Milliman

Group Hospitalization and Medical Services, Inc.

Review and Consideration of Optimal Surplus Target Range

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A. INTRODUCTION

In May of 2011 Milliman issued a report titled "*CareFirst, Inc. Group Hospitalization and Medical Services, Inc.; Development of 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 optimal surplus target range within which the company should strive to operate, under normal circumstances.

In May, 2012 Milliman was asked by GHMSI to (among other things) carry out a brief, limited review of GHMSI's then-current circumstances, in order to consider what, if any, subsequent developments had occurred that we would expect to materially affect the surplus target range produced in our 2011 study. Our report, titled "*CareFirst, Inc. Group Hospitalization and Medical Services, Inc.; Review and Consideration of Optimal Surplus Target Range" was issued on May 30, 2012.*

We have once again been asked to consider circumstances and developments affecting GHMSI subsequent to our 2011 study, and whether any of these would be expected to materially affect the company's surplus target range. This report presents our response.

It should be noted that, while we expect to perform an update of our 2011 target surplus analysis for GHMSI at some point later this year, 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.

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 (CFBC). For consistency with our 2011 report, we will refer to CFBC rather than CFH when discussing the GHMSI ownership share of those companies.

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 2011 study, if we were to undertake a similar study today. This is not to say that certain factors will not differ 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.

B. BACKGROUND: RESULTS OF 2011 STUDY

Summary of Surplus Target Range from 2011 Study – Milliman's May 31, 2011 report presented the conclusions of our analysis of surplus requirements for GHMSI, as follows:

(a) ***Optimal Surplus Target Range for GHMSI*** – *Based on our analysis, we conclude that an appropriate target for GHMSI's surplus falls in the range of **1050% to 1300% of RBC-ACL**[1], taking into account the impact of federal health care reforms currently in effect. These reforms include: (a) the new minimum loss ratio (MLR) standards that became effective in 2011, requiring the payment of rebates if minimum loss ratio levels are not met, (b) the increased regulatory review of premium rate increases, and (c) the new benefit coverage requirements that became effective in 2010 as a result of the passage of the Affordable Care Act (ACA).*

(b) ***Future Adverse Selection and Operation of Exchanges*** – *While we have not directly incorporated in our analysis the potential impact of the health care reform provisions that are scheduled for implementation beginning in 2014 or later, including the new health care exchanges, we have separately considered certain aspects of those provisions. Specifically, we have estimated the impact on the GHMSI surplus target range of potential increases in adverse selection in the individual and small group markets that would not be anticipated in premium rates, and would not be fully offset by the risk mitigation programs that are required by the ACA to be established after the implementation of new rating and underwriting rules in 2014[2].*

*Any such estimate is subject to significantly increased uncertainty, due in part to the current lack of regulations prescribing how the exchanges and the risk mitigation programs will operate, but more importantly, a lack of knowledge as to how health plans, plan sponsors, and consumers will respond. We estimate that the surplus target range for GHMSI could be expected to **increase by 100% to 150%** of RBC-ACL, if the potential for such adverse selection were taken into account. We would characterize this as an indication of the directional nature of the impact of the health care exchanges, rather than a precise quantification of their potential financial consequences.*

[1] 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.

[2] The ACA calls for the following risk mitigation programs to be implemented effective in 2014 and later: (i) transitional reinsurance program for the individual market; (ii) risk corridors for plans in individual and small group markets; and (iii) risk adjustment in the individual and small group markets.

Treatment of Health Care Reform – The health care reform law has had an impact on many aspects of the operations of health plans, and will ultimately have an even far greater impact. While a number of the law's provisions are now in effect, some of the most significant have yet to occur, with many of them scheduled to take effect in 2014. Regulations implementing those provisions are complex, and their effects cannot be fully anticipated at this time. In particular, the impact on individual health plans will depend on not only the specific provisions of the applicable regulations, but also the manner in which they are enforced, and, more importantly, the actions of other health plans and of employers and health plan participants.

Recognizing this complexity and uncertainty, it was impossible at the time of our 2011 study to fully anticipate or reflect in our analysis the impact of health care reform on GHMSI's surplus requirements, and we did not attempt to do so. As noted above, however, we did incorporate techniques to simulate the effects of the minimum loss ratio standards and rebate requirements as well as the potential restrictions on premium rate increases, and we reflected the impact of the new benefit coverage requirements that became effective in 2010.

