IMPACT OF DISTRIBUTION OF SURPLUS BY GROUP HOSPITALIZATION AND MEDICAL SERVICES ON COMMONWEALTH OF VIRGINIA

PRESENTED TO

VIRGINIA BUREAU OF INSURANCE

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Impact of Distribution of Surplus on GHMSI

INTRODUCTION

Lewis & Ellis, Inc. (L&E) was engaged by the Virginia Bureau of Insurance (VBOI) as part of the examination required pursuant to §38.2-4229.2 of the Code of Virginia. This Code Section provides that if another state enacts a law that requires a health services plan operating in the Commonwealth to provide a program or benefits for the residents of the other state, the Commission may conduct a proceeding to review and evaluate the impact of the law on the health services plan. The Commission shall direct the Commissioner to conduct an examination of the health services plan, in accordance with Article 4 (§ 38.2-1317 *et. seq.*) of Chapter 13 and report the findings to the Commission, including the impact on (i) surplus; (ii) premium rates for residents of the Commonwealth covered by policies issued or delivered either in the Commonwealth or in any other state; and (iii) solvency. L&E conducted this study solely to determine the impact of the distribution of surplus by Group Hospitalization and Medical Services, Inc. (GHMSI) on the Commonwealth of Virginia. GHMSI was ordered to make this distribution by the District of Columbia Department of Insurance, Securities and Banking (DISB) on December 30, 2014. DISB found that as of December 31, 2011, GHMSI surplus was excessive and that 21% of GHMSI's surplus is attributable to D.C. residents and insureds of GHMSI. DISB ordered GHMSI to submit a plan to the D.C. Commissioner for distribution of its excess of 2011 surplus attributable to D.C. for community health reinvestment in a fair and equitable manner. Our study focused strictly on the following issues.

a. Impact of the DISB ordered distribution on GHMSI surplus.
b. Impact that the DISB ordered distribution has had or could have on premium rates charged to Virginia residents.
c. Impact of the DISB ordered distribution on GHMSI solvency for Virginia residents.

This report describes the methodology used in our study and presents our findings and observations. The report is intended for the use of the Virginia Bureau of Insurance and the Virginia State Corporation Commission.

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Our study and findings followed and comply with the applicable standards of practice as prescribed by the American Academy of Actuaries.

DATA AND REPORTS REVIEWED

There was a significant amount of research done by DISB, GHMSI and their consulting firms relative to the proper level of surplus that GHMSI needed to retain. Our process was to review those studies and reports pursuant to Section 38.2-4229.2 of the Code of Virginia. With the detail and depth addressed in the reports listed below, L&E concluded there was no further need to prepare an additional detailed study. GHMSI hired Milliman, Inc. to prepare a recommendation on appropriate levels of surplus. CareFirst, Inc., parent of GHMSI, hired The Lewin Group to prepare a recommendation on appropriate levels of surplus. Finally, DISB hired Rector & Associates, Inc. to review the calculations prepared by Milliman. There were several follow-up models prepared by Milliman in response to questions and requests from Rector so we felt the issue was fully explored and analyzed. The material L&E reviewed is provided on the first page of the Appendix which will also include copies of each of the reports reviewed. See the Organizational Chart (from Schedule Y of the 2014 Annual Statement) attached to the report for corporate structure of GHMSI.

Impact of Distribution on GHMSI Surplus

The DISB Order No. 14-MIE-012 states that the appropriate level for GHMSI surplus was 721% of RBC-ACL. This equates to a 95% confidence interval that surplus will not drop below the 200% RBC-ACL trigger (Authorized Control Level). The definition of RBC-ACL is in the Appendix portion of this report. This level was developed in review item 7 in the Appendix. At December 31, 2011 the actual GHMSI surplus was $963,581,310 which is equivalent to 998.3% of the RBC-ACL of $96,518,715. Also in the DISB Order, the portion of the GHMSI surplus attributable to the District of Columbia is 21%. The table below develops the impact of the distribution on the December 31, 2011 and the December 31, 2014 GHMSI surplus.

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	12-31-2011 Results	12-31-2014 Results
Actual Yearend GHMSI Surplus	$963,581,310	$934,408,634
Yearend RBC-ACL	$96,518,715	$106,473,786
12-31-2011 Surplus at 721% of RBC-ACL	$695,899,935	
Surplus above 721% at 12-31-2011	$267,681,375	
DC Distribution at 21% of excess	$56,213,089	$56,213,089
Yearend Surplus after distribution	$907,368,221	$878,195,545
Surplus % of RBC-ACL after distribution	940.1%	824.8%

So after the DC distribution, there will still be surplus remaining equivalent to 940% of the RBC-ACL at December 31, 2011 and 825% at December 31, 2014.

Impact of Distribution on GHMSI Rates to Virginia Residents

L&E reviewed past rate filings made by GHMSI with the VBOI. The most likely component of a rate filing to be impacted by the surplus distribution or excessive surplus will be in the Contribution to Reserve (CtR) component that is part of the rate filing. An explanation of Contribution to Reserve is included with the Appendix. If there is excessive surplus then GHMSI may lower or eliminate the CtR included in the rates. We looked at all the components of the rate filing but paid particular attention to the CtR component.

The rate filing methodology used by GHMSI is as follows.

1. Start with the most current 12 months of data, including enrollment, revenue and claims. Claims will have 2-3 months of run-out and then are completed.
2. Claims are trended using a trend derived based on prior history and the most current direction of the observed rolling 12 month trend.
3. The rolling 12 month trend is normalized for changes in benefits and rate-ups (changes in rates due to age, area, etc.).
4. After applying trend, GHMSI determines the amount of revenue needed to match the Desired Incurred Claims Ratio.

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5. Adjustments are applied to written premium using Income Adjustment Factors to account for all prior rate changes. This provides the Income at Current Rate Level.
6. The "Needed Incremental" rate change equals the revenue needed adjusted by the Income at Current Rate Level.

The CtR component did change in the 15 rate filings reviewed. The CtR values are expressed as a percent of premium. The adjustments to the Contribution to Reserve within the filings are explained as follows.

2012 – Contribution to Reserve (CtR) and federal taxes increased 2.5% due to the higher RBC range. The CtR + Tax equaled -5.0% at July 1, 2012 and increased to -2.5% at October 1, 2012. GHMSI indicated that the increase was previously modeled for VBOI and they expected to keep increasing CtR until it was positive. GHMSI indicated that the higher RBC range comes from the recommendations by Milliman and Lewin for GHMSI and CareFirst of Maryland, Inc. (CFMI) equal to 1000-1300% and 1050-1350%, respectively.

January 1, 2013 - Contribution to reserve (CtR) and federal taxes increased 2.5%, due to the higher RBC range. The CtR + Tax equaled 0.0% at January 1, 2013.

April 1, 2013 - Contribution to reserve (CtR) and federal taxes increased 1.0%, due to the higher RBC range. The CtR + Tax equaled 1.0% at April 1, 2013.

July 1, 2013 - Contribution to reserve (CtR) and federal taxes increased 2.0%, due to the higher RBC range. The CtR + Tax equaled 3.0% at July 1, 2013.

2014 and 2015 - Contribution to reserve (CtR) and federal taxes decreased 3.0% so they equaled 0.0%. This set them at a level consistent with Exchange filings and the GHMSI corporate mission to provide affordable and accessible care. For Small Group policies, the CtR equaled 3.2%.

Based on rate filings with effective dates for 2012 through 2015, the CtR has had a number of changes. The changes for 2012 and 2013 were tied to the target RBC range (1050% - 1300% of RBC-ACL). The changes for 2014 and 2015 were based on consistency with rates filed on the

Exchange. Typically, the CtR would tie to the target surplus levels as observed for 2012 and 2013. But market considerations (Exchange) resulted in different changes in 2014 and 2015.

If the DISB ruling is used as the target surplus, then CtR will remain at 0% or maybe even be negative to lower the ratio to 721% of RBC-ACL. This will result in lower rate of growth. If the higher target surplus ratios recommended by Milliman/Lewin are used then the CtR will likely adjust to a higher level and be greater than 0% when the actual surplus is below the target level. This would result in higher rate increases versus the rate changes with the lower surplus target from DISB.

Impact of Distribution on GHMSI Solvency

There was a significant discussion leading up to the DISB Order 14-MIE-012. The sequence of events in the discussion leading to the DISB decision is described below.

A. CareFirst, Inc./GHMSI hired two actuarial firms to analyze and prepare recommendations for target surplus levels for December 31, 2011. Both firms created models simulating thousands of scenarios to determine appropriate surplus levels. Both determined that the best benchmark threshold would be the NAIC 200% RBC-ACL level. The major decision point for the 200% RBC-ACL is the target confidence interval (CI) for the surplus. Values ranging from 70% to 98% were tested. The two models were similar and both provided a range of values for the appropriate surplus.

Milliman (hired by GHMSI)	1050 – 1300% of RBC-ACL / 98% CI
Lewin (hired by CareFirst/GHMSI)	1000 – 1550% of RBC-ACL / 95% CI

L&E Comment – The Milliman range is the range approved by the GHMSI board and used in subsequent rate filings in 2012 and 2013.

B. In 2013, DISB hired Rector & Associates to review the target surplus level being used by GHMSI and prepare recommendations for appropriate surplus. Rector issued their report on December 9, 2013. Rector worked predominantly with the Milliman analysis and made the following changes to the Milliman assumptions, Model and recommendations.

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a) Milliman applied premium growth (7% and 11%) and trend miss (period of time actual trend differs from anticipated trend – 2 years and 3 years) assumptions after the stochastic modeling process. Rector asked them to make the two assumptions part of the stochastic model.

b) Removed effect of restricted rate increases used in rating adequacy and fluctuation uncertainty.

c) Removed base charge of 2.5% (of non FEP premium) from catastrophic events uncertainty assumption.

d) Lowered the provision for unidentified growth and development (9% versus 20%).

Rector agreed with Milliman use of 200% RBC-ACL and a 98% confidence interval. After Milliman reran their model with the Rector changes, Rector identified a target of 958% of RBC-ACL. Using the year to year change in RBC ratio for 2004 – 2012 of 82.5% then the Rector range for target surplus is 875% (958% - 82.5%) - 1040% (958% + 82.5%) RBC-ACL.

L&E Comment – The Rector adjustments make sense and are more reasonable when reviewing historical results. The premium growth assumptions recommended by Rector (9.1% to 16.1%) do seem high.

C. October 2014, Milliman provided additional target calculations per requests from DISB. These changes were applied to the Milliman model modified per Rector suggestions. The key changes were an alternate premium growth rate and different confidence levels. The two tables below display the changes and resulting surplus targets.

Non-FEP Business			FEP Business	
Previous Growth Rate	Alternative Growth rate	Probability	Growth Rate	Probability
9.1%	4.5%	25%	6.5%	25%
12.4%	8.0%	50%	7.5%	50%
16.1%	12.2%	25%	8.4%	25%

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L&E Comment – The alternative growth rate is more consistent with the historical measured values for GHMSI. The values are slightly higher than measured values for 2005 to 2014 but they do recognize additional growth from ACA enrollment.

Surplus Target Calculations – Based on Modified Milliman Model

Using 200% RBC-ACL as Base

Confidence Level	Previous Growth rate	Alternative Growth Rate
90%	631%	575%
93%	714%	653%
95%	788%	721%
98%	958%	880%

DISB chose the alternative growth rate model and the 95% confidence level as the target surplus level (721%) using the 200% RBC-ACL as the benchmark.

L&E agrees with the alternative growth rate but we consider the 98% confidence level to be more appropriate for a target surplus (880%) with 200% RBC-ACL as the benchmark. L&E also thinks that using +/- 82.5% to set the range is appropriate. Our recommended target range is therefore, 798% (880% - 82.5%) - 963% (880% + 82.5%) of RBC-ACL.

Since the DISB distribution has not been applied yet, let's consider the impact to December 31, 2014. If the full $56,213,089 were deducted at December 31, 2014, the remaining capital is $878,195,545. This equates to 824.8% RBC-ACL. Solvency is still maintained within the L&E recommended range (798% - 963%) after the distribution, assuming it is only done based on the 12-31-2011 valuation.

Conclusions

Pursuant to §38.2-4229.2 of the Code of Virginia, we have the following conclusions, assuming a one-time only distribution of $56,213,089 regarding the impact on:

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i. Surplus; the distribution of the $56,213,089 (12-31-2011 value) reduces the capital and surplus roughly 6% when applied to the initial capital and surplus reported at each year end for 2011 through 2014.

ii. Premium rates for Commonwealth residents; if the DISB target surplus is the target surplus, then the contribution to reserve level will be lower and rate changes will be lower.

iii. Solvency; the distribution will lower the capital and surplus level and the ratio to RBC-ACL but the ratio to RBC-ACL will not drop lower than the range of 798% - 963% that L&E recommends as a sufficient level relative to the NAIC 200% RBC-ACL level.

Our conclusions are based on information supplied by the Virginia Bureau of Insurance and the D.C. Department of Insurance, Securities and Banking. The evaluations performed have all been based on comparisons to RBC-ACL. In the future, VBOI will have the use of Own Risk and Solvency Assessment (ORSA) (See Appendix for definition) to provide an additional analysis for determining appropriate levels of capital and surplus in addition to RBC-ACL. ORSA is a confidential document prepared by insurers for use by the VBOI only.

SPECIAL CASE OF THE 2015 HEALTH INSURER FEE

The Affordable Care Act (ACA) included an annual assessment to be paid by health insurers. The assessment became effective January 1, 2014. Statement of Statutory Accounting Principles SSAP No. 106 (Affordable Care Act Section 9010 Assessment) was issued to address the impact of the Health Insurer Fee (HIF) on health insurers and financial statement reporting requirements. GMHSI is required to follow these Statements of Statutory Accounting Practices in the development of their financial statements.

SSAP No. 106 requires that health insurers reclassify from unassigned surplus to special surplus an amount estimated to equal the subsequent year assessment. As of December 31, 2014, a portion of the $934,408,634 capital and surplus was allocated to a Special Surplus account of

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$70,000,000 for the 2015 Health Insurer Fee (HIF). This left unassigned surplus at $864,408,634. This Health Insurer Fee is determined as follows.

- The annual fee applies to covered entities engaged in the business of providing health insurance in the United States.
- A covered entity is liable for the annual fee if its aggregate net premiums for covered health insurance policies exceed $25 million in the calendar year (2014) immediately preceding the year in which the fee is assessed and they have covered health insurance in force on January 1 of the fee year (2015).
- The annual fee is due by September 30 of each applicable fee year.
- The amount of the annual fee equals the health insurer portion of the total covered health insurance of all health insurers times the total to be collected for the calendar year. For 2014, the total to be collected is $8 billion. For 2015, the total to be collected is $11.3 billion. The GHMSI fee of $70 million equates to 0.62% of the $11.3 billion total.

GHMSI did pay the 2014 Health Insurer Fee in 2014 and that amount was $45,743,000.

At December 31, 2014, GHMSI was not technically liable for the 2015 fee. However, GHMSI continued to have health insurance business into 2015 so it did become liable for the 2015 HIF on January 1, 2015 per SSAP No. 106. At this point, the $70 million becomes a liability on the balance sheet and capital and surplus drops to $864.4 million. In addition to the $70 million GHMSI owes, their assets are reduced by another $27.5 million for their 50% share in the 2015 HIF for which CareFirst Blue Choice, Inc. (CFBC) will be responsible. According to the required accounting treatment, the capital and surplus at January 1, 2015 is further reduced to $836,908,634. The following table displays the impact to capital and surplus at January 1, 2015 following the requirements of SSAP No. 106 after the DISB distribution is applied.

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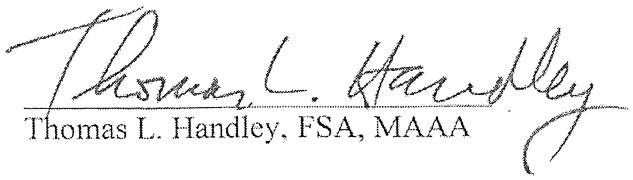
	12-31-2014 Results	1-1-2015 Results
Actual Yearend GHMSI Surplus	$934,408,634	$934,408,634
Yearend RBC-ACL	$106,473,786	$106,473,786
1-1-2015 HIF (GHMSI, CFBC)		$97,500,000
Capital and surplus 1-1-2015		$836,908,634
DC Distribution at 21% of excess	$56,213,089	$56,213,089
Surplus after distribution	$878,195,545	$780,695,545
Surplus % of RBC-ACL after distribution	824.8%	733.2%

With the statutory accounting requirements applicable to the Health Insurer Fee, as of January 1, 2015, the capital and surplus falls below the low end of the range (798%) recommended by L&E to maintain long term solvency. Therefore, following statutory guidelines, on January 1, 2015, payment of the DISB distribution ($56 million) will have an adverse impact to GHMSI long term solvency.

However, during 2015 GHMSI will collect revenue sufficient to pay this fee. Statutory accounting principles do not allow insurers to recognize this future fee revenue at the time the liability is recognized. The GHMSI rate filings began including a load for this fee beginning July 2013 (for the 2014 fee year). Subsequent rate filings have continued to include rate loadings sufficient to pay this fee when due. When the $70 million (estimated) is required to be paid no later than September 30, 2015, GHMSI will have collected sufficient revenue to pay it. The same can be argued for CareFirst Blue Choice and its 2015 HIF liability. At that point, capital and surplus will be back to $934.4 million, all other items remaining unchanged. Since the decrease in capital and surplus is only temporary and cash is not impacted, L&E does not believe that the 2015 Health Insurance Fee should be considered in the determination of the impact of the DISB distribution on GHMSI surplus. We understand that this is contrary to the statutory calculations for January 1, 2015, discussed above but believe a full recognition of the 2015 HIF should include consideration of the revenues to be collected.

Respectfully Submitted,



Thomas L. Handley, FSA, MAAA

Lewis & Ellis, Inc.

April 8, 2015

APPENDIX

Reports Reviewed by Lewis & Ellis, Inc.

Attachment 1:	Milliman Response to DISB (UNDER SEAL)
Attachment 2:	Milliman Response to Rector Request (UNDER SEAL)
Attachment 3:	Milliman Report on Optimal Surplus Target Range (5/31/11)
Attachment 4:	Milliman Report on Optimal Surplus Target Range (12/4/08)
Attachment 5:	CareFirst Request for Action letter from Burrell (1/22/15)
Attachment 6:	Rector & Associates Report to DISB (12/9/13)
Attachment 7:	Milliman Response to DISB Order (10/15/14)
Attachment 8:	DISB Order No. 14-MIE-012
Attachment 9:	Lewin Report on Recommended Surplus Range (5/20/11)
Attachment 10:	Rector Response on Premium Growth and ACA Reforms (3/31/14)
Attachment 11:	GHMSI/Milliman Response on Attributable Surplus (10/31/14)
Attachment 12:	Rector Review of GHMSI/Milliman Response
Attachment 13:	GHMSI Annual Reports 2009-2013, 9/30/14 Quarterly Report
Attachment 14:	Links to GHMSI Virginia Rate Filings for 2012-2015
Attachment 15:	GHMSI 2014 Annual Report