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September 2, 2010

The Honorable Gennet Purcell
Commissioner
Department of Insurance, Securities and Banking
Government of the District of Columbia
810 1st Street, NE
Suite 701
Washington, DC 20002

Dear Commissioner Purcell,

Pursuant to your Order of August 6, 2010, attached is GHMSI's response containing additional information about the various impacts of Federal Healthcare Reform on GHMSI's operations and reserves.

As always, we stand ready to respond to any questions you may have or any request for additional information.

Sincerely yours,

Chet Burrell
President & Chief Executive Officer

Attachment

Group Hospitalization and Medical Services, Inc.

SUPPLEMENTAL REPORT ON EFFECTS OF FEDERAL HEALTH CARE REFORM

DISB Review of GHMSI Surplus Pursuant to the Medical Insurance Empowerment Amendment Act, D.C. Code § 31-3506 *et seq.*

September 3, 2010

TABLE OF CONTENTS

Page

INTRODUCTION AND OVERVIEW i

I. FEDERAL HEALTH CARE REFORM WILL INCREASE GHMSI'S RISKS AND SUBSTANTIALLY INCREASE THE COMPANY'S RBC-ACL TARGETS 1

A. FHCR Fundamentally Changes the Health Insurance Landscape 1

B. Milliman and Lewin Both Conclude That FHCR Will Materially Increase GHMSI's Reserve Needs 3

C. Reports Produced By Other Experts Support The Milliman And Lewin Analyses 6

D. Conclusions 7

II. REACTION TO THE RECTOR REPORT 8

III. CLARIFYING OBSERVATIONS REGARDING THE COMMISSIONER'S ORDER 12

CONCLUSION 15

ATTACHMENT A – REPORT OF MILLIMAN, INC.

ATTACHMENT B – REPORT OF THE LEWIN GROUP

ATTACHMENT C – MILLIMAN RESPONSE TO RECTOR

INTRODUCTION AND OVERVIEW

On August 6, 2010, the Commissioner of the Department of Insurance, Securities, and Banking ("DISB") ordered Group Hospitalization and Medical Services, Inc. ("GHMSI") to "submit to the Commissioner comprehensive information regarding the financial impact of the Federal Health Reform Acts on GHMSI, including the appropriate level of GHMSI's surplus and GHMSI's financial obligations arising in connection with the conduct of its insurance business as required pursuant to section 7(f)." (The "2010 Order").[1]

GHMSI respectfully submits this summary report, and the accompanying reports and exhibits, in response to that Order. As detailed below and in the attached reports, Federal Health Care Reform ("FHCR") has introduced tremendous uncertainty into the health insurance marketplace, thereby increasing GHMSI's risk profile. GHMSI's filing includes the following components:

Part I responds to the Commissioner's request for information on how FHCR will affect GHMSI's finances, risk profile, and surplus requirements. The information we provide is drawn from new analyses conducted by Milliman, Inc. and The Lewin Group, as well as from publicly-available data on the impacts of FHCR. These analyses all reach the same conclusion: While the precise financial impact of FHCR remains uncertain – as it must, considering that regulations explaining how reform will work have not yet been written – FHCR creates substantial new risks for insurers like GHMSI. Based on the best available advice, we believe this means ***"surplus requirements have increased materially, at least 100% to 200% of RBC-ACL and quite possibly substantially more***, as a result of the changes to the environment since [Milliman] issued [its 2008 report] on an optimal surplus range for GHMSI." Milliman Inc., *Impact of Federal Health Care Reform on GHMSI's Risk Profile and Optimal Surplus Targets* at 3-4 (Aug. 26, 2010) ("*Milliman FHCR Report*") (emphasis added).

This fundamental shift in the landscape has several important implications:

- First, the RBC-ACL figures derived in 2008 and 2009 by Milliman, Lewin, Invotex, and Rector & Associates are all now too low. We note that while Rector identified the uncertainties produced by FHCR as a relevant factor in its report, it did not actually build FHCR's effects into its RBC-ACL calculations.
- Second, the ranges that result from those recalculations will be substantially higher than those discussed in the 2010 Order. For example, if the Rector RBC-ACL figures were adjusted upward by 100 points (the low end of Milliman's estimate), this would produce an RBC-ACL target of 950% – instead of Rector's previous 850% – to ensure continued reserves above 375% RBC-ACL at a 95% confidence level.

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[1] *In re Surplus Review & Determination Regarding GHMSI* at 25, Order No. 09-MIE-006 (DISB Aug. 6, 2010).

- Third, the precise upward shift in GHMSI's risk profile and reserve requirements may not be calculable for some months or even several years, given that regulations setting FHCR's parameters are still a work in progress and the market/financial impacts will take time to materialize and be understood.
- Fourth, because the advent of FHCR likely will cause Invotex's RBC-ACL range to rise – and because that, in turn, may affect the determinations reached by the Maryland Insurance Administration ("MIA") – we believe it would be appropriate for the DISB and the MIA to coordinate and update their earlier reviews of GHMSI's reserves to reflect the new context created by FHCR. As the Commissioner herself observed last year, failure to coordinate in this manner would create "a substantial and detrimental risk that the sequential surplus reviews by the [DISB] and the MIA could result in conflicting surplus findings and competing orders to GHMSI."[2]

Part II responds to portions of the report submitted by Rector & Associates ("Rector Report"). Drawing on a document prepared by Milliman, this portion of the report reacts to and rebuts a number of Rector's key observations regarding Milliman's assumptions on catastrophic events, unidentified development and growth, management intervention, and other risk factors. It also identifies potential flaws in Rector's proposed attribution factors and accompanying data.

Part III offers certain clarifications regarding the Commissioner's 2010 Order so that the record may be corrected while it remains open.

Finally, attached are the new reports Milliman and Lewin submitted at GHMSI's request in order to assist in responding to the 2010 Order. Attachment A is the Milliman FHCR Report. Attachment B is a similar new report from Lewin. Attachment C is a second Milliman document, responding in detail to certain characterizations made in the Rector Report.

These materials collectively provide the DISB with GHMSI's best current understanding of the impacts FHCR will have on the company's finances and risk profile. GHMSI would be pleased to provide the Commissioner with any additional information she may need.

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[2] *Order Enlarging Time for the DISB to Issue Surplus Determination & Extension of Hearing Record* at 3, Order No. 09-MIE-001 (DISB 2009).

I. FEDERAL HEALTH CARE REFORM WILL INCREASE GHMSI'S RISKS AND SUBSTANTIALLY INCREASE THE COMPANY'S RBC-ACL TARGETS.

GHMSI's reserve needs *have* changed as a result of FHCR. Indeed, FHCR is likely to trigger a material increase in the company's reserve needs – at least 100% to 200% of RBC-ACL and quite possibly substantially more.

While the experts GHMSI consulted agree that the company's risks have grown, they also agree that calculating the change with precision is impossible until the FHCR regulations are promulgated and the details of FHCR's effects on insurers become clearer.

A. FHCR Fundamentally Changes The Health Insurance Landscape.

FHCR imposes unprecedented new requirements, restrictions and mandated benefits on health insurers that will have far-reaching implications. In many cases, these changes affect the health care costs that employers will pay. In others, they represent direct costs for insurance companies which may or may not be passed on to policyholders. The effect of FHCR on insurers like GHMSI, in short, is massive. The Patient Protection and Affordability Act ("PPACA")[3] requires GHMSI to implement complex and costly operational changes and will have a direct impact on the marketplace – and thus on the company's pricing decisions – going forward.

FHCR's impacts are too wide-ranging to be thoroughly discussed in a filing of reasonable length. Below we summarize its impacts in broad terms:

1. ***Expanded benefits.*** FHCR law requires a number of significant changes in benefits, including extending coverage for adult children to age 26, prohibiting cost sharing for immunizations or preventive services, barring exclusions on pre-existing conditions for children under age 19, prohibiting annual restrictions and lifetime limits on essential health benefits, and limiting contract rescissions, among many others. Many of these changes must be implemented on new, non-grandfathered plans, effective September 23, 2010. This will cost policyholders more.

2. ***Administrative Costs.*** The law imposes new transparency rules that will require insurers to implement major systems and operational changes. In addition to the costs of developing and implementing systems and processes needed to comply with an array of new reporting requirements, GHMSI faces costs associated with regulatory filings, marketing and other extensive communications to members, accounts, brokers and health care providers for

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[3] What we refer to in this submission as "FHCR" is in fact comprised of two statutes: the "Patient Protection and Affordable Care Act," P.L. 111-148, and the "Health Care and Education Affordability Reconciliation Act of 2010," PL 111-152, which amends PPACA. FHCR also will include a massive number of implementing regulations, which, as we discuss below, mostly remain to be enacted.

the new or revised plans required as a result of PPACA, all of which will drive up administrative costs.

3. ***Federal Minimum Medical Loss Ratios.*** The "Medical Loss Ratio," or "MLR," captures the "[c]ost ratio" of a health insurer's "total benefits used compared to revenues received" – in other words, the percentage of premiums used to pay customers' medical claims (and some related quality services), as opposed to administrative overhead and other expenses.[4] FHCR requires carriers to achieve a minimum MLR of at least 85% on Large Group (100+ employees) and 80% on Small Group and Individual plans. Plans that fail to meet the minimum MLR threshold will be required to issue rebates or refunds to policyholders – a requirement that can be extremely costly and is sure to be very difficult to administer. Under the MLR mandate, GHMSI faces an "asymmetric" risk profile: the upside (potential gain) is capped but the downside (potential loss) is unlimited. This is so because GHMSI likely will need to price its products low enough to avoid triggering refunds. If actual medical costs exceed projections, GHMSI could incur significant losses. But, the minimum MLR threshold and the FHCR's new rate-review requirement limit GHMSI's ability to recoup such losses through higher premiums.[5] For these reasons, the MLR mandate will make GHMSI's pricing decisions extremely challenging going forward.

