**Chet Burrell**
President and Chief Executive Officer

**CareFirst BlueCross BlueShield**
1501 S. Clinton Street, 17th Floor
Baltimore, MD 21224-5744
Tel: 410-605-2558
Fax: 410-781-7606
chet.burrell@carefirst.com

June 1, 2016

Hon. Stephen Taylor
Commissioner
Department of Insurance, Securities and Banking
810 First Street NE, Suite 701
Washington, D 20002

Dear Commissioner Taylor:

I write on behalf of Group Hospitalization and Medical Services, Inc. ("GHMSI" or "Company") to submit the enclosed report regarding GHMSI's surplus at Year-End 2015, pursuant to 26A DCMR 4601.1. GHMSI's overall surplus at Year-End 2015 was 882 percent risk-based capital, authorized control level ("RBC"), compared to 878 percent at Year-End 2014 and 932 percent at Year-End 2013.

In June 2014, GHMSI obtained a full, actuarial surplus analysis performed by Milliman. A copy of this analysis was filed with the Department of Insurance, Securities, and Banking ("DISB") as part of GHMSI'S June 2014 surplus report. In that analysis, Milliman noted the uncertainties caused by federal health care reform with respect to product pricing, the impact of risk adjustment mechanisms, medical loss ratio and rating constraints, the potential unavailability of the risk corridors program, and other uncertainties that relate to the major market changes due to the implementation of the ACA.

In June 2015, GHMSI obtained from Milliman an updated analysis, which was filed with GHMSI's 2015 surplus report. In December 2015, the Boards of GHMSI and CareFirst, Inc. ("CFI") concluded that GHMSI's target surplus range continues to be appropriate based on Milliman's updated analysis.

GHMSI has now obtained from Milliman a subsequent updated analysis for 2016, which is attached hereto. Milliman concludes that there has been no material variation in the analyses that were performed in 2014 and 2015, and Milliman's recommended target surplus range has not changed. GHMSI's surplus is well below the mid-point of Milliman's recommended range and the range approved by the Board in December 2015 as shown in Chart 1 attached. The second attached chart identifies the numerous studies of GHMSI surplus that have been conducted since 2005, including the latest Milliman update.

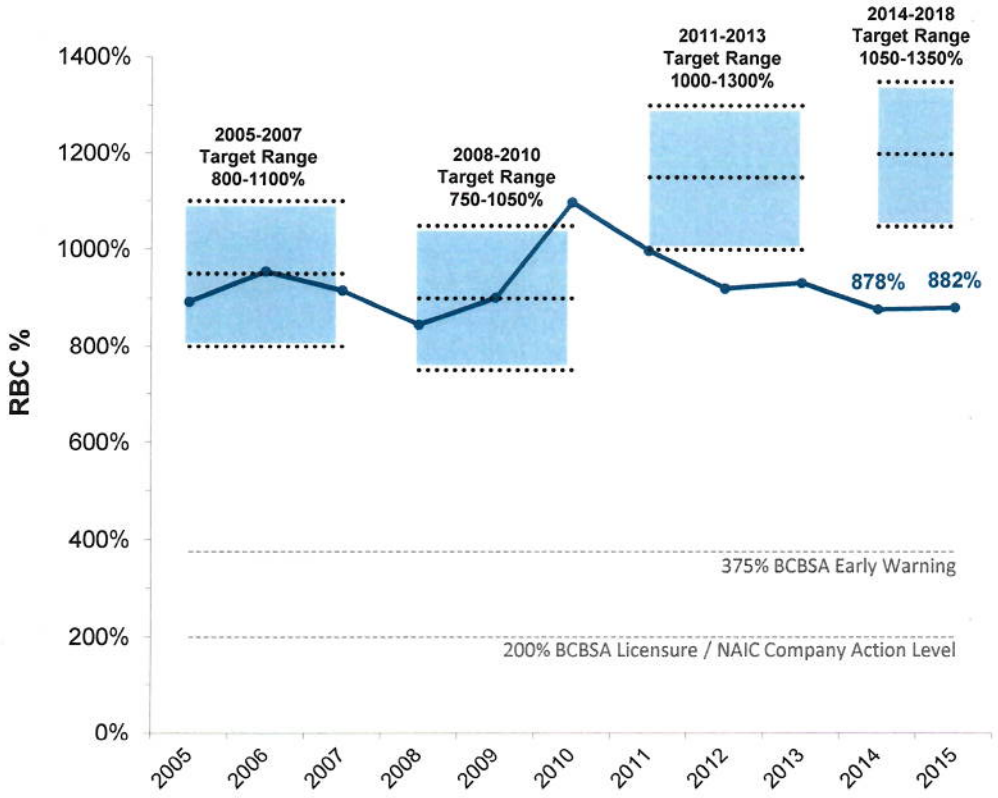
Please do not hesitate to contact me if you have questions.

