- First, our review of the development of surplus targets set forth by the Milliman report suggests that the approach and range of potential targets developed is generally reasonable based on our understanding of their model and our consideration of their assumptions as discussed in their report. We have several models we might apply, and exercises such as the loss cycle model can produce a range of answers based on input assumptions and output parameters. Therefore our answers may differ as to the precise RBC percentages recommended. However, the model Milliman applied is consistent with an approach we would consider, the outcomes do not differ significantly from those we might expect, and the choice of probability for sufficiency among potential outcomes seems appropriate, specifically the 90% to 95% confidence that surplus would not go below the 375% RBC level and 98% confidence that surplus would not go below the 200% RBC level. Here I would like to make a comment on our experience with Milliman. As actuaries and consultants we often encounter Milliman both as a competitor and as a colleague in our client engagements. It is our experience that Milliman always maintains its professionalism and technical competence and as a firm it is highly respected in the actuarial arena, as Bob discussed in his testimony. Their tools and models are well known and are respected throughout the industry in our experience. We were taken aback by the unprofessional nature of some of the commentary filed by others.
- Second, the RBC calculation was never designed to *regulate* the upper limits of insurer surplus. RBC calculations should be applied as an element in determining minimum regulatory solvency – consistent with the purpose which they were developed. In recent years regulators and insurers alike have used RBC beyond its original intent. Insurers want to provide an adequate margin of safety so that the company can endure periods of adverse experience without triggering any form of regulatory intervention while maintaining operational vitality and the ability to nimbly respond to unfolding market conditions. Many insurers, including GHMSI, use RBC as one tool by which that “margin of safety” can be measured. However, the use of RBC as a regulatory mechanism is much more controversial, as it can lead to several unintended consequences within the market place, which we discuss later in our testimony.

- Third, the attribution of any "excess" surplus to a geographic area is not a straightforward or easily determined outcome.

Other States' Actions

I now will discuss other states' actions. Two states currently enforce upper limits on the amount of surplus BCBS companies can hold, while two other states have recently repealed surplus limits. Minnesota repealed its surplus cap in 2005, when it enacted NAIC's Model Health RBC Act. Hawaii repealed its cap, which applied to all non-profit insurers, several years ago. The two states that currently enforce upper limits on surplus are Pennsylvania and Michigan. I will discuss Pennsylvania in more detail later. Michigan, the other state, passed a law in 2003 that stipulates that the BCBS insurer operating in that state shall not maintain an RBC ratio greater than 1000%.

A few other states have considered action to set upper surplus limits. Three to four years ago, several states, including Rhode Island, Washington, Minnesota, North Carolina and New Jersey considered action to either limit the accumulation of surplus or force the plans to draw down on surplus levels. There were two common themes that led to this interest. First, each state has a BCBS plan, and those Blues plans started seeing large increases in their earnings. Second, the economy softened at the same time that health care costs swelled. This increased the numbers of uninsured and made it harder for those having insurance to afford it. Some stakeholders argued that the BCBS plans in each state should give up portions of their surpluses to help make health coverage more affordable. However, in each instance, these states elected to not set an upper limit on insurer surplus levels. In some instances changes in the underwriting cycle limited future surplus levels, and as the surplus levels declined other matters became more pressing. In other instances, such as Rhode Island, the Insurance Commissioner has been using more traditional mechanisms for managing insurer surplus, such as denying premium rate increases.

Another reason often cited for not placing limits on surplus is the potential for market disruption. When a regulation limits the amount of surplus that a company can hold with the potential of losing their surplus they will likely respond by lowering premium rates temporarily to get rid of the excess. The resulting lower premiums would likely harm other carriers in the market, and discourage new carriers from entering the market. If limits were followed by a prolonged decline in underwriting profit the solvency of the company may also be threatened, which would impact the ability of providers in the market to be reimbursed for services as well as disrupt the subscribers of the health plan.

Most recently, in addition to the focus on GHMSI's surplus, we have seen renewed interest in insurer surplus in a few states, including Massachusetts and Washington. This new focus is not surprising, given state budgetary shortfalls as well as the

current economic crisis. However, much of this recent scrutiny is on ensuring the solvency of health insurers and the affordability of health care to subscribers, rather than setting maximum levels on surplus.

Pennsylvania Background

As previously mentioned, Pennsylvania is only one of two states that actively set limits on surplus accumulation. Lewin was engaged by Pennsylvania's Legislative Budget and Finance Committee to examine options and alternatives available to the Commonwealth with respect to the regulation, oversight and disposition of reserves and surpluses of health insurers. Lewin's report focused on other states' surplus regulation, the capping of surplus, determining an optimal amount of surplus and action needed regarding Pennsylvania Blue plans' surplus.

In February 2005, the Pennsylvania Insurance Department defined acceptable ranges for the Blue Plans' level of surplus capital, giving a lower range of 550 – 750% of RBC for the largest two plans - Independence and Highmark, and a higher range of 750 – 950% of RBC for the two smaller plans - Capital Blue Cross (CBC) and BC of Northeastern Pennsylvania (NEPA). None of the plans were above their range, however three of the plans were deemed as having "sufficient" capital, which precluded these three plans from including "risk and contingency factors" in future rate requests. In other words, the plans moderated rate increases to their subscribers in light of their healthy reserve levels. The Commonwealth also executed an "Agreement on Community Health Reinvestment" with the four Blue plans, setting forth a program by which the Blues pledged somewhat more than one percent of their premium revenues to community benefits for the years 2005 – 2010. Making a high-level comparisons of the Pennsylvania Blue plans with GHMSI, we observe that CBC is the most similar to GHMSI with respect to premium and enrollment. Of course there are a number of additional risk factors and individual market considerations that should be considered when comparing surplus needs, but GHMSI is a similar size plan in terms of premium and enrollment, and they are currently within the Pennsylvania's recommended surplus range for CBC in Pennsylvania.

Lewin's Pennsylvania analysis concluded that the Commissioner's ruling set reasonable bounds on the Blue plans' accumulation of surplus. We found that it is not likely that the ruling will disrupt the Pennsylvania insurance market, as the process set forth for managing surplus offers both the Blues and the Commissioner sufficient latitude to act prudently. The upper limits on surplus that the Commissioner chose (950% surplus ratio for Blue Cross of Northeastern Pennsylvania and Capital Blue Cross; 750% for Highmark and Independence Blue Cross) will slow premium growth somewhat because no risk contingencies were allowed, but not trigger large premium reductions that might have disrupted the competitive landscape. For Blue plans found to have "sufficient" reserves, the Department will not approve premium rates which include any risk

and contingency factors. This policy change should have the effect of slowing premium growth, while still assuring a reasonably competitive market.

The Commonwealth's surplus limits also reflect the fact that less diversified plans experience more volatility with respect to their annual profits and losses, and therefore holding a higher reserve is appropriate.

Furthermore we found that it would be unproductive to require a Blue plan to return surplus to customers due to potential market disruption which I discussed above. Prudent accumulation of surplus, within reasonable limits, plus long-term rate stabilization for customers, is both sound business strategy for the Blues and good public policy. Our quantitative analysis suggested that the surpluses of the four PA Blue plans could be justified in order to maintain a high degree of confidence that they could withstand an extended period of adverse underwriting experience.

In summary:

- Milliman's approach and range seem reasonable
- RBC is not an appropriate mechanism for assessing upper limits of insurers' surplus, and
- Attributing surplus to a specific geographic region is not a straightforward process.

In closing, we appreciate the opportunity to provide testimony to you today on this issue and look forward to any questions you may have on our report or on our experience in working on this important issue with other states.