4. ***Taxes and Fees.*** Beginning in 2014, health insurers cumulatively will begin paying an $8 billion annual federal "assessment" – in effect, a federal premium tax. The fee grows to $14 billion by 2018. CareFirst's share of this assessment is projected to be about $100 million in 2014, rising to more than $175 million in 2018. Also looming in 2018 is FHCR's tax on high-cost employer-sponsored health coverage (the so-called "Cadillac Plan" penalty). How much of these taxes GHMSI can recoup through higher premiums remains to be seen and will depend in large part on its competitive positioning.

Further, GHMSI is among 19 Blues Plans that could be affected by FHCR's limits on a special federal tax deduction that GHMSI currently receives under Section 833(b) of the Internal Revenue Code. Going forward, Blue Plans will need to spend at least 85% of their premium revenues on clinical services. GHMSI could lose the special federal deduction it currently enjoys if it falls short of this 85% minimum MLR threshold. This would result in GHMSI being taxed at the 35% corporate rate rather than the 20% Alternative Minimum Tax (AMT) level.

5. ***Marketplace Realignment.*** Though the FHCR provisions outlined above will substantially affect GHMSI's risk profile, their effects pale in comparison to the impact that will be produced by FHCR-triggered shifts in the competitive marketplace and accompanying

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[4] *See Glossary of Terms in Managed Care, available online at* http://www.pohly.com/terms_m.html (last checked Aug. 27, 2010).

[5] It is important to recognize that PPACA's separate requirement that rate filings meet a "reasonable rate" test adds additional uncertainty and burden for insurers trying to find the correct price level for their products.

changes in the company's distribution strategy. The establishment of state-based insurance exchanges in 2014, for example, could threaten GHMSI's share of the Individual Market. GHMSI's competitive position also could be adversely affected if the "guaranteed issue" mandate of FHCR, scheduled to take effect in 2014, attracts a disproportionate share of less healthy, more costly members. In responding to these challenges, GHMSI will need to invest in developing new products, branding, and marketing outreach to appeal to those purchasing their health coverage through the exchanges.

6. ***Community Giving.*** A major issue for mission-driven insurers like GHMSI is how charitable contributions to the community will be counted in the calculation of MLR. The National Association of Insurance Commissioners is likely to recommend allowing charitable gifts to be deducted from the denominator only up to the level that they apply as payments in lieu of taxes. Since GHMSI is not exempted from the District's premium tax, none of its current community giving in D.C. offsets any local taxes – which means, in plain language, that all of GHMSI's contributions to the community may be considered "administrative expenses" that drive down the company's MLR and put it at risk of MLR non-compliance. It also remains unclear whether insurers will be permitted to subtract from their "administrative expenses" certain other state assessments and fees, including such District-mandated GHMSI contributions as the $5 million annual grant to the Healthy DC Fund and the $500,000 annual grant to cover senior wellness programs. Likewise, it is not yet clear whether GHMSI will be permitted to exclude its losses on the mandated D.C. Open Enrollment program, projected to total nearly $3 million in 2010. These expenditures, too, could drive GHMSI's MLR down and put the company at risk of triggering FHCR's rebate provision.

B. Milliman and Lewin Both Conclude That FHCR Will Materially Increase GHMSI's Reserve Needs.

Milliman and Lewin evaluated the FHCR provisions outlined above and reached the same fundamental conclusions regarding FHCR's impact on reserves: Reserve needs are driven upward by uncertainty and by limitations on the ability to recover losses. FHCR dramatically increases the uncertainty facing insurers like GHMSI and limits their ability to recover losses. The result: GHMSI's reserve needs – and thus its optimal RBC-ACL goals – have increased substantially under the new FHCR regime.

1. ***The Milliman Report.*** The Milliman FHCR Report, attached as Exhibit A, explains that "[t]he healthcare reforms that were passed by Congress and signed into law by President Obama . . . will have a far-reaching impact on virtually all aspects of the operations of health insurance companies." *Milliman FHCR Report* at 2. "There are reform provisions dealing with the commercial markets (individual and group) and public programs (Medicaid and Medicare), as well as new individual and employer requirements. Other requirements affect health care providers and vendors, and many new responsibilities are assigned to states." *Id.*

"The law is complex and can be expected to spawn volumes of regulations (of which only a few have been released to date) spelling out the manner in which it will be implemented and, with respect to a number of provisions, filling in the details as to what will actually be entailed." *Id.* While this early-stage rule development means the precise impacts of FHCR cannot yet be calculated, one thing is abundantly clear: FHCR will increase insurers' operating risks on multiple fronts.

Indeed, Milliman catalogues no less than eight categories of "downside risks" for GHMSI. Perhaps the most significant downside risk is the new MLR requirement which requires insurers to maintain their MLRs at a certain percentage. If the ratio slips below that target, the law requires that insurers rebate the difference to policyholders. Though the precise impact of the MLR rule will depend on how regulations are structured, it has the potential to cost a given insurer millions of dollars in a single year. That is so, among other reasons, because MLRs are notoriously difficult to predict and to hold steady, especially for moderate-sized payers that offer small-group and individual plans. As Milliman observed, the MLR rules will "require rebates when there are financial gains but restrict the ability to recoup losses" – a recipe for increased uncertainty and potential financial losses.

Among the other new risk factors Milliman identified are the following:

- "[a]dditional rate review at both the local and national level, with the potential for rate restrictions based on arbitrary caps on the level of change rather than appropriate analyses of actuarial rate requirements";
- "[r]equirement of guaranteed issue in the individual market with no ability to exclude pre-existing conditions";
- "[r]estrictions and prohibitions on rating variations (age, geographic area, health status) for the individual and small group markets, requiring subsidization of higher cost risks";
- "enrollment turnover with attendant adverse selection, and unstable insurance risk pools"; and
- "[i]ncreased cost of compliance, coupled with intensified pressure to constrain administrative expenses."

Each of these changes will produce increased risk for GHMSI and all insurers and the potential for financial losses. But Milliman makes clear that the risk to GHMSI does not just stem from the *known* downsides. On the contrary, it stems in large part from the very uncertainty about what FHCR will entail:

> There is uncertainty in how the regulations to implement the legislation will be written, interpreted and enforced. There is uncertainty in how some of the changes will affect behavior of consumers and providers. There is uncertainty in how the market will react to the creation of

> exchanges. What is known is that methods that health plans have used to manage risk, such as risk classification, underwriting, rating, benefit limitations and the use of margins, will be increasingly restricted, going forward.

These fundamental business uncertainties, combined with the known financial downsides of FHCR and the constraints on loss avoidance, create an unsurprising multiplier effect: They substantially increase GHMSI's risk profile and necessarily, therefore, counsel in favor of more robust surplus. As Milliman explains: "Uncertainty and limitations on how risk is to be managed are major drivers of the need for a health plan to maintain adequate surplus. . . . ***While it is impossible to quantify currently, it is our belief that surplus requirements have increased materially, at least 100% to 200% of RBC-ACL and quite possibly substantially more***, as a result of the changes to the environment since we issued our report on an optimal surplus range for GHMSI." (emphasis added).

2. ***The Lewin Report.*** The report produced by Lewin reaches similar conclusions. Lewin emphasizes that surplus needs are "fundamentally driven by" two factors: "uncertainty in outcomes" and "the ability to . . . react[ ] and recover[ ]" from loss events and unexpected regulatory burdens. Lewin, *Reaction & Response to the Rector Report to the DISB & Subsequent Order Regarding GHMSI Surplus Levels* at 3 (Aug. 27, 2010) ("*Lewin FHCR Report*"). Lewin concludes that "[m]ost aspects of [FHCR] introduce more uncertainty and adversely impact the ability to react and recover." *Id.* Systemic risks increase as a result – and so does the necessity for more reserves to guard against those risks.

Lewin, like Milliman, endeavors to break the new risks facing GHMSI into their component parts. There is increased trend risk because "[r]eform changes will create entirely new mixes of morbidity and products for payers," thus "greatly diminish[ing] the reliability of historical trends as a basis for rate projections and therefore increas[ing] the likelihood of a trend miss and resulting negative impact on surplus." *Id.* The risk of pricing error also will increase because "the impact of reform on trend issues related to historical data will . . . greatly increase the potential for misstatement of liabilities," and estimates of those incurred liabilities play into pricing decisions. *Id.* Insurers' ability to recover from these misses likewise will be less certain, in part because "[e]arly outcomes on reform have clearly shown a willingness" by federal regulators "to pressure payers to reduce rate increases or deny them realistic rate levels." *Id.* at 4. Administrative, tax, and regulatory costs are all highly uncertain, and likely to increase, as FHCR's details are hammered out. *Id.* at 4-5. And, of course, "Minimum Loss Ratio requirements," taken together with hard-to-predict shifts in membership and expenses, create risk for insurers that they will miss targets and face financial penalties. *Id.* at 5.

Lewin concludes that these "reform initiatives suggest a negative [financial] impact or increased uncertainty in every category by which surplus needs are typically assessed." *Id.* But Lewin, like Milliman, also observes that the very fact that FHCR's details have not been finalized

itself increases financial risk and reserve requirements: "In terms of normal surplus management objectives, the very lack of clarity speaks to the need to hold increased surplus due to increased uncertainty." *Id.* at 3. Lewin accordingly concludes that FHCR's effect on surplus requirements is "very material to meeting the objectives of holding adequate target surplus," *id.* at 6, and therefore in "[a]ssessing the potential impact in terms of the model logic we used to determine surplus needs, we can very easily envision GHMSI's *required surplus increasing by more than 10%* over the pre-reform levels we previously modeled." *Id.* (emphasis added). Lewin thus believes that at minimum, FHCR requires that Lewin's recommended RBC-ACL ratio range for GHMSI be adjusted upward to 825%-1100%.