Sincerely,

Chet Burrell
President and CEO

## Chart 1
## Board Approved RBC Ranges
## 2005 – Present

## GHMSI



# Surplus Studies: GHMSI
## 2005 to Present

| | | | GHMSI | |
|---|---|---|---|---|
| Study Year | Consultant | Engaged by | RBC Range | Actual RBC |
| 2005 | Milliman | CareFirst | 800-1100 | 893 |
| | **Board Adopted for 2005-2007** | | **800-1100** | |
| 2008 | Milliman | CareFirst | 750-1050 | |
| | Lewin | CareFirst | 750-1000 | 845 |
| | **Board Adopted for 2008-2010** | | **750-1050** | |
| 2009 | Invotex | MIA | 700-950 | 902 |
| | Rector | DISB | 600-850 | |
| 2011 | Milliman* | CareFirst | 1050-1300 | |
| | Lewin | CareFirst | 1000-1550 | 998 |
| | **Board Adopted for 2011-2013** | | **1000-1300** | |
| | RSM McGladrey | MIA | 1000-1300 | |
| 2012 | Milliman | CareFirst | 1000-1300 | 921 |
| | Lewin | CareFirst | 1000-1300 | |
| 2013 | Milliman | CareFirst | 1000-1300 | 932 |
| 2014 | Rector | DISB | 875-1040 | |
| | Milliman | CareFirst | 1050-1350 | 878 |
| | **Board Adopted for 2014-2017** | | **1050-1350** | |
| 2015 | Milliman | CareFirst | 1050-1350 | |
| | Lewis & Ellis | MIA | 1000-1300 | 882 |
| | VBOI/Lewis & Ellis | VBOI | 798-963 | |
| 2016 | Milliman | CareFirst | 1050-1350 | |

Milliman

# Group Hospitalization and Medical Services, Inc.

## Review and Consideration of Optimal Surplus Target Range

June 1, 2016

Phyllis A. Doran, FSA, MAAA
James A. Dunlap, FSA, MAAA
Ronald J. Harris, FSA, MAAA

# A. INTRODUCTION

In June of 2014 Milliman issued a report titled "*CareFirst, Inc. Group Hospitalization and Medical Services, Inc.; Development of Appropriate Surplus Target and Optimal Surplus Target Range*". The purpose of the report and its underlying analysis was to address the need for statutory surplus for GHMSI, including its ownership share of CareFirst Holdings, LLC (CFH) and to quantify an appropriate surplus target and optimal surplus target range within which we believe the company should strive to operate, under normal circumstances.

Milliman has been asked by GHMSI to carry out a brief, limited review of circumstances and developments affecting GHMSI subsequent to our 2014 study, and to determine whether any of these would be expected to materially affect the company's surplus target range. This report presents the findings from our current review. We carried out a similar review last year, and issued a report summarizing our findings on June 15, 2016[1].

It should be noted that in carrying out this review we have not performed an update of our 2014 surplus target analysis; the modeling and analytical framework required to carry out such an update is beyond the scope of this current assignment. If and when we do complete such an update, it is possible that our conclusions will differ from those presented in this report, due to the differences in the nature of the assignment and the scope of the accompanying analysis, as well as potential subsequent developments; however, at this time we would not expect any such differences in conclusions to be material.

For the purpose of this report, GHMSI is understood to mean the combination of 100% of the business of GHMSI itself and 50% of the business of CFH, the vast majority of which consists of CareFirst BlueChoice, an HMO operating in the District of Columbia, Maryland and certain counties in Virginia. For consistency with our 2014 report, we will refer to CareFirst BlueChoice or CFBC rather than CareFirst Holdings or CFH when discussing the GHMSI ownership share of those companies. The business of CareFirst of Maryland, Inc. (CFMI) is not reflected in this report.