Pricing Margins – In our 2011 modeling, we assumed an average pricing margin of 2.8% on underwritten business (excluding the Federal Employee Program). The assumed overall average underwriting margin was 1.6%, including FEP business and gains/(losses) from ASC business. Based on our analysis of the financial operations of GHMSI, we estimated that if the company's surplus were at a level equal to 900% of RBC-ACL, an average margin of 2.8% for the non-FEP insured business would be sufficient to maintain that 900% level on an ongoing basis, assuming that premium were to grow at an annual rate of 9% and that experience were to develop as anticipated in pricing. To maintain surplus at the higher levels indicated by our 2011 study (1050% to 1300% of RBC-ACL) would require even greater margins, unless premium growth rates were lower than the 9% assumed.[3]

[3] In this analysis, premium growth is a proxy for growth in claims and expenses, as the two tend to mirror each other to a significant degree. Growth in claims and expenses produces a higher RBC-ACL value, which requires higher surplus in order to maintain a constant percentage.

C. CONSIDERATION OF CURRENT GHMSI CIRCUMSTANCES

As mentioned above, 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 2011 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 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 2011 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 2011 surplus analysis modeling:

- **Pricing Margins** – As noted above, in our 2011 modeling we assumed an average pricing margin of 2.8% on non-FEP underwritten business. The reported underwriting margins for 2011 and 2012, measured on a comparable basis[4], were 1.3% and (1.6)%, respectively. We understand that the significant reduction in margin experienced in 2012 occurred in part due to a decision to limit the level of premium increases in the individual product lines. The incorporation of a lower assumed pricing margin in our 2011 analysis would lead to a higher surplus target, in the absence of other changes in values or assumptions.

  GHMSI (along with CFBC) has filed proposed 2014 premium rates for its individual and small group product lines in each of the jurisdictions within which it operates – i.e., the District of Columbia, Maryland, and Virginia. It is our understanding that in some cases the regulating authorities have approved rates that are lower than those originally filed, and in other cases final approvals may still be pending.

  Based on information provided by GHMSI and CareFirst staff, the overall average pricing margin for 2014 non-FEP underwritten business premiums is estimated to be 2.8%, if the originally filed rates were approved. After reflecting the lower approved rates, however, the implied average overall pricing margin is estimated to be 1.8%. This 1.8% estimate does not reflect the potential impact of the risk corridor programs which will become effective in 2014, and which could be expected to increase the effective margin.

[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 2011 report.

While we understand that current expectations for pricing margins in subsequent years are closer to the 2.8% assumption in our analysis, there is obviously a great deal of uncertainty regarding pricing and experience levels over the next several years. We will consider these factors as part of our update of our GHMSI surplus analysis later this year.

- **Annual Premium Growth** – GHMSI's reported annual premium growth, at 4.6% in 2012, was slightly higher than in previous years (2.2% in 2010 and 3.8% in 2011, considering GHMSI plus its ownership share of CFBC). Based on the company's projections, premium growth is expected to increase in future years, reflecting the anticipated impact of health care reform. We believe it is prudent to assume such future increases, given the potential for membership increases.

- **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 2011 analysis.

Health Care Reform Environment – As mentioned above, the estimated surplus target range produced by our 2011 study did not incorporate the potential impact of the health care reform provisions that are scheduled for implementation beginning in 2014 or later due to the significant uncertainty involved at that time.

We now have additional information regarding the details of these provisions, primarily in the form of the numerous regulations that have been issued by the federal agencies charged with implementing the provisions of the ACA. Additionally, premium rates for plans to be sold in the health care exchanges in the District of Columbia, Maryland and Virginia, as filed by health plans operating in those jurisdictions, have been made public. We have not had an opportunity to examine that premium rate information, but expect to do so as part of our future update.

Though numerous regulations have been issued regarding the implementation of various provisions of the ACA, a great deal of uncertainty remains. The new programs in 2014 include the health care exchanges, the insurance reforms and three new risk mitigation programs. These risk mitigation programs are designed to mitigate the impact of potential adverse selection and stabilize premiums in the individual and small group markets as insurance reforms and the exchanges are implemented.

The manner in which employers and plan participants will react to these changes could significantly alter the composition of GHMSI's membership and risk profile. Because these changes cannot be fully anticipated, they cannot be fully reflected in premium rates.

This continued uncertainty entails financial risk to the company, and therefore tends to indicate the need for higher levels of surplus than would otherwise be considered prudent. In particular, the potential for significant membership growth as the individual mandate takes effect in 2014 would call for conservatism in selecting a surplus target range, given the direct correlation between growth in membership and an increase in the RBC-ACL value: A growth in membership will lead to an increase

in claims and expenses and therefore in the RBC-ACL value, which will in turn lower the surplus when measured as a percentage of RBC-ACL.

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 2011 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.

D. LIMITATIONS AND CAVEATS

Milliman has prepared this report for the specific purpose of providing a brief, limited review of GHMSI surplus targets. 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 2011 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.