C. Reports Produced By Other Experts Support The Milliman And Lewin Analyses.

Milliman and Lewin's conclusions that FHCR will increase GHMSI's risks, and that GHMSI accordingly would be well-advised to hold additional reserve capital, are supported by the publicly available reports of highly regarded industry analysts. PricewaterhouseCoopers, for example, found that "[m]any underwriting mechanisms that insurers have used to manage risks are prohibited under health reform" and concluded that necessarily will mean "[g]reater claim risk for payers."[6] Brokerage Edward Jones, likewise, noted that FHCR is causing "massive uncertainty" in the health care industry, and concluded in a report that it is "concerned that market structure changes, profit limitations and rebates, and ever-present political/regulatory pressures will negatively impact future profit growth and more than offset the anticipated influx of newly insured members."[7] And Booz & Co. concluded that "[n]othing short of a sea change awaits the payor sector of healthcare," that "[p]rofit margins will be asymmetrically squeezed," and that "[w]ith the advent of state-by-state insurance exchanges for the individual and small-group segments, the Blues will come under intense pricing pressure from 'commercial' plans, . . . especially for the most profitable piece of their business."[8] The upshot: For a company (and especially a Blue Cross Blue Shield Company like GHMSI) to survive this upheaval with its financial stability intact, "capital formation and preservation will be key." *Id.* at 3.

As Milliman and Lewin have suggested, these increased risks and costs stem from all aspects of FHCR operating in conjunction. With respect to MLR, for example, Deloitte opined in a 2010 report that "[t]he implications of the MLR mandate are expected to be significant to health plans, with impacts on plan design, plan pricing, administration, network contracting,

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[6] PricewaterhouseCoopers, *Health Reform* at 20 (2010). *Available online at* http://www.pwc.com/us/en/health-industries/publications/prospering-in-a-post-reform-world.jhtml (last checked Aug. 27, 2010).

[7] L. Krauskopf, *Avoid U.S. Health Insurers After Reform, Brokerage Says*, Yahoo! News (Aug. 2, 2010).*Available online at* http://health.yahoo.net/news/s/nm/us_healthinsurers (last checked Aug. 27, 2010).

[8] Booz & Co., *2010 Health Industry Perspective* at 2-3 (2010).*Available online at* http://www.booz.com/media/uploads/Health_Perspective_2010.pdf (last checked Aug. 27, 2010).

health management, and profitability."[9] This will increase risk not just because of the potential for sizeable MLR rebates, but also because insurers simply will not know the scope of the MLR program when they design their pricing structures for next year: "As health plans move into the 2011 rate setting process, they will need to strike a delicate balance: pricing appropriately while also placing bets around how the final MLR definitions will impact their current expenditures and allocations." *Id.* at 2.

The individual mandate also increases insurer costs and risks. "[T]he individual mandate requiring people to buy insurance is relatively weak; in other words, people may wait to buy insurance until they're sick," concluded Edward Jones. "If this actually occurs, many of the new members in the insurance exchange will be sicker and costlier than average, and could become a drag on managed care profits."[10]

Health insurers will also face financial uncertainty due to the inability to accurately estimate the industry fees implemented by the health reform law. These fees are ultimately determined by the federal government based on market share data for the prior calendar year, making budgeting for these fees unpredictable.[11]

These, of course, are just a few of the studies cataloguing the ways in which FHCR increases the costs – and the risks – faced by insurers. Such studies uniformly support Milliman's and Lewin's conclusion that FHCR serves as a one-way ratchet increasing GHMSI's risk profile and, therefore, its reserve needs.

D. Conclusions

The conclusions reached by Milliman and Lewin are as follows:

- **First**, and most obviously, Milliman's conclusion that "surplus requirements have increased materially, at least 100% to 200% of RBC-ACL and quite possibly substantially more," *Milliman FHCR Report* at 3, means that the various RBC-ACL calculations performed during the course of DISB's review of GHMSI's reserve levels – by Milliman, Lewin, Invotex, and Rector – will need to be recalculated. FHCR already has substantially increased GHMSI's risks. *See id.* And, as Rector correctly observed, "[t]he analysis performed by all of the consultants, including [Rector], did not attempt to incorporate or measure the effect of such changes on GHMSI's surplus." *Rector Report* at 10. The analyses must be updated to reflect the changed landscape.

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[9] Deloitte, *Medical Loss Ratios & 2011 Rate Setting* at 1 (2010).

[10] Edward Jones, *Health Care Reform: Understanding the Investment Implications* at 2 (April 15, 2010) (*available online at* http://www.edwardjones.com/groups/ejw_content/@ejw/@us/@research/documents/web_content/web222678.pdf (last checked Aug. 27, 2010)).

[11] *See* Deloitte, *Prescription for Change "Filled": Tax provisions in the Patient Protection and Affordable Care Act* at 10 (Mar. 21, 2010) (*available online at* http://www.deloitte.com/view/en_US/us/Services/tax/112a52f1b5277210VgnVCM100000ba42f00aRCRD.htm (last checked Aug. 27, 2010)).

These recalculations are likely to produce substantial revisions to the consultants' recommended RBC-ACL figures. Taking Milliman's low-end estimate of a 100-point increase as a benchmark, and applying it to the ranges prepared by the four outside experts to whom the Commissioner accorded weight, yields a mean of 931.25% RBC-ACL – a percentage that is higher than GHMSI's end-of-year 2009 reserves, and higher than GHMSI's average reserve range over the last decade.

- **Second**, the recalculations will become more feasible as FHCR's parameters are fully fleshed out. Both Milliman and Lewin observed that, while there is no question that FHCR will substantially increase (and has already substantially increased) the risks GHMSI faces, it is difficult to create a workable model to precisely quantify those increased risks until the critical FHCR regulations are in place and experience under them emerges.

- **Third**, until these recalculations can be undertaken, it seems to us difficult, if not impossible, to conclude that GHMSI's reserves are "excessive" – that is, both "unreasonably large" and "inconsistent" with the District's community health reinvestment requirement – which is the key judgment the Commissioner is called upon to make under District law with respect to GHMSI's reserves. Further, given that the full import of FHCR on GHMSI's risk profile is not only an issue for the District but also for Maryland and Virginia, we respectfully ask the Commissioner to coordinate analysis of GHMSI's future RBC-ACL ranges with the Maryland Insurance Administration and the Virginia Bureau of Insurance.

II. REACTION TO THE RECTOR REPORT

The Rector & Associates Report contains a number of data and observations that we believe are inaccurate or constitute a mischaracterization of fact.

1. Rector's Critiques of Milliman's Methodology.

Rector stated that "[t]he Milliman methodology does not validate GHMSI historical results over the last 13 years" and that "[b]ased on a statistical analysis of the Milliman loss curve, it seems highly improbable that GHMSI's actual results could have been generated using the Milliman approach, a critical test for the validity of any modeling approach." *Rector Report* at 5. In its response, Milliman demonstrates in detail that "[a]fter recognizing the low rates of investment income currently experienced and anticipated for some time to come, [its] assumptions as to underwriting gains (losses) and net income before taxes are consistent with GHMSI's history of results, including the 13-year historical period cited by Rector." *Milliman Response* at 2-3.

Rector likewise asserted that "the Milliman loss curve assumes that liability and asset risks are independent of each other and the yield curve. Rather than projecting periodic cash flows with dynamic interactions between assets and liabilities, all the risk assumptions are smoothed and blended into a loss ratio representing an entire underwriting cycle. The

theoretical basis for such an approach is outdated." *Rector Report* at 5. But Milliman explains why the approach described by Rector is not relevant for "term coverages, such as group health and most comprehensive individual medical products." *Milliman Response* at 3. Because "linking terms and maturity dates for certain investment blocks to claims payout" generally "is not meaningful for a company like GHMSI," the approach followed by Milliman is more appropriate. *See id.*

2. Rector's Adjustments to Milliman's Model.

Rector makes various numerical adjustments to Milliman's model, but most are inappropriate, as Milliman describes in some detail. *See Milliman Response* at 4-7. For example, Rector makes downward adjustments to Milliman's loss-curve model on the theory that funding to protect against catastrophic events "would be provided for in the company's operating budget." Rector Report at 6. But, as Milliman rightly points out, "[i]t is not appropriate to make advance funding provision for . . . unanticipated extraordinary events in the company's operating budget, and therefore provision must be made in surplus." *Milliman Response* at 4. Rector also made downward adjustments on the theory that management could quickly react to a downward reserve trend "by increasing pricing margins and/or implementing more stringent underwriting standards." Rector Report at 8. But, that is an unrealistically quick response-time assumption: Milliman notes that its modeling "indicated that a reasonable estimate of the average elapsed time between the initial development of adverse experience and the point at which management corrections would be realized in rates . . . is 2 to 2.5 years, due to the impact of GHMSI's business characteristics with respect to each of these factors." *Milliman Response* at 6-7. And importantly, that 2 to 2.5-year metric "*assum[es] the ability of management to act without undue regulatory or other constraints*," *id.* at 6 (emphasis added) – a highly optimistic assumption, given the new constraints imposed by federal and local law.

Additional detail on Rector's proposed numerical adjustments to Milliman's model, and Milliman's explanation as to why many of those adjustments are inappropriate, is available at pages 4-7 of the *Milliman Response,* attached to this report as Attachment C.

3. Rector's Observations Regarding Effects of FHCR.

GHMSI agrees with Rector's conclusion – further buttressed by both the Milliman and Lewin reports – that FHCR works "significant" changes to the health-care industry and that the new regime deserves study as part of the RBC-ACL analysis. We do not agree, however, with Rector's suggestion that nothing can yet be determined about which way FHCR's impact will cut. On the contrary, the Milliman and Lewin reports discussed above – as well as analyses conducted independent of this case by a host of the nation's best-known market analysts – make abundantly clear that FHCR will bring with it increased costs and risks for insurers.

