Milliman

District of Columbia Department of Insurance, Securities and Banking

Public Hearing to Review the Surplus and Community Health Re-Investment of GHMSI June 25, 2014

Testimony of Phyllis Doran, F.S.A., M.A.A.A.

INTRODUCTION AND BACKGROUND

I, Phyllis Doran, am a consulting actuary with Milliman and am presenting this testimony at the request of our client, Group Hospitalization and Medical Services, Inc. (GHMSI). I am a Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries, and I meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinions contained herein. I have been employed by Milliman as a Consulting Actuary working with health insurance plans for over 30 years. I have served as a board member and a vice president of the Society of Actuaries.

Milliman is among the world's largest independent actuarial and consulting firms. We have an outstanding reputation and are widely recognized in the health care industry as the premier actuarial firm, with 270 fully qualified health actuaries. We have worked for the majority of Blue Cross and Blue Shield Plans and other health insurance companies and performed numerous surplus evaluations in addition to advising companies on surplus related issues.

The purpose of this testimony is to preliminarily address certain erroneous assumptions and conclusions set forth in the reports submitted by D.C. Appleseed and Mark Shaw on June 10, 2014. I am working on a full written response to Mr. Shaw's report, and I plan to submit that response into the post-hearing record.

ANALYSIS AND CONCLUSIONS

I. Appleseed's proposed 90% confidence level is not consistent with financial soundness.

Appleseed proposes that the Commissioner should adopt an analysis giving GHMSI only 90% confidence of remaining above 200% RBC-ACL. As I testify below, that confidence level is unreasonably low.

There has been wide support among other actuaries who have reviewed GHMSI's surplus -- including Mark Shaw[1] -- for a confidence level of 98%. In January 2013, I attended a meeting at DISB's offices, as part of these proceedings. Both Mr. Shaw and representatives of D.C. Appleseed agreed at that meeting and in subsequent correspondence that 98% was the appropriate confidence level for assessing GHMSI's likelihood of remaining above 200% RBC-ACL. In addition, Walter Smith of D.C. Appleseed has stated, with respect to the use of a standard involving *". . . a surplus that avoids falling below 200% RBC with 98% confidence. . .,"* that *"It seems to us that this is sufficient to protect soundness and efficiency, both as a matter of actuarial soundness, as well as under the MIEAA standard."*[2]

The State of Maryland has also endorsed a 98% confidence level. In its 2012 Consent Order, it adopted the analysis of its consultant, RSM McGladrey, Inc., which approved a 98% confidence metric as reasonable.

Those conclusions comport with other analogous data points in the industry. To take just one example, under the Standard & Poor's Rating Services' risk-based capital (RBC) adequacy model for insurers, a 99.4% confidence level is required for A ratings, 99.7% for AA, and 99.9% for AAA. Under their rating system a 90% confidence level would equate to junk status.

Appleseed's proposed confidence level permits an excessive level of risk. Under Appleseed's approach, the Company would have a 1 in 10 chance of falling below 200% RBC-ACL. In other words, one could expect that GHMSI's surplus would fall below 200% RBC-ACL, triggering regulatory supervision and potential loss of the BlueCross BlueShield trademarks, once every ten years. Such a risk is exceedingly high and not financially sound. To the contrary, we find that the use of a 98% confidence level is reasonable, financially sound, and widespread in the insurance industry.

Appleseed takes issue with the significance of the 200% RBC-ACL threshold, stating that BCBSA would not act to terminate GHMSI's license if GHMSI fell below that level.

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[1] Letter from Mark Shaw to Walter Smith, dated April 12, 2012, Page 5, *available at* http://disb.dc.gov/node/311282; and Letter from Mark Shaw to Walter Smith, dated January 18, 2013, Page 4, *available at* http://disb.dc.gov/node/850492

[2] Letter from Walter Smith to Sarah Schroeder, dated January 18, 2013, Page 4, *available at* http://disb.dc.gov/node/850492

Appleseed, however, provides no support for its assertion, which appears unfounded. The BCBSA has maintained capital benchmarks and minimum surplus requirements for many years, not just because of the "credibility of the Blues brand" as cited by Appleseed, but also because of the risk of liability to all other Blues entities if one member plan becomes insolvent.