## Conclusions

Based on our limited review and the observations presented in this report, we would not expect the GHMSI surplus target range to vary materially from that produced in our 2014 study, if we were to undertake a similar study today. This is not to say that certain factors will not differ if and when we do update our analysis, or that the overall results will not change. However, in the absence of having completed such an update, at this time we would not expect materially differing results.

[1] Milliman, *Group Hospitalization and Medical Services, Inc.; Review and Consideration of Optimal Surplus Target Range*, June 15, 2016,

# B. BACKGROUND: 2014 STUDY

## Surplus Target Range from 2014 Study

Based on the analysis presented in Milliman's June 27, 2014 report, we concluded at that time that an appropriate target for GHMSI's surplus is 1200% of RBC-ACL, and that an optimal surplus target range is 1050% to 1350% of RBC-ACL[2].

In developing this surplus target and optimal range we considered, among other factors, the changes in the health care marketplace resulting from federal health care reform legislation. Our analysis recognized the considerable uncertainty that remained, with respect to both the implementation of the health care reform initiatives, and the financial implications for a health plan such as GHMSI, including increased potential for adverse financial outcomes over the subsequent years.

Our modeling approach involves an assessment of the risks and contingencies faced by GHMSI. The most important of these – which we refer to as the rating adequacy and fluctuation contingency -- relates to the risk that actual claims and expenses incurred by the company will differ from the amounts for which provision is made in premium rates. While this risk, also characterized as the underwriting risk, is a fundamental component of any insurance program, it is heightened in today's health care reform environment.

A surplus target range is by its nature a multi-year target. While it should be updated periodically, it should also be designed to allow for adequate planning and implementation of actions consistent with financial objectives, and to be applicable over a period of time beyond the immediate next year. For these reasons, in our 2014 surplus target modeling we focused on the period beyond the health care reform transition, beginning in 2017 when most of the ACA provisions will have been fully implemented and the temporary risk mitigation programs will be eliminated. We also carried out testing to determine whether this target range was likely to be appropriate from 2014 through the transition period, and concluded that it was.

Therefore our surplus target of 1200% of RBC-ACL is intended to apply through and beyond the transition period of 2014 to 2016. Future developments should be monitored closely to evaluate the continued appropriateness of this target.

[2] RBC-ACL refers to the Risk Based Capital Authorized Control Level, a key reference value for the National Association of Insurance Commissioners (NAIC) risk based capital formula and a commonly accepted measure of surplus levels for insurance organizations. Multiples of the RBC-ACL (e.g., 1000% of RBC-ACL) are used to establish surplus thresholds, with higher multiples producing an increased likelihood of security against insolvency.

## Pricing Margins

In our 2014 modeling, we assumed an average pricing margin of 3.0% on underwritten business (excluding the Federal Employee Program). The assumed overall average underwriting margin was 1.7%, including FEP business and gains/(losses) from ASC business, expressed as a percentage of total underwritten premium (non-FEP and FEP).

The 3.0% margin for non-FEP insured business that we assumed reflected the longer-term average pricing expectation for GHMSI (including its ownership share of CFBC), where in this context longer term refers to 2016 and beyond. This assumption was based on analysis of emerging experience and forward-looking information provided by CareFirst staff.

Based on the information provided, average pricing margins for 2014 and 2015 were expected to be less than half of this 3.0%. If we were to have reduced the assumed pricing margin by 50%, to 1.5%, the resulting surplus target produced by our assumptions would be 1300% of RBC-ACL, rather than the 1200% produced in our study. Further, we estimated that in order to maintain the company's surplus at a level equal to the 1200% of RBC-ACL target, an average margin of 4.3% would be required for the non-FEP insured business, assuming that premiums were to grow at an annual rate of 9% and that experience were to develop as anticipated in pricing.

In the absence of financial experience more favorable than that currently anticipated, there is significant potential for the company's surplus levels to erode, in an environment where recovery will be made more difficult by the impact of health care reform provisions.

## C. IMPACT OF HEALTH CARE REFORM

The passage of federal health care reform legislation in the form of the Patient Protection and Affordable Care Act (ACA) in 2010 has resulted in significant changes in the health insurance marketplace. The effects of these changes continue to emerge with the evolution of the health care exchanges, the risk mitigation programs, and the associated legal and regulatory environment. GHMSI and other health plans continue to face uncertainty and challenges as the longer-term implications of the various components of the law unfold.

The ACA has brought a wide range of operational changes to the health care marketplace, including an individual mandate for coverage and an employer mandate. New market rules have been implemented, requiring guaranteed availability of coverage and premium rating restrictions. Along with the health care exchanges are the premium subsidies and the standardization of benefits sold through the exchanges. (Note that the original ACA provision requiring the extension of the small group market to include group sizes 51 to 100 beginning in 2016 was repealed, and it is our understanding that the jurisdictions in which GHMSI operates do not require such an extension).

The combination of these marketplace changes provides many opportunities for increased adverse selection against health plans, both in terms of the population choosing to enroll and in the selection of benefit levels. At the same time, health plans are subjected to extended timelines for the filing of new premium rates, as well as increased regulatory scrutiny of such rates. GHMSI must file its individual and small group premium rates in May for the following year. This timing does not allow the company to assess the experience of the current year in making assumptions for the subsequent year. Given the rapidly changing environment, such timing lags add significantly to the risk of inadequate premium rates.

The medical loss ratio standards and rebate requirements established by the ACA were first implemented in 2011. These provisions require GHMSI to separately report experience by market segment (individual, small group and large group), jurisdiction (D.C., Maryland and Virginia), and company (GHMSI and CFBC), resulting in 18 different segments for reporting purposes. Rebates must be paid for any such segment that does not meet the minimum medical loss ratio, with no opportunity to offset losses in other segments or jurisdictions. This situation severely limits the ability of the company to increase surplus levels if they should become depleted.

In addition to the impacts of these marketplace provisions and medical loss ratio standards, the ultimate costs of the exchange plans are affected by the cost and payment transfers under the premium stabilization or risk mitigation programs which became effective on January 1, 2014. These include the permanent risk adjustment provision as well as the transitional reinsurance and temporary risk corridor programs, both of which will expire at the end of 2016. The full effects of these new programs are still unknown and will not be determined until after the close of each respective plan year – which occurs after the submission of the following year's premium rates.

It is important to note that GHMSI does not expect to receive its full risk corridor payments due in accordance with the risk corridor payment formula, given the lack of government funding for such payments beyond amounts collected from other health plans. On October 1, 2015, the Centers for Medicare and Medicaid Services (CMS) announced that risk corridor payments made in 2015 for the 2014 plan year would be paid out at 12.6 percent of claims, assuming full collections of contributions

owed. There is no assurance that full payment of such amounts will be realized with respect to any of the three program years of 2014 through 2016, meaning that this program fails to provide its intended stabilization impact on the marketplace.

In another recent development, a U.S. District Court judge ruled[3] on May 12, 2016 that the Obama administration does not have budget authority to reimburse insurers for Cost Share Reduction (CSR) subsidies to low-income members, and that doing so without authority is unconstitutional. CareFirst, along with other health care plans operating on the health care Exchanges, has received such CSR subsidies, and has expected to receive additional subsidies in 2016, to offset reduced out-of-pocket costs that the plans were required to provide to eligible lower-income individuals. While this ruling has been stayed pending appeal, it has significant potential financial implications for CareFirst, and it illustrates the ongoing risks associated with the evolving legal and regulatory environment surrounding the implementation of the ACA.

[3] U.S. House of Representatives v. Burwell

# D. CONSIDERATION OF CURRENT GHMSI CIRCUMSTANCES

As previously mentioned, GHMSI has asked us to carry out a limited review of GHMSI's current circumstances in order to consider what, if any, developments have occurred subsequent to the development of our 2014 study that we would expect to materially affect the surplus target range produced in that study. We were not asked to update our previous surplus analysis modeling, and we have not done so. Further, we have not attempted to quantify the specific impact of any given factor on the target surplus range that we previously developed. To do so would require a level of analysis that is beyond the scope of our assignment.

Our approach has consisted of a review of the company's recent financial experience as well as the current financial forecast, and of the current health care reform environment as it affects GHMSI. Based on this limited review, we would not expect the surplus target range for GHMSI to differ materially from the results of our 2014 study, if we were to update the study based on current information.