4. Rector's Inclusion of For-Profit Insurers in the Peer Group.

Rector's decision to include for-profit insurers in its peer review charts makes little sense for exactly the reasons Rector itself identified: "[F]or-profit stock insurers often have access to capital that is not available to nonprofit Blue Cross/Blue Shield plans. In many situations, for-profit stock insurers have ultimate parents that are publicly traded companies that can capitalize their insurers, as needed. Consequently, a for-profit insurer might not need as much surplus as a nonprofit insurer." *Rector Report* at 12. That is quite right – and it serves to underscore why Rector's peer-group comparison is flawed. As Milliman explains: "An evaluation of a company's operating efficiency has to recognize any constraints that the company cannot alter. In the case of publicly held companies, their holding company structures enable (and encourage) holding capital and maintaining access to additional insurance company surplus outside of the insurance operating companies themselves." *Milliman Response* at 8. "As a result, these organizations are simply not comparable when it comes to the structuring, reporting, and level of statutory surplus held." *Id.*

Moreover, it is worth noting that the two corporations identified as having reserves below 500% RBC-ACL are not individual companies but instead "holding company systems" that "consist of over 20 individual insurers," including "subsidiary insurers that are similar to GHMSI in terms of revenue size, lines of business written (including FEP business), and the number of states in which the insurers operate." *"Rector Report* at 13". That provides a second reason why these for-profit holding companies can operate with a lower surplus: Since the appropriate RBC-ACL range is inversely proportional to the company's size, these much larger, more diversified groups need not carry as much in reserve, percentage-wise, as a smaller, regional insurer like GHMSI.

5. Rector's Attribution Data.

In determining the relevant data to derive GHMSI's reserves "attributable to the District," D.C. Code § 31-3506, Rector first calculates "number of policies by jurisdiction" and "number of providers by jurisdiction," as contemplated by the applicable regulation. *See* 26-A DCMR § 4699.2. However, Rector goes on to "identif[y] four additional factors the Commissioner might wish to consider": premiums by jurisdiction, certificateholders by jurisdiction, claims expense by jurisdiction of policyholder, and paid claim expenses by jurisdiction. *Rector Report* at 18. The Commissioner mentions two of these factors in her 2010 Order—premiums by jurisdiction and claims expense by jurisdiction of policy holder—but neither can be relied on in making her determination on GHMSI's surplus, for two reasons.

First, both factors represent a "situs" approach to attribution, meaning that under these factors all reserves are "attributable" to the jurisdiction where the *employer* is based (the "situs" of the group contract), even if the certificate holders who pay a substantial portion of the premiums, and generally incur claims near where they live. And, they live overwhelmingly in

other jurisdictions. But, as we have previously explained, the "residency" approach – not the situs approach – is compelled by the terms of the statute governing this proceeding. *See* GHMSI Prehearing Report Attachment G (Aug. 31, 2009); *id.* Exhibit A (Milliman Report on attribution).[12]

The statutory term "attributable" means "belonging to" or "caused by," and an insurer's surplus is "caused by" premiums paid by, or on behalf of, certificate holders. Likewise, to the extent an insurer's surplus "belongs to" anyone, it belongs to the subscribers, in the sense that it is held to pay for future claims made by those subscribers. Moreover, the governing statute provides that if GHMSI's surplus were to be deemed excessive, GHMSI could draw down the excess "entirely [by] expenditures for the benefit of current subscribers of the corporation." D.C. Code § 31-3506(g)(2). As Milliman observed:

> [T]he intent of the legislation is to have any distribution of surplus that results from the application of the requirements of the law benefit residents of the District of Columbia. It was our conclusion based on this understanding, that the residence method is the appropriate alternative. If the funds are to be used to benefit only D.C. residents, then it would seem that they should be comprised of amounts that are attributable to only D.C. residents. The situs approach, if used instead, could have the effect of causing surplus that was attributable in part to residents of Maryland and Virginia to be expended on behalf of residents of D.C. only. This would not be equitable, and we concluded that the situs approach would therefore not be appropriate.

GHMSI Prehearing Report Exhibit A (p. 40 of PDF). The situs approach attributes the premium payments that built GHMSI's reserves to the District even where they were "caused by" subscribers in Maryland, Virginia, and other jurisdictions. For this reason, Rector's factors should not be used.[13]

Second, the "situs" approach also deviates from the regulation DISB promulgated interpreting the attribution statute. That regulation, 26-A DCMR § 4699.2, states that reserves "attributable to the District" are derived by looking to: "(a) The number of policies by geographic area; (b) The number of health care providers under contract with the company by geographic area; and (c) Any other factor that the Commissioner deems to be relevant based on the record of a public hearing held pursuant to section 4602." Using Rector's data, the two enumerated

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[12] The cited attachment and exhibit are at pp. 31-41 of the GHMSI Prehearing Report PDF on the DISB's website. They contain the bulk of GHMSI's pre-hearing attribution analysis.

[13] To the extent that the Commissioner relies on extra-regulatory factors identified by Rector (and she should not), we note that the 2010 Order does not cite to the factor that Rector analyzed which suggests a significantly smaller attribution to D.C. Rector points out that 12% of GHMSI's "paid claim expense by jurisdiction" occurs in the District. Rector Report 18, 22. We believe the Commissioner cannot selectively choose to rely only on factors that suggest a higher attribution to D.C.

factors, averaged together, produce an attribution percentage of 21.85%[14] – higher than the 11.6% produced by the statutorily-mandated pure residency analysis, but at least in the same ballpark. To allow those data points to be trumped by situs-based factors that call for an attribution to the District in excess of 60%, *see Rector Report* at 18, would be inconsistent with the regulations.[15]

III. CLARIFYING OBSERVATIONS REGARDING THE COMMISSIONER'S ORDER

Finally, we highlight a few points in the 2010 Order to ensure that any issues are resolved before the Commissioner issues a final order regarding GHMSI's surplus.

1. The Attribution Issue.

We understand that this paragraph – and specifically its statement that "approximately 69% of GHMSI's premiums for this ten-year time frame were attributable to policies or contracts issued in the District," 2010 Order at 11, ¶ 8 – merely recounts the findings of the Rector Report, rather than suggests that the Commissioner will adopt a "situs" approach to attribution. As discussed above, a "situs" approach would run counter to the statute and regulations governing the Commissioner's review of GHMSI's reserves. Moreover, the amount of reserves "attributable to *policies or contracts issued in* the District," 2010 Order at 11, ¶ 8 (emphasis added), cannot be equated with the amount of reserves "attributable to the District," D.C. Code § 31-3506, without adding words to the statute – a statutory-interpretation taboo.[16]

2. The Lewin Group's Assumptions and Methodology.

Again apparently relying upon Rector, the Commissioner states that "it is not clear what methodology or assumptions Lewin used in its analysis." 2010 Order at 12, ¶ 14. As already discussed, this is inaccurate. While the Lewin Post-Hearing Report does not provide the same level of detail as Milliman, Lewin, nevertheless, does describe its assumptions and approach in

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[14] We derive this figure by adding Rector's "policies by jurisdiction" and "providers by jurisdiction" figures together and dividing by two. *See* Rector Report at 18.

[15] The Regulation's "[a]ny other factor" language does not allow reliance on these factors because it is a "catchall" phrase. "Under the venerable interpretive canons of *noscitur a sociis* and *ejusdem generis*, the meaning of a catchall phrase is given precise content by the specific terms that precede it." *United States* v. *Phillips*, 543 F.3d 1197, 1206 (10th Cir. 2008) (citing, *inter alia*, *Norton* v. *South Utah Wilderness Alliance*, 542 U.S. 55, 62 (2004)); *accord Santa Fe Pacific R. Co.* v. *Secretary of Interior*, 830 F.2d 1168, 1175 (D.C. Cir. 1987) (*ejusdem generis* "that the catchall provision should be read to include only rights similar in character to those conferred by the statutes enumerated"). Applied here, those canons prohibit an interpreter to import, through the catchall, a factor that would cause the result to deviate from that produced by the enumerated factors. Such a factor would not be "similar in character" to those that the DISB enumerated when it promulgated the regulation. *Santa Fe Pacific R. Co.*, 830 F.2d at 1175.

[16] *United States* v. *Curtis*, 755 A.2d 1011, 1017 (D.C. 2000).

its earlier report and explains how Rector mischaracterized them, in the report attached hereto. *See Lewin FHCR Report* at 2.

3. The Invotex RBC-ACL Range.

The Commissioner states that the RBC-ACL range derived by Invotex is "700-900%." 2010 Order at 13, ¶ 17. This is incorrect. The range in fact is 700-*950%*. *See* Invotex Report at 81 (Oct. 30, 2009). We presume this is merely a scrivener's error, as the Commissioner correctly states the Invotex range on page 23 of her Order.

The Commissioner likewise states that "it is not clear how the assumptions made by Invotex resulted in its range." 2010 Order at 13, ¶ 17. Invotex provided a highly detailed recounting of its methodology. *See Invotex Report* at 9-65 (Oct. 30, 2009). While its report does not reveal every calculation required to derive Invotex's reserve range, the same can be said of every consultant report submitted by every party in this proceeding. We note that the Invotex Report was adopted by the MIA as a sound basis for deriving a reasonable range for GHMSI's surplus and for concluding that GHMSI's surplus was "neither unreasonably large nor excessive." The MIA Report on CareFirst Premiums and Surplus (Jan. 2010) states that following a hearing on the Invotex report, the MIA adopts the targeted surplus ranges recommended by Invotex for CFMI and GHMSI and finds that the surpluses for CFMI and GHMSI, respectively, are neither unreasonably large nor excessive.

4. Purported GHMSI Advance Accounting For FHCR Costs.

The Commissioner states on page 15, paragraph 25, that "GHMSI's financial position accounted for unknown financial pressures that it anticipated would result from federal health care reform." This discussion is inaccurate. As GHMSI explained prior to the hearing and explains again in this report, it was (and remains) difficult to anticipate the precise impact of federal healthcare reform: "[N]o one knows the full impact or downstream consequences of such a requirement – only that it could produce losses that would cut deeply into the reserves of GHMSI." GHMSI Pre-Hearing Report at 19. Because the impacts of FHCR cannot yet be quantified, GHMSI has *not* set aside reserves to account for them. The testimony the Commissioner cites to support her finding in paragraph 5 is not to the contrary. In the cited passage (which actually is on page 39 of the September 11 transcript, not pages 41-42), GHMSI CEO Chet Burrell testified: "[I]t will have impacts on us and others that neither we nor anyone else can fully see. It will change our risk profile, we hope in productive ways for society. . . . [I]t will put pressure on the company's financial position. We welcome that but we want to be prepared for that." Sept. 11, 2009 Hearing Tr. at 39. Mr. Burrell's statement that GHMSI wants to retain the flexibility to prepare for coming changes does not mean GHMSI is *already* financially prepared for them. GHMSI has not yet "accounted for" the effects of FHCR. 2010 Order at 15.

5. The Rector RBC-ACL Range & Recent Legal Developments.

On pages 23-24, the Commissioner recites Rector's proposed RBC-ACL figures and then states: "Importantly, the Rector Report had the benefit of including in its analysis the most recent health care reform legislation and Department orders regarding GHMSI's premium rate increases." 2010 Order at 24. To the extent this statement suggests that Rector actually built the effects of FHCR and recent DISB orders into its RBC-ACL findings, it is inaccurate. In fact, Rector made very clear that its data did *not* account for these legal developments:

> [T]he analyses performed by all of the consultants, *including R&A*, sought to measure GHMSI's surplus needs as of December 31, 2008. However, there have been very significant changes in the District and US regulatory frameworks since that time that will have a significant impact on GHMSI's future operations and results. *The analysis performed by all of the consultants, including R&A, did not attempt to incorporate or measure the effect of such changes on GHMSI's surplus.*

Rector Report at 10. Thus Rector's RBC-ACL figures, just like the ranges derived by Milliman, Lewin, and Invotex, will likely need to be adjusted upward once the effects of FHCR and recent District orders can be quantified.

CONCLUSION

Federal health care reform was a watershed event for the health insurance industry and its effect on the industry will be – and has already been – dramatic. While much remains to be fleshed out with respect to FHCR, one important point is already clear: Reform has increased the risks faced by insurers like GHMSI because (i) it introduces new pricing pressures, (ii) it forces insurers to adopt new, untested business models, (iii) it limits insurers' authority to recoup their losses through underwriting, and – last but not least – (iv) it creates massive uncertainty due to the very fact that the contours of reform are still in flux.

The expert analysts uniformly concur with this understanding of GHMSI's new risks. The RBC-ACL ranges calculated by these experts in 2008 and 2009 accordingly are no longer sufficient and will need substantial upward adjustment once greater clarity on FHCR is available. This could take some time – perhaps well into 2011 and beyond. In the meantime, based on the analyses and assessments of the various expert consultants, it is clear that GHMSI's surplus is not "excessive," as defined by District law.

We therefore respectfully suggest that the most prudent approach would be for the Commissioner to so find. We would propose that this examination of GHMSI's reserves be concluded and a new evaluation be undertaken once the financial impacts of reform are better understood and quantifiable. In any case, consistent with the policies on reserves of both the GHMSI and CFI Boards, GHMSI will engage its own consultants to undertake a fresh analysis of optimal and appropriate surplus ranges before the end of 2011 in order to update its target reserve range for CFMI and GHMSI in light of the new context created by FHCR. These analyses, of course, will be provided to the Commissioner.

September 3, 2010

ATTACHMENTS

ATTACHMENT A

CareFirst, Inc.
Group Hospitalization and Medical Services, Inc.

Impact of Federal Health Care Reform

on

GHMSI's Risk Profile and Optimal Surplus Targets

September 1, 2010

Robert H. Dobson, FSA, MAAA
Phyllis A. Doran, FSA, MAAA
James A. Dunlap, FSA, MAAA
Ronald G. Harris, FSA, MAAA

Introduction

CareFirst generally and its Group Hospitalization and Medical Services, Inc. (GHMSI) affiliate specifically asked Milliman to:

1. Identify and articulate in broad terms the likely downside and upside risks to CareFirst (GHMSI) arising from PPACA (or federal health care reform), based upon what is now known and utilizing a reasonable set of assumptions given the most recent federal guidance.

2. Discuss from our perspective how PPACA will affect the short-term and longer term risk profile of managed care organizations, generally, and of GHMSI, specifically. To the degree possible, comment on PPACA's impact on GHMSI's risk profile, especially as it affects the optimal surplus ranges previously recommended by our firm.

This report presents our response to this specific request. It may not be appropriate for other purposes. The authors, identified on the cover page, are members of the American Academy of Actuaries and meet its qualification standards for forming the types of opinions expressed herein. Such opinions are those of the authors and may not represent the opinions of other Milliman consultants.

We should note two things at the outset concerning our approach to this assignment. First, we view the future environment as including approximately a five-year time horizon. This means we have considered impacts that are likely to affect carriers both during the transition from the current environment and through the implementation of the most significant health care reforms in 2014. We are not focused on longer term impacts that are not set to begin until the latter part of the decade such as the expansion of the definition of small group and the excise tax on especially expensive health plans. Second, we have considered the immediate impact of increased rate review and scrutiny in today's environment, including but not limited to non-actuarially-based restrictions such as the temporary order in DC that restricted premium rate increases to no more than 10%, with exceptions permitted under certain circumstances up to 15%.

Background

An order related to the surplus review and determination regarding Group Hospitalization and Medical Services, Inc. (GHMSI) was issued by Gennet Purcell, Commissioner of the Department of Insurance, Securities and Banking (DISB) of the District of Columbia, on August 6, 2010. Among other things, the order requires GHMSI to "submit to the Commissioner comprehensive information regarding the financial impact of the Federal Health Reform Acts on GHMSI, including the appropriate level of GHMSI's surplus and GHMSI's financial obligations..."

Milliman has previously prepared two reports for GHMSI that have been submitted to the DISB and reviewed by Rector & Associates, Inc. (Rector), consultants to the DISB. The first of these reports concerned optimal surplus levels for the corporation and the second concerned attribution

of surplus to jurisdiction. In addition, Milliman submitted written testimony at the Commissioner's hearing on the subject and Robert H. Dobson testified at the hearing.

Rector's review of the Milliman work has been documented in a report that was posted on the DISB website. We are separately preparing our response to that report.

The healthcare reforms that were passed by Congress and signed into law by President Obama earlier this year (PPACA) will have a far-reaching impact on virtually all aspects of the operations of health insurance companies.[1] Most of the regulations implementing the new law have yet to be issued. Some changes have become effective within the first six months since enactment, while many others will not occur until 2014 or later. The law is complex and can be expected to spawn volumes of regulations (of which only a few have been released to date) spelling out the manner in which it will be implemented and, with respect to a number of provisions, filling in the details as to what will actually be entailed. It is clear that the industry will face a new layer of regulatory complexity, and that health plans will be more heavily scrutinized at both the state and federal levels.

There are reform provisions dealing with the commercial markets (individual and group) and public programs (Medicaid and Medicare), as well as new individual and employer requirements. Other requirements affect health care providers and vendors, and many new responsibilities are assigned to states. These and other aspects of the new law, including premium and cost-sharing subsidies for lower- income individuals and families, have significant implications for health insurers. Health plans will be forced to balance challenging cost dynamics against the need for affordable policies, and will need to focus on administrative efficiency as well as compliance.

Results

There are potential upside and downside impacts from federal health care reform. This section briefly discusses some of those impacts.

The upside impacts of federal health care reform to the risks faced by CareFirst and other managed care organizations include:

1. The potential for more customers (beginning in 2014) due to the individual mandate, government provided subsidies and penalties,
2. Potentially higher revenue per customer because of enhanced benefits due to the imposition of new benefit minimum, expanded coverage for preventive services and elimination of lifetime maximums,
3. Growth opportunities resulting from changes in the competitive environment and Medicaid expansion,

[1] The law consists of the Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Affordability Reconciliation Act of 2010 (Reconciliation Act), with the latter amending certain provisions of the former. As used in this paper, the term federal health care reform will refer to the final legislation, as amended by the Reconciliation Act.

4. Exchanges could offer simplified administration and a new, effective distribution channel (although they also involve new risks and costs due to the uncertainties and compliance requirements involved), and
5. To the extent that the legislation results in a major shift in how care is delivered and paid for (perhaps through accountable care organizations), there may be opportunities to benefit from reduced health care cost trends.

The downside risks are substantial, however. They include the following:

1. Financial impact of minimum loss ratio requirements which require rebates when there are financial gains but restrict the ability to recoup losses,
2. Additional rate review at both the local and national level, with the potential for rate restrictions based on arbitrary caps on the level of change rather than appropriate analyses of actuarial rate requirements,
3. Necessary increases in rates for enhanced benefits that may result in additional lapsation and/or adverse selection,
4. Requirement of guaranteed issue in the individual market with no ability to exclude pre-existing conditions,
5. Restrictions and prohibitions on rating variations (age, geographic area, health status) for the individual and small group markets, requiring subsidization of higher cost risks,
6. Adverse selection in decision making by individuals and groups with regard to retaining current "grandfathered" plans versus replacement with health plans subject to the new benefit and pricing standards,
7. Likely shift from employer-sponsored group to Medicaid and individual coverage, enrollment turnover with attendant adverse selection, and unstable insurance risk pools, and
8. Increased cost of compliance, coupled with intensified pressure to constrain administrative expenses.

While there are some provisions for reinsurance and risk adjustment, it is not clear at this point how much, if any, relief they will provide.

The overall theme in the current environment is uncertainty coupled with major limitations on how carriers are allowed to manage risk. There is uncertainty in how the regulations to implement the legislation will be written, interpreted and enforced. There is uncertainty in how some of the changes will affect behavior of consumers and providers. There is uncertainty in how the market will react to the creation of exchanges. What is known is that methods that health plans have used to manage risk, such as risk classification, underwriting, rating, benefit limitations and the use of margins, will be increasingly restricted, going forward.

Conclusion

Uncertainty and limitations on how risk is to be managed are major drivers of the need for a health plan to maintain adequate surplus. In today's uncertain and increasingly restrictive environment, we believe it would be imprudent of management or a board of directors to intentionally decrease surplus or its target surplus range. While it is impossible to quantify currently, it is our belief that surplus requirements have increased materially, at least 100 to

200% of RBC-ACL and quite possibly substantially more, as a result of the changes to the environment since we issued our report on an optimal surplus range for GHMSI (December, 2008).

Caveats

This report is only to be relied upon by the management of CareFirst. No portion of this report may be provided to any other party without Milliman's prior written consent. We understand that CareFirst may wish to share this report with regulators and their professional advisors in the District of Columbia, Maryland and Virginia, or other appropriate regulators. We hereby grant permission, so long as the entire report is provided. We recommend that any party receiving this report have its own actuary or other qualified professional review this report to ensure that the party understands the assumptions and uncertainties inherent in our estimates. Judgments as to the conclusions contained in our report should be made only after studying the report in its entirety. Furthermore, conclusions reached by review of a section or sections on an isolated basis may be incorrect. Milliman does not intend to benefit any third party either through this analysis or by granting permission for this report to be shared with other parties.

ATTACHMENT B

The LEWIN GROUP®

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memorandum

Date: September 2, 2010

To: Mark Chaney, Jeanne Kennedy, Kenny Kan

From: John Lloyd, Tom Carlson

RE: REACTION TO RECTOR REPORT AND DC DISB ORDER OF 8/6/2010

Per conversations with Mark Chaney, Jeanne Kennedy and Kenny Kan, our team has been reviewing the Rector report and issues raised by the report and subsequent DISB order regarding GHMSI surplus levels. It is our overall opinion that the surplus range in the Rector and Associates (R & A) report is too low, with the 750%-1000% recommended by our report and the Milliman report being a more appropriate surplus target range.

As discussed with Carefirst management, while we have a number of minor clarifications, we did not feel the R&A report necessarily required a full rebuttal as to outcomes or detailed fact-checking. There are a number of important caveats within the report and conclusions which are somewhat off-target. However, the most important issue is that, while the range calculated by R & A is comparable to the ranges calculated by Lewin, Milliman, and Invotex, none of these outcomes address national and local health care reforms. The R & A report contains an overview of the local regulatory changes that have recently been enacted and have already begun to affect CareFirst's pricing.

While not a detailed analysis, we have provided commentary in the attached discussion on basis issues we believe should be addressed:

- Appropriate acknowledgement of the nature of the Lewin modeling and the importance of the similarity of surplus range outcomes when created by a completely independent modeling exercise – compared to a process of adjustment of assumptions sets from the Milliman model.
- Commentary on attribution of surplus without providing full consideration of the implications.
- Introduction of the impact of reform on required surplus without suggesting, even directionally, the magnitude and direction of that potential impact.

We have addressed each of these issues based on conversations with Carefirst staff as to where they are headed with discussions related to GHMSI.

LEWIN CONSULTING
REACTION AND RESPONSE TO THE RECTOR REPORT TO THE DISB AND SUBSEQUENT ORDER REGARDING GHMSI SURPLUS LEVELS

We were asked to provide a review the Rector & Associates (R&A) report to the DISB and comment on any issues we might see related to the DISB order regarding GHMSI surplus levels. It is our overall opinion that the surplus range in the Rector and Associates (R & A) report is too low, with values in the 750%-1000% ranges recommended by our report and the Milliman report being a more appropriate surplus target. As noted below, there were areas in which we thought the R&A report failed to address topics appropriately, or introduced issues which we believe require comment.

CONSIDERATION OF SURPLUS NEEDS AS DESCRIBED BY LEWIN MODELS

The Rector report fails to consider the Lewin modeling outcomes in the assessment of Carefirst surplus needs. The report dismisses our modeling by suggesting that the Lewin Group failed to provide assumptions or methodology. In fact, our report provided a fairly detailed description of the structure and assumptions in the analysis we undertook. R&A did not contact us to develop any additional insight into how we arrived at our outcomes. We could have easily worked to help them understand the nature of our analysis and the interpretation and implication of our results.

We mention this mainly because it fundamentally understates the value of the Lewin modeling. The true value of the similarity to the other consulting firm outcomes was precisely the fact that it was developed independently from Milliman's model. Using similar information regarding GHMSI provided by Carefirst, Lewin constructed an independent modeling approach which simulated business results of GHMSI using statistical modeling techniques.

Invotex and R & A worked with the Milliman model to revise input parameters and thereby calculated ranges that overlapped Milliman and Lewin. However, none of the other reviewers actually created an independent model. Both Invotex and Rector relied on Milliman's model and modified input assumptions. We find this much less compelling than the Lewin approach of providing a completely different modeling exercise. The Lewin range therefore provides greater validation as a completely independent calculation of RBC ranges; it was constructed by another group of qualified actuaries and resulted in a very similar outcome. This observation was not made in the R & A report, but it should have done so to provide greater support for the validity of the ranges that all four firms produced. It further would argue that the 750% -1000% RBC range created by Lewin and initial Milliman outcomes might be given greater consideration than end-points of a slightly different range created by tweaking assumptions in the Milliman model.

REMARKS RELATED TO ATTRIBUTION OF SURPLUS

Regarding the R & A report's discussion on attribution, we realize that R & A may not have been tasked with outlining political decisions when discussing attribution. However we feel that the political considerations are at least as important as purely mathematical exercise of attributing surplus to a group of policyholders. Other areas of the R & A report thoroughly discuss the conclusions of The Invotex Group. However, the attribution discussion does not mention Invotex or other regulatory agencies' comments and actions. This strikes us as a gap in the report, since it assumes that Maryland's Department of Insurance and Virginia's Department of Insurance will have no jurisdiction or input on the attribution of surplus.

IMPACT OF REFORM ON SURPLUS REQUIREMENTS

The R&A report and DISB order raises questions as to the impact of potential changes in healthcare insurance and delivery, but R&A actually only says that "it is not clear" and that "there will be significant evolution" in terms of payer impact. This clearly involves a complex set of issues which currently lack a great deal of clarity as to potential outcomes. However, general reasoning applied to fundamental drivers of surplus needs, such as the framework Lewin identified in our previous report, provides fairly clear direction as to potential outcomes. In terms of normal surplus management objectives, the very lack of clarity speaks to the need to hold increased surplus due to increased uncertainty.

In our initial report, we indicated that surplus needs are fundamentally driven by uncertainty in outcomes and the ability to maintain minimum viable surplus levels while reacting and recovering from those issues. Most aspects of reform introduce more uncertainty and adversely impact the ability to react and recover. RBC ratios can be quite volatile, with significant swings year-over-year even in relatively stable operating environments. In the exercise below, we apply our initial general reasoning as to adverse RBC outcomes due to potential reform issues within the context of RBC development:

1) Underwriting Risk. Surplus is required for maintaining solvency in the face of potential long-term fluctuations in underwriting results for healthcare operations.

   Healthcare reform increases the potential for adverse fluctuations in underwriting results in a variety of areas:

   - *Trend.* An error in trend estimate is one of the primary drivers of underwriting loses and the resulting need for surplus. Reform changes will create entirely new mixes of morbidity and products for payers. These will greatly diminish the reliability of historical trends as a basis for rate projections and therefore increase the likelihood of a trend miss and resulting negative impact on surplus.
   - *IBNR.* Liability estimates in a post-reform environment have an increased potential for errors of estimation in incurred claims estimates used in pricing projections. The above impact of reform on trend issues related to historical data will also greatly increase the potential for misstatement of liabilities and pricing errors.

- *Regulatory Limits on Increases.* Surplus is needed to meet the potential that rate increases can be capped or restricted by regulators and thereby lengthen the period of recovery for pricing errors. Early outcomes on reform have clearly shown a willingness of HHS and CMS to pressure payers to reduce rate increases or deny them realistic rate levels.
- *Marketplace Limits on Increases.* Surplus is also required if the collective actions of the marketplace restricts recovery beyond any constraints already imposed by regulators. The new marketplace of Exchanges and post-reform delivery vehicles will very likely impose greater limits on pricing which will further limit the ability to adjust prices for recovery.
- *Shifts in Product Mix.* Contribution to surplus and pricing recovery are both long-term propositions. In the short-tem, surplus is needed to avoid a period of insufficient surplus levels until a long-term margin/surplus pricing solution becomes effective. The implementation of Exchanges, Medicaid availability for members of certain income levels, and new employer subsidies/penalties are likely to change the mix of membership by product. This changes the margins available to each product compared to the historical plan strategies.

2) Asset Risk. Since healthcare insurer profit margins are relatively thin, investment income on accumulated surplus can be relatively significant. Working surplus must be available to handle the risk of short-term liquidity requirements in the face of adverse cash flow. We will not attempt to explore the topic of current and future rates of return available on portfolios. However, the installation of entire new programs and processes through reform will very likely reduce margins, reduce cash flow, and cut available surplus in a period in which it will be difficult to earn a return that contributes significantly to surplus.

3) Cost of Capital and Credit Risk. Surplus requirements must consider the impact of solvency and cash flow issues stemming from contracts with healthcare providers, self-funded employers, and other vendors.

   We fully anticipate reform to create new cash flow impacts and risk arrangements with providers – whether mandated by reform initiatives or a result of the marketplace. Carrying costs and the potential for an outcome with adverse cash flow from these initiatives will create an increased need for surplus. The perception of the credit risk associated with healthcare payers is unknown as we enter a post-reform environment, but constraints that the investment market may impose cannot be dismissed.

4) Operational and Business Risk. Surplus is required to fund risks associated with general business operations which create unfunded adverse outcomes until such time as pricing solutions can be reset. Impacts from health reform will likely include:
   - Regulatory and tax changes that cannot be anticipated or built into current pricing cycles seem to be very likely outcomes as the government wrestles with practical implementation of the rather broadly stated healthcare objectives.

- Expense recovery will likely be adversely impacted by expense and membership shifts due to reform initiatives. This will also create new relationships in regard to fixed and variable administrative expenses. These changes will be compounded by reform constraints on Minimum Loss Ratio requirements and the ability to recover sunk costs. At a minimum, surplus demands will be created until pricing can be resolved, along with the potential that such recovery is limited by regulation or market response.

VITALITY AND CAPITAL FUNDS TO MEET REFORM MANDATED CHANGES

Additionally, Lewin considers it important to address "vitality" spending, namely spending on operations and infrastructure needed to remain a viable company. This is critical, particularly in the upcoming response to healthcare reform. Funding for changes to remain a viable entity in a post-reform market will likely not be available from current profits in the short-term. Failure of the other consultants to address this use of surplus funds is an important shortcoming of the other range estimates, and one which must be considered even more strongly as a consequence of reform.

QUANTIFICATION AND OVERALL SURPLUS IMPLICATIONS

While we agree with the R&A report that the implications of reform are still somewhat obscure, the very uncertainty reform introduces becomes the strongest argument for increased surplus requirements. As noted above, reform initiatives suggest a negative impact or increased uncertainty in every category by which surplus needs are typically assessed. Since many of these impacts are not even directly correlated, their RBC impact can actually be additive. Significant issues in the important RBC area of underwriting uncertainty, and the potential failure to react and recover on a timely basis, can create a very significant impact to a payer's RBC level and damage surplus levels over an extended period.

In terms of the second aspect of surplus management, we see the ability of the payer to react to this uncertainty and recover financially to be further challenged in the marketplace created by reform initiatives. This comes during a period in which reform pressure on administrative expenditures (minimum loss ratios) limits the health plan's administrative spending on potential solutions. Surplus becomes the buffer which allows the payer time to recover while unforeseen expense issues and adverse outcomes are being addressed.

The exact quantification of the impact is obviously a complex problem and will not be fully known in the timeframe established by the DISB order. This is a problem being addressed by most payers as they build a strategic response to reform. There is still much work to be done and discovery to be pursued. However, we one must conclude that the impact of reform must be material in terms of surplus needed by a plan under almost every combination of outcomes we can envision.

As noted, reform impacts many factors which increase the need for payers to hold additional surplus. The uncertainty in the range of impacts on those factors is significant, and therefore

the magnitude of the surplus impact is very material to meeting the objectives of holding adequate target surplus. Assessing the potential impact in terms of the model logic we used to determine surplus needs, we can very easily envision GHMSI's required surplus increasing by more than 10% over the pre-reform levels we previously modeled. In fact, depending upon assumptions as to the form and substance of reform initiatives ultimately implemented, there may be significantly greater impact. We would certainly argue that now would not be the time to argue for anything other than increased surplus holdings as plans enter a post-reform environment.

ATTACHMENT C

CareFirst, Inc.
Group Hospitalization and Medical Services, Inc.

Milliman Response to
Rector & Associates, Inc. Report Titled:

"Report to the D.C. Department of Insurance, Securities and Banking Group Hospitalization and Medical Services, Inc."

September 1, 2010

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A. Background

Milliman issued a December 4, 2008 report to CareFirst, Inc. titled "Group Hospitalization and Medical Services, Inc.; Need for Statutory Surplus and Development of Optimal Surplus Target Range." The purpose of the report was to address the need for statutory surplus for GHMSI (including its proportionate share of CareFirst BlueChoice) and to quantify an optimal surplus target range within which we believe GHMSI should strive to operate, under normal circumstances.

Milliman's report was submitted by CareFirst to the Commissioner of the DC Department of Insurance, Securities and Banking (DISB). The report, along with other materials, was submitted in response to the requirement established by the DISB in the emergency and proposed regulations promulgated on July 10, 2009. That ruling defined procedures for a September 10, 2009 hearing to review the reserves of Group Hospitalization and Medical Services, Inc. (GHMSI), and to determine whether the portion of the surplus attributable to the District is excessive.

DISB hired Rector & Associates (Rector) to review the Milliman work. A report by Rector presenting their conclusions from this review was posted on the DISB website in August 2010. This report presents our response to that report. Our purpose in preparing this response is to correct what we believe are a number of mischaracterizations of Milliman's analysis, and to respond to certain comments made by Rector regarding the assumptions and methodology underlying our results. We stand behind the assumptions that we have made and believe that they are appropriate for the purpose for which our report was prepared.

This response was prepared for CareFirst for the reasons stated above. It can be shared with the DISB so long as it is shared in its entirety. In agreeing to allow the distribution of this report, Milliman does not intend to benefit or create a legal duty to any third party recipient of its work. The authors, identified on the cover page, are members of the American Academy of Actuaries, and meet its qualification standards for forming the types of opinions expressed herein.

B. Discussion

The Rector report as posted on the DISB website is undated and does not identify the authors. It is not clear to us which portions of the report are intended to represent actuarial findings, and therefore what the foundation may be for some of the comments on our work that are contained in the report. Nevertheless, in the discussion that follows we respond as actuaries to a number of the comments made in the Rector report that pertain to the analysis performed by Milliman. Our comments are presented in the order in which they are presented in the Rector report.

Milliman Methodology

The authors make a number of statements regarding Milliman's methodology that we would like to address:

- The report states that ***"the Milliman methodology does not validate GHMSI historical results over the last 13 years. Based on a statistical analysis of the Milliman loss curve, it seems highly improbable that GHMSI's actual results could have been generated using the Milliman approach, a critical test for the validity of any modeling approach."***

  We disagree with this characterization. The Milliman methodology is composed of two key sets of assumptions – baseline pro forma projection assumptions, and severe adverse cycle loss assumptions.

  The first constitutes the expectations for the company based on its history, its business characteristics, and its operating environment and policies (looking forward). In setting the projection assumptions, we analyzed GHMSI's financial history and incorporated assumptions that were consistent with that history or, where appropriate, that reflected future expectations which varied somewhat from recent history.

  The second set of assumptions focuses on unexpected events and outcomes, but outcomes that nevertheless can occur at some point and which would create great harm to the company and its subscribers if and when they were to occur. Although the probabilities of such events occurring during any finite period are unknown, and therefore setting assumptions about them is highly judgmental, doing so is useful for actuarial analysis of the risks involved. In so doing, Milliman focused on what we believe to be the major categories of risk facing GHMSI and on adverse outcomes associated with such risks.

  Each of these two sets of assumptions reflects underlying expected or mean annual values for the rating margin on non-FEP insured business, underwriting gains (losses), and net income before taxes. The many Monte Carlo simulations of variances about these mean values then reflect the potential dispersion of results for multi-year periods, while reproducing as an average the underlying expected or mean values.

  The expected or mean rating margin on non-FEP insured business in the Milliman baseline pro forma projection assumptions is 3.5% per year, the mean statutory annual underwriting gain is slightly less than this, and the mean net annual income before taxes is approximately 5%. Milliman has previously provided the year-by-year history of

underwriting gains (losses).[1] After recognizing the low rates of investment income currently experienced and anticipated for some time to come, these assumptions as to underwriting gains (losses) and net income before taxes are consistent with GHMSI's history of results, including the 13-year historical period cited by Rector.

Our surplus analysis then deals with 90th and 98th percentile of simulated multi-year results, in terms of adversity. In descriptive terms, it is those results that might occur every 10 to 50 years. A single 13-year observation period does almost nothing to provide historical validation for such assumptions as to dispersion in results due to low frequency events; even to look at 1-in-10-year events, one needs many 10-year periods to observe their frequency. However, if one does look at a much longer historical period for GHMSI (or other BCBS Plans), severe loss periods have indeed occurred, and with greater frequency than assumed in the Milliman analysis[2].

- The authors go on to state that ***"the Milliman loss curve assumes that liability and asset risks are independent of each other and the yield curve. Rather than projecting periodic cash flows with dynamic interactions between assets and liabilities, all the risk assumptions are smoothed and blended into a loss ratio representing an entire underwriting cycle. The theoretical basis for such an approach is outdated. For the last 20 years, industry practice for surplus analysis has incorporated dynamic asset/liability matching in the form of Cash Flow Testing, Dynamic Financial Analysis, and, more recently, Enterprise Risk Management tools."***

  Milliman is well aware of industry techniques for addressing important dynamic interactions between assets and liabilities, where the time value of money (i.e., the mix of terms to maturity and associated rates of return for specific blocks of invested assets) is a critical assumption. This is the case with whole life insurance, long-term care insurance, certain property/casualty insurance, and other insurance products where there are typically major timing mismatches between the collection of premium and the payment of benefits.

  In term coverages, such as group health and most comprehensive individual medical products, this is not the case. Instead, a company like GHMSI prices and reserves on a term insurance basis, and investment portfolios are kept fairly liquid; the expectation in most years for a stable block of business is that premium earned and collected for a group of policies will largely equate to benefits and expenses incurred for those same policies (unlike coverages where payout of benefits is concentrated far into the future); and most BCBS Plans roll their portfolios regularly so as not to hold large unrealized gains or losses that are not reported on their balance sheets. As a result, linking terms and maturity dates for certain investment blocks to claims payout is not meaningful for a company like GHMSI, given its product lines (other than to consider the risk characteristics of the investment portfolio overall, which we have done in our analysis).

[1] Presentation material provided to representative of Rector & Associates on October 12, 2009.

[2] See *CareFirst, Inc. Group Health and Medical Services, Inc.; Need for Statutory Surplus and Development of Optimal Surplus Target Range*, Milliman, December 4, 2008, page 51.

Milliman Loss Distribution Assumptions

Rector also discusses the loss distribution assumptions incorporated in Milliman's analysis. We have the following comments regarding that discussion:

- **Interest Rate and Asset Values:** The report discusses this assumption as follows: ***"In order to develop interest rate assumptions, Milliman estimated a range of deviations of projected asset values and interest rates from a 4% base earned rate assumption. Based on our review of the assumed interest rate changes, we made downward adjustments to the loss curve of between 0.75% and 1.75%, depending on the level of confidence chosen in the modeling."***

  In view of the historically low market yields and high volatility of security valuations in the current environment, we believe that any reduction to our loss distribution assumption for this item is not prudent or appropriate.

- **Catastrophic Events:** The authors contend that ***"Milliman's catastrophic event assumption results in a charge of 2.5% of non-FEP premiums in each underwriting cycle – a $75 million regular expense, or $25 million per year. As a practical matter, a recurring expenditure of this nature would be provided for in the company's operating budget and a separate provision in surplus for this amount would not be needed."***

  This is not, in fact, a charge per cycle or per year, and it is not a recurring expenditure (or any type of expenditure). Rather, it is a portion of the provision for surplus to be held against the impact of catastrophic events, in case they should materialize at some point in the future.

  Such events include extraordinary medical costs due to terrorism, epidemics or pandemics, and natural or public health disasters. They also include other events with a potentially extraordinary adverse financial impact – such as major fire or other business interruption disaster, excessive damage awards from major class action or other litigation, or extraordinarily large changes in the financial markets with attendant adverse impacts on asset valuations and financial obligations. For example, during the recent financial downturn many insurers experienced significant reductions to their asset portfolios, and those with defined benefit pension plans may be facing material additional funding requirements.

  It is not appropriate to make advance funding provision for such unanticipated extraordinary events in the company's operating budget, and therefore provision must be made in surplus. As we stated in our December 2008 report, we believe that a prudent insurer must provide protection against such risks, so that the company is not exposed to ruin or incapacity from such an event. This is necessary to remain a viable company. It is also necessary to protect the ability of GHMSI's members, providers, and vendors to safely rely on the company for the financial security that they believe they have contracted for or purchased. Prudence dictates that surplus for GHMSI be sufficient to withstand the risk created by such threats, to the maximum extent possible.

- **Provision for Unidentified Development and Growth:** In a similar

mischaracterization, the authors refer to the risk category defined by Milliman as "provision for unidentified development and growth" as "growth and development ***charges***" (emphasis added). They state that ***"Growth and development charges are extraordinary expenditures resulting from unanticipated growth, including technology and infrastructure investments."***

This risk provision is not a charge or expenditure. It represents a portion of the provision for surplus to be held against the need for such expenditures unexpectedly at some point in the future.

In our 2008 report we described this provision as follows: *"To maintain competitiveness and ongoing viability, as discussed previously, GHMSI must periodically make substantial investments in developmental activities and the acquisition of operational capabilities. These include such far ranging items as new product development, rebuilding of delivery networks, enhancement of care management capabilities, acquisition of new communications or information technology capacities, and adaptation of existing and integration of new administrative processes. Often these capital expenditures do not produce admitted assets, which means that they generally must be absorbed directly and immediately out of surplus. Likewise, developing and absorbing growth requires equity capital to fund developmental costs, to cover the initial losses resulting from the need to be price-competitive at the outset in order to become established, to absorb any initial losses resulting from setbacks or inexperience in the new market, and to withstand the short-term surplus strain (i.e., growth in enrollment or volume of business in force, without corresponding immediate growth in surplus). Obviously, a prerequisite for financially sound growth is strong surplus."*

It is interesting to observe that, while the specific features of the recent national health care reform legislation were not identifiable at the time of our report, every one of the issues included in this description represents a likely or certain requirement now facing GHMSI as a result of the new legislation. These requirements, while surfacing in a general sense as potential consequences of legislative efforts, were as recently as one year ago not yet defined as specific requirements, and therefore would not have been included in the company's operating budget.

Additional Assumptions

- **Pension Plan Charges** – Rector made upward adjustments to the loss distribution of between 1.00% and 1.75% to reflect possible pension plan risks. We agree that it is appropriate to reflect such risks, and have implicitly recognized them in our other assumptions (see comments above under Catastrophic Events).

- **Management Interventions** – The authors quote Milliman staff as indicating that we did not consider the effect that management intervention might have on GHMSI's operations. We wish to clarify that point. The impacts of such interventions were directly reflected in the underlying loss distribution assumptions. The rating adequacy and fluctuation risk assumptions incorporated the impact of management corrections to rate levels in response to emerging adverse experience (see discussion below). Similarly, our

assumptions for risks associated with unanticipated fluctuation in the level of administrative expense recoveries (overhead expense recovery risk) reflect the estimated lag between a reduction in revenue and the implementation of appropriate corrective actions.

Rector made downward adjustments to Milliman's loss distribution assumptions to reflect actions that management can take to mitigate the impact of certain risks, as follows:

- **Reserve Margins.** Rector refers to the approximately 10% provision for adverse deviation in GHMSI's unpaid claims reserves, stating that ***"It is reasonable to expect that if management were concerned about crossing a particular RBC threshold, management would react by reducing reserve margins and releasing redundant reserves into surplus. Accordingly, we made downward adjustments to the loss curve of between 0.5% and 1.5%, depending on the level of confidence chosen in the modeling."***

  We disagree with this conclusion that the company could elect to dampen the reported losses on its statutory blank by weakening its accounting policies and practices regarding the reporting of its liability for unpaid claims. In our experience, auditors require a consistent level of provision for adverse deviation (or margin) in claim reserves over time. At a time of potential financial impairment, in particular, such an action would not likely be accepted, since it would weaken provision by the company to pay outstanding claims. Maintaining adequate surplus avoids the need for attempting to pursue imprudent actions such as this during a time of financial downturn, even (or especially) a severe one.

- **Pricing Margins and Underwriting Standards.** The report states that ***"The Milliman model assumes a pricing margin on its non-FEP insured business. It is reasonable to expect that if management were concerned about crossing a particular RBC threshold, management would react by increasing pricing margins and/or implementing more stringent underwriting standards. For purposes of developing assumptions for these actions, we assumed that management would identify and respond to a deteriorating situation in year two and implement changes that affect pricing margins and underwriting standards in year three. Accordingly, we made downward adjustments to the loss curve of 1.50% at all confidence levels."***

  The 2 and 2.5 year rating correction periods used in our modeling were based on an assessment as to the time required to identify and respond to deterioration in financial results due to rate inadequacy. These assumptions are supported by separate modeling of the combination of: (i) rate renewal distributions by month, (ii) advance rate notification (or filing and approval) periods, and (iii) adequate periods of experience to enable recognition, validation and response to adverse financial developments. This modeling indicated that a reasonable estimate of the average elapsed time between the initial development of adverse experience and the point at which management corrections would be realized in rates (assuming the ability of management to act without undue regulatory or other constraints) is

2 to 2.5 years, due to the impact of GHMSI's business characteristics with respect to each of these factors.

Thus, our loss distribution assumptions directly reflect the impact of timely management response and intervention to correct for emerging adverse experience deviations.

- **Infrastructure Investments.** According to the authors, ***"Historical information provided by GHMSI indicates that GHMSI incurred baseline capital expenditures of approximately $45 million per year during the past decade. It is reasonable to expect that if management were concerned about crossing a particular RBC threshold, management would react by delaying or canceling at least some infrastructure investments. Accordingly, we made downward adjustments to the loss curve of between 0.0% and 1.0%, depending on the level of confidence chosen in the modeling."***

  Our experience is that capital expenditures are typically part of a longer term business planning and development process. Many of the projects involved entail multi-year lead times and commitments (staffing, vendor contracts, equipment ordering, etc.). These often cannot be altered quickly without severe cost and/or operational consequences. Avoidance of such consequences by having sufficient surplus is, we believe, a compelling reason to hold sufficient surplus.

Financial Projection Assumptions

We wish to address Rector's comments regarding Milliman's assumption that GHMSI would have no tax impact from the annual losses produced in our projected loss scenarios, as follows:

- **Tax Impact:** The authors state the following with regard to the impact of the tax rate. ***"The Milliman projections do not include the value of deferred tax credits that would result from GHMSI's projected losses. Because such tax credits would have value if GHMSI remains a going concern, it appears appropriate to recognize such credits in the financial projections. For purposes of assumptions used in the financial projections, we assumed that GHMSI would be subject to a 20% tax rate on an ongoing basis."***

  We do not agree with this treatment of the tax assumption, for the purpose of evaluating surplus needs. In our modeling, we are testing periods of multi-year losses that will lead to financial impairment of the type defined by our loss thresholds (i.e., the 375% and 200% RBC thresholds). Under such circumstances, we do not believe that there would be any reportable tax benefit to GHMSI on its statutory blank.

  The assumption proposed by Rector is that GHMSI could accumulate a deferred tax asset on its statutory balance sheet during a period of severe multi-year losses. In our experience, this is not consistent with company accounting policies or with auditor practices. Instead, creation of a deferred tax asset is generally restricted to periods of demonstrated and anticipated continuing gains, in order to assure its validity as an asset (conditions not present during a multi-year adverse loss period).

Changes in District and US Regulatory Frameworks

We agree with the authors' observation that there have been very significant changes in the District and US regulatory frameworks since the time that Milliman prepared its report and that these changes will have a significant impact on GHMSI's future operations and results. We have issued a separate report to GHMSI management addressing the potential impact of these developments on the target surplus range for GHMSI.

Peer Review Analysis

Rector presents a "peer review analysis" consisting of summaries of reported surplus levels for other health plans, including summaries produced by other consultants. Unlike the other consultants, the authors have chosen to include peer companies that comprise for-profit stock insurance holding company systems. In presenting their rationale for including these organizations, they state that they ***"believe that it is appropriate to consider for-profit insurers as additional data points in the peer review analysis in part because of the provisions of DC law that GHMSI engage in community health reinvestment to the maximum feasible extent consistent with financial soundness and "efficiency". Because for-profit insurers often are recognized as having efficient operations due to the pressures exerted by the capital markets on for-profit insurers' profitability goals, considering such companies may provide additional information regarding what level of capital may be consistent with efficient operations."***

In our opinion, comparing a company's surplus level to that of peer plans is interesting, but it simply is not a valid means to determine optimal surplus levels.

In addition, we disagree with the authors' contention that for-profit insurers present a reasonable basis of comparison for the surplus level of GHMSI. An evaluation of a company's operating efficiency has to recognize any constraints that the company cannot alter. In the case of publicly held companies, their holding company structures enable (and encourage) holding capital and maintaining access to additional insurance company surplus outside of the insurance operating companies themselves. As a result, these organizations are simply not comparable when it comes to the structuring, reporting, and level of statutory surplus held -- within the broader context of enterprise capitalization.

* * * *

As stated previously, our purpose in submitting this report is to respond to certain comments made by Rector, and to correct mischaracterizations of Milliman's work. We would be happy to provide CareFirst or the DC Insurance Commissioner with any additional information that may be helpful in order to supplement our comments.