In this regard, BCBSA has informed Commissioner McPherson in its letter dated June 24, 2014[3] that *"If a Plan's HRBC ratio were to fall below 200 percent, BCBSA's Board of Directors (composed of the CEO's of all 37 Plans and BCBSA) would immediately commence actions to terminate that company's license to use the Blue Brands. BCBSA intentionally set its minimum capital requirement at the same point as the highest of the four Levels of Action under the NAIC"s Risk-Based Capital Model Act."*

In short, Appleseed's argument that falling below 200% RBC-ACL would not entail serious consequences for GHMSI is without merit and without any evidence to support it.

II. Mr. Shaw's calculations have a number of serious errors and omissions.

I explore the problems with Mr. Shaw's proposed adjustments in some detail in my testimony below. But it bears noting at the outset that Mr. Shaw's analysis contains a number of basic analytical, conceptual, and factual errors that skew his results. A few examples:

1. Mr. Shaw's conclusions with respect to rating adequacy and fluctuation risk should be disregarded since they are based on an approach that is indirect, potentially biased, and of limited (if any) applicability to GHMSI. He inappropriately limits the range of possible outcomes to those experienced by a small group of companies that he handpicked, including companies that are not comparable to GHMSI in terms of size, mix of business, or nonprofit status and that do not even satisfy the criteria that he articulated for selecting them. He also limited his analysis to the twelve-year period between 2002 and 2013, a period of unprecedented stability in health plan underwriting results. His approach fails to encompass the universe of potential financial outcomes for GHMSI, which is an essential element of risk analysis. I address this issue in greater detail below.

2. In his discussion of the Affordable Care Act ("ACA"), Mr. Shaw inappropriately limits his analysis to those provisions intended to *mitigate* risk, ignoring entirely the features of the ACA that will enhance risk. Further, his application of the provisions he does consider is flawed in several respects. Specifically, Mr. Shaw misapplies the medical loss ratio ("MLR") rules by erroneously assuming that every segment of GHMSI's business will achieve a gain if GHMSI achieves an overall gain.

[3] Letter from Scott B Serota, President and Chief Executive Officer, BlueCross BlueShield Association, to The Honorable Chester A. McPherson, Interim Insurance Commissioner, DISB, dated June 24, 2014.

That is not correct. Between GHMSI and BlueChoice, there are 18 different market segments in which GHMSI may suffer a loss or be required to pay rebates *independent* of any other results in any other market segments. Mr. Shaw also incorrectly implies in his calculations that the risk corridors program applies to all business when it actually applies only to portions of the individual and small group markets.

3. In his analysis of Equity Portfolio Asset Values ("EPAV"), Mr. Shaw makes several serious conceptual errors. First, he double-counts the revenue generated by returns on corporate equity assets. Second, he inappropriately includes returns on pension assets, which are already reflected in the pension valuation; this treatment is duplicative. Third, he omits CareFirst BlueChoice ("CFBC") premium and equity amounts, thereby significantly overstating the impact of expected asset returns. I explain these errors in greater detail below.

4. Mr. Shaw's analysis of the premium growth ratio is based on an examination of premium increases for the limited and uncharacteristic five-year period between 2009 and 2013. This produces an average growth assumption that is unreasonably low for the purpose of establishing a surplus target for the company, particularly in anticipation of an improving economy and the implementation of health care reform. Potential growth due to the individual and employer mandates, as well as possible increases in medical costs due to enrollment of higher-cost individuals, coupled with the ACA fees and other marketplace influences all contribute to a likelihood that premium growth rates will increase in future years. As is true of Mr. Shaw's rating adequacy analysis, there is no reasonable basis to believe that the negative patterns with respect to premium growth that occurred during the particular years that he selected will continue. To the contrary, improving economic circumstances and the implementation of health care reform are likely to lead to an upturn in premium growth. I discuss this in more detail below.