## Observations Based on Recent GHMSI Financial Information

Following are some of our observations regarding recent GHMSI financial experience compared to the assumptions underlying our 2014 surplus analysis modeling:

- **Pricing Margins** – As noted above, in our 2014 modeling we assumed an average pricing margin of 3.0% on non-FEP underwritten business. The reported underwriting margin for 2014, measured on a comparable basis[4], was (1.6%). This underwriting loss was driven by a significant (20%) loss for the individual under age 65 business. For 2015 the reported margin was 0.6%, with a 13% loss on the individual under age 65 business.

  Based on information provided by GHMSI and CareFirst staff, the non-FEP underwritten business is expected to generate a 1.0% underwriting gain in 2016. The incorporation of an assumed pricing margin lower than the 3.0% reflected in our 2014 analysis would lead to a higher surplus target, in the absence of other changes in values or assumptions.

  Based on the current mix of business and the most recent pricing information provided by CareFirst and GHMSI staff, the updated average pricing margin would be 2.6%, using an approach consistent with that used to develop our 2014 assumption of 3.0% (i.e., reflecting longer-term average pricing expectations). In our review, we have considered the potential effect of this lower pricing margin on the optimal surplus target range for GHMSI.

[4] The estimated premium margins presented in this report apply to the total non-FEP underwritten business of GHMSI plus its ownership share of CFBC, consistent with the values from our 2014 report.

- **Annual Premium Growth** – GHMSI's reported annual premium growth rate was 7.7% in 2014 and 5.6% in 2015. These growth rates reflect premium for GHMSI plus its ownership share of CFBC, and they include FEP premium. Our 2014 analysis incorporated future premium growth assumptions of 7% to 11%. In view of the company's recent premium growth experience, we believe that growth assumptions of 3% to 7% would be appropriate at this time. In carrying out our current review, we have considered the potential effect of these lower premium growth assumptions on the optimal surplus target range for GHMSI.

- **Other Modeling Assumptions** – In other regards, we found GHMSI's recent reported financial experience, taken as a whole, to be generally consistent with the assumptions underlying our 2014 analysis.

## Health Care Reform Environment

As discussed above, health care reform has fundamentally changed the health care marketplace. Heightened uncertainty relative to the past is likely to continue as long as the ACA remains in its current form. The structure and provisions of the ACA are complex, and their implementation continues to involve policy revisions, confusion, controversy and legal challenges. Continual enrollment turnover among health plans and metal tiers can also be expected. The resulting uncertainty entails financial risk to GHMSI, and therefore tends to indicate the need for higher levels of surplus than would otherwise be considered prudent.

Further, the minimum loss ratio standards serve to limit the company's ability to achieve a level of underwriting gains that would allow it to generate the income needed to restore surplus funds, if they should be materially depleted due to unfavorable financial experience or inadequate premium rates. It is therefore essential for GHMSI to strive to maintain adequate surplus levels at all times, in order to minimize the need to grow surplus at a rate beyond that which is achievable under the constraints of health care reform.

## Conclusions

Based on our limited review and the observations summarized above, at this time we would not expect the GHMSI surplus target range to vary materially from that produced in our 2014 study, if we were to undertake a similar study today. This is not to say that certain factors would not differ if we were to update our analysis, or that the overall results would not change. However, in the absence of completing a new study, we would not expect materially differing results.

# E. LIMITATIONS AND CAVEATS

This report refers to, and relates to, Milliman's June 27, 2014 report for GHMSI on the Development of an Appropriate Surplus Target and Optimal Surplus Target Range. It should be considered only in connection with that report.

Milliman has prepared this report for the specific purpose of providing a brief, limited review of GHMSI's surplus target. This report should not be used for any other purpose. This report has been prepared solely for the internal business use of and is only to be relied upon by the management of GHMSI. We understand that GHMSI 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.

In order to provide the information requested by GHMSI, at the time of our 2014 analysis we constructed several projection models. Differences between these projections and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience.

In performing this analysis, we relied on data and other information provided by GHMSI. We have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete. We performed a limited review of the data used directly in our analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of our assignment.

The authors of this report are Consulting Actuaries for Milliman, are members of the American Academy of Actuaries, and meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinions contained herein.