

January 18, 2013

Mr. Walter Smith, Esq.
The DC Appleseed Center for Law and Justice, Inc
1111 14th Street NW, Suite 510
Washington, DC 20005

RE: Group Hospitalization and Medical Services, Inc. (“GHMSI”) Surplus

Dear Mr. Smith,

At your request, based on our recent January 10th meeting at the DISB, I am summarizing my thoughts regarding the appropriateness of the surplus levels of GHMSI and the independent review of GHMSI’s surplus which is being undertaken by Rector and Associates, Inc. (“Rector”).

Based on the discussion at our meeting, I have the following specific suggestions concerning how Rector should approach the model that will determine the appropriate level of GHMSI’s surplus. I have divided my suggestions among the five issues that were the primary topics of discussion related to the model: (1) loss cycles; (2) catastrophic events and unidentified growth and development; (3) revenue growth assumptions; (4) the Affordable Care Act; and (5) confidence intervals.

1. Loss Cycles

- A. The Milliman model apparently takes a number of potential events and probabilities of variations of outcome for each such event and aggregates them to create a “loss cycle”. To date, we have not been provided any information concerning the probabilities/values for any given event or the overall curve of potential losses. The potential losses and the magnitude and probability thereof are apparently not based simply on GHMSI data, but on other insurer data as well as judgment.¹ We assume that full disclosure about these issues will be made to Rector. We believe this same information should be provided to us so we can assess its reasonableness. Otherwise, our assessments of whether the use of loss cycles in the model is fair and in the public interest would likely be based on different data, which could give rise to needless complexity and controversy.
- B. After review of each modeled event and the appropriateness of the corresponding probabilities and outcomes thereof, there should be a validation of the overall aggregated “loss cycle” against historic GHMSI results – specifically the last 15

¹ On page 16 of Milliman’s May 31, 2011 report, they describe the development of the probabilities and values as being based partially on some undisclosed data from “various” Blue Cross and Blue Shield plans and partially on professional judgment. Full disclosure is needed to determine the appropriateness and applicability of the source data used and to open the judgmental aspects to review by other qualified actuaries.

years. It is during this time period that modern capital standards and management approaches have been consistently applied both by GHMSI and the market and have been reflected in company results. I believe the appropriateness of the aggregated loss cycle will be demonstrated by:

- 1) The 50th percentile of the loss cycle curve should be consistent with average GHMSI net underwriting results (across all product lines, not just non-FEP) over the last 10-15 years. For all product lines combined, GHMSI's average net underwriting gain over the last 15 years has been 1.5%, and over the last 10 years has also been 1.5%.
- 2) The variability in underwriting gains and losses (again, across all product lines) results will be consistent with the variability GHMSI has seen over the last 10-15 years. Over the last 15 years the largest underwriting loss has been -0.1% and the largest gain has been 3.9%. The standard deviation in results has been 1.1%.
- 3) Given the results of a) and b) and assuming a normal distribution, this would indicate that to be realistic the aggregate loss cycle should have approximately 95.4% of the results being within 2 standard deviations of the mean or between a 3.7% gain and a -0.7% loss.

2. Catastrophic Events and Unidentified Growth and Development

Per the discussion at the meeting, it appears that Milliman has included a charge of 2.5% for catastrophic events and a charge of 2% for unidentified growth and development in every scenario in its model. There is an obvious issue with this - any event that occurs in every scenario is neither catastrophic nor unidentified. Moreover, to the extent that these items occur on a regular basis they are already built into the historic results of the company. I therefore completely agree with the proposition that Rector stated in its original report² with respect to each of these items, "a separate provision in surplus for this amount would not be needed."

It should also be noted that the recurring charge for catastrophic events was only the beginning of the charges that Milliman built into the model for catastrophic events. They indicated there are other catastrophic event charges ranging from 0-5% with varying probabilities for such events.

Finally, as I shared at the meeting based on my experience as a senior executive at three different Fortune 500 insurers, charges for unidentified growth and development only occur when there is an opportunity to make some additional profits and to the extent that such costs arise, there would be a cost/benefit analysis of the opportunity conducted and the expenditures would only be made if the expected profit from the opportunity would more than offset the costs. This makes an additional charge to surplus inappropriate.

² See pages 6 and 7 of the Rector and Associates report.

3. Revenue Growth

I continue to believe the assumptions for revenue growth in the Milliman model are too high. We discussed the calculation of growth rates at the meeting and there were 3 different outcomes: 2.0% (calculated as the compound growth rates of GHMSI revenue from 2007-2011), 2.6% (calculated as the compound growth rate of GHMSI revenue from 2008-2011) and 4.8% (calculated by Milliman excluding FEP premium, but including revenues from BlueChoice). However, the Milliman model tests surplus *only* at 7% and 11% growth rates. A reasonable range should include actually experienced growth rates. I propose that the range of growth rates tested be 2% to 6% - which would include the experienced growth rate (no matter how calculated) and also be sufficient to test a higher than experienced growth rate.

4. Affordable Care Act

Milliman's accounting for the provisions of the Affordable Care Act (ACA) do not appear to me to be appropriate. There are two separate sets of impacts to be evaluated under ACA – the changes that have already been implemented and the changes that will begin to be implemented effective 1/1/2014. I will discuss these two separately:

- A. The changes that have already been implemented under ACA (elimination of annual limits, dependent eligibility, 1st dollar wellness benefits, medical loss ratios, etc.) have already been incorporated in market prices and experience with no significant perceptible negative impacts on GHMSI (or most other insurers for that matter). Despite this, the Milliman model has attached dramatic and costly risk impacts to the already implemented changes of ACA³. They attach a loss of 8-9% of non-FEP premium at the 98th percentile and a 5-6% of non-FEP premium impact at the 90th percentile. How they came to these estimates is not apparent, but these impacts appear to be wholly inconsistent with GHMSI and industry experience. I recommend that any adjustments to the model for changes already implemented under ACA be shared and explained so they can be reviewed for reasonableness. I also recommend that those changes be based on actual experience.
- B. The changes that have yet to be implemented under ACA include exchanges, subsidies to insureds, and insurer risk mitigation tools (reinsurance, risk corridors and risk adjustment). As discussed at the meeting and confirmed by CareFirst's Kenny Kan, CMS has recently conducted a simulation of what may happen when these changes are implemented. The result for the Blues plan in the simulation was favorable – both increased revenues and profits. As a result, I do not believe that the model should speculatively include additional surplus for what is likely a positive event for the company. Milliman indicated at the meeting they tweaked a few assumptions in their model and were seeing potential negative impacts of 100-150% of RBC-ACL. As with adjustments to the model made for changes already implemented in the ACA, I recommend that any adjustments made based

³ See Chart 6 of the Milliman May 31, 2011 report.

on expected future impacts be explained and shared, and that they be based on expected actual impacts on GHMSI.

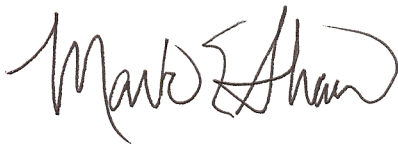
5. Confidence Intervals

Confidence intervals were discussed at the meeting. Milliman has proposed a “near certainty” threshold of 98% relative to the 200% RBC, which is itself twice the level at which regulatory intervention is authorized. I concur as to the reasonability of that threshold as long as the “loss cycle” that determines 98% is appropriately constructed. I agree with Rector’s suggestion at the meeting that a surplus level with that degree of protection does not need the added protection of additional surplus to guard against falling below the Blue Cross Blue Shield Association 375% Increased Monitoring threshold.

In any case, everyone agrees that a lower level of confidence should be used with regard to the 375% level. Dipping below that level does not have an immediate impact on policyholders (after all, it is almost double the 200% standard which itself was set by the NAIC at a level designed to be protective). Milliman proposed a “high likelihood” standard be applicable. I believe that a 75% threshold is consistent with that language and given that CareFirst was not able to articulate at the meeting any certain impacts⁴ of dropping below that threshold, I believe any higher standard is excessive. Thus, my proposal would be that if the 375% level is to be used at all, the target surplus that GHMSI should manage to is the higher of what is needed to be 98% certain of remaining above 200% RBC-ACL and 75% certain of remaining above 375% RBC-ACL.

I am available to clarify or expound on any of the recommendations made herein. I am also available to review the detailed model and data to make the recommended adjustments in order to produce an appropriate surplus range for GHMSI. I again offer to sign an appropriate confidentiality agreement to facilitate that review.

Sincerely,



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⁴ CareFirst stated that the most likely impact of dipping below 375% RBC-ACL would be a loss of confidence among some large groups. The quantification of that loss of confidence was not proffered.