5. Mr. Shaw's conclusion regarding a reduction in GHMSI's expense and the impact that such a reduction would have on the company's target surplus should be disregarded completely as simply wrong. Mr. Shaw's treatment of this item implies that he believes that any reduction in expense level that might occur for GHMSI would be kept by the company year after year as profit; this obviously would not be the case, either as a matter of GHMSI policy or of DISB oversight. In addition, he concludes that GHMSI is inefficient administratively using only a gross comparison among a selection of hand-picked "peer" companies, with no attempt to adjust for differences in characteristics among companies and their marketing and operating environments, some of which are clearly apparent without any detailed analysis. I explain these errors and inadequacies in greater detail below.

III. Many of Mr. Shaw's proposed adjustments are either based on an incorrect understanding or actuarially unsound.

In the testimony below, I explain why each of Mr. Shaw's proposed adjustments is either based on an incorrect understanding or actuarially unsound. I intend to expand on this testimony in Milliman's planned post-hearing report.

A. Rating Adequacy and Fluctuation

In choosing his assumptions for rating adequacy and fluctuation, Mr. Shaw has chosen to tablulate underwriting results from a disparate group of health plans as a "proxy" which he attempts to extend to GHMSI. For this proxy, he uses the underwriting results reported by a handpicked group of 10 companies reflecting varying corporate structures, conducting business in different markets, offering a different mix of products, and operating under widely varying practices and circumstances; therefore, Mr. Shaw's approach relies on indirect inferences and is potentially biased in any applicability to rating adequacy and fluctuation for GHMSI.

In contrast to Mr. Shaw's arbitrary selection of 10 companies, which involved using underwriting gain/(loss) percentages from statutory filings for each of the companies for a specific period of 12 years, Milliman's approach simulates GHMSI's rating processes using a large universe of health care costs (nationwide health expenditures for the non-Medicare population), measured over an extended period of time (from 1986 through 2010). This approach focused directly on measuring rating adequacy and fluctuations, using GHMSI's rating approaches applied to a data set of health care costs that represents a diverse range of potential circumstances.

Overall, we believe that it cannot be reasonably assumed that the many factors affecting underwriting results at a handful of selected companies -- factors such as pricing practices, regulatory restrictions, marketing strategy, mix of products, healthcare delivery networks and competitive environments, and state and local taxes and fees -- are sufficiently consistent with those of GHMSI to justify the use of these results to assess surplus requirements for GHMSI. Additionally, historical underwriting results as measured from the statutory statements of health insurance companies are subject to accounting differences -- particularly the treatment of self-funded or ASC groups and of the "other income/expense" category -- that can distort comparisons among companies. As a result, we conclude that Mr. Shaw's approach to evaluating the rating adequacy and fluctuation risk should be disregarded since it is indirect, potentially biased, and of limited (if any) applicability to GHMSI. We believe that Milliman's approach to simulating rate adequacy and fluctuations directly for GHMSI is robust, sound, and superior.

In one instance Mr. Shaw has misidentified a Blue Plan subsidiary as the company

itself,[4] and in no instance has he included ownership interests in subsidiaries and affiliates (i.e., the parent Blue Cross Blue Shield Plan plus its subsidiaries and owned affiliates). Further, we observed Mr. Shaw did not, in fact, select the 10 Blue Cross Blue Shield Plans most comparable to GHMSI in non-FEP premium revenue in the 2000's, although he claims to have done so in his report.

While he referenced the Invotex report as a source for some of the companies, we noted that there were two companies identified by Invotex that Mr. Shaw chose not to include. Those two companies experienced net underwriting losses overall during the 2002-2013 time period that Mr. Shaw selected, while each of the companies that he did include experienced overall net gains during that period. His approach is infinitely malleable – selection of ten different companies would lead to completely different results from those posited by Mr. Shaw, and he makes no effort to explain why other companies were excluded from his analysis.

In addition to the inappropriateness of the approach and problems with Mr. Shaw's selection of "peer" companies, the period of time covered in his inter-company analysis, 2002 to 2013, is a period of relatively favorable underwriting experience. Among these 10 companies, all but 3 experienced underwriting losses at some point in the preceding 3 years (1999-2001) and all but one of them in the preceding 5 years (1997-2001). Leaving such periods of loss out of the study period results in a distorted distribution of gain/loss amounts.

The time period selected by Mr. Shaw was historically unprecedented in terms of the relative stability of underwriting results. For purposes of developing a surplus target which is intended to ensure the company's financial viability, it is not appropriate to assume that this level of stability will continue in the future nor to assume that a limited sample of observed events represents the universe of potential outcomes.

B. Equity Portfolio Asset Values (EPAV)

Mr. Shaw argues that Rector's surplus target should be reduced by $216 million based on a supposed evaluation of the Company's expected equity returns, but his analysis underlying that argument is completely wrong based on a number of analytical errors.

As a conceptual point, Mr. Shaw's approach to calculating EPAV assumptions results in "double counting" of the revenue generated by returns on equity assets. Milliman's pro forma projection model generates annual investment income based on an expected average rate of return. The purpose of the risk assessment for return on equities is to reflect the risk that the actual rate of return deviates from this average rate, and our assumed EPAV values represent the financial impact of such deviations. In Mr. Shaw's distribution the assumed values represent three-year full rates of return, rather than deviations from an expected rate of return. The result

[4] Mr. Shaw lists Horizon Blue Cross Blue Shield of NJ on page 10 of his report, but includes data for its HMO subsidiary only.

is that, in Mr. Shaw's model, GHMSI's return on corporate equities would be more than double what could reasonably be expected, i.e., it is double counted.

Mr. Shaw's analysis of the EPAV is also flawed because:

1. It includes returns on pension assets. This produces an overstatement in the level of expected returns, because future returns on pension assets are already incorporated in reported pension values. Milliman's approach reflects the impact of a deviation in the rate of return on pension assets from the assumption underlying the reported values; and

2. It omits CFBC premium and equity amounts in the development of the ratio of equity assets to non-FEP premium. The resulting ratio is therefore overstated (25% vs. the correct ratio of 16%), which in turn leads to an overstatement of the impact of expected asset returns on GHMSI's surplus.

C. Premium Growth Assumptions

Mr. Shaw's use of a 3.8% premium growth ratio to argue that Rector's surplus target should be reduced by $207 million is not financially sound. Mr. Shaw's 3.8% growth rate assumption was based on GHMSI experience for a period (2009 to 2013) of atypically low growth rates -- the lowest of any period in recent history – as well as significant benefit downgrades (i.e., increases in member cost-sharing) and other changes in mix of business.

The lower rates of premium growth during this period were almost certainly affected to a significant degree by the recent economic recession. According to a study published by the Employee Benefit Research Institute [5], employment-based insurance coverage declined nationwide by 6% during the period 2008 through 2011, after increasing annually throughout the previous four years. It is not appropriate to assume that growth will continue at these historically low levels.

In addition, implementation of the ACA is expected to produce substantial growth in certain market segments; such growth is expected to continue for a period of time. Increased medical costs associated with ACA growth, due to disproportionate enrollment of higher cost individuals, are likely to occur; and the ACA imposes new fees and alters market conditions in ways that almost certainly will increase costs.

Further, the effect of benefit downgrades is to obscure the underlying rate of growth in medical costs and enrollment. When the rate of downgrades slows or reverses the growth rate will increase, all other factors being equal.

GHMSI's growth rates have varied substantially over time, and the company's

[5] Employee Benefit Research Institute, *Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2013 Current Population Survey*, dated September 2013, available at http://www.ebri.org/pdf/briefspdf/EBRI_IB_09-13.No390.Sources1.pdf, page 5.

expectations for growth for 2014-2016 are higher than during recent years due to expected improvements in the economy, implementation of the ACA, with its individual and employer mandates, and reductions in the rate of benefit downgrades and other changes in mix of business.

D. Expenses

Mr. Shaw suggests that Rector's surplus target should be reduced by $153 million on account of supposed "inefficiency" in GHMSI's operation. Again, his analysis rests on conceptual misunderstanding, and analytical error. Mr. Shaw's conclusion in this matter should be disregarded completely as simply wrong.

Neither Rector's nor Milliman's surplus analysis would change if GHMSI reduced its administrative expenses, because actual administrative expenses are reflected in annual rate filings and group rate renewals. If GHMSI reduces expenses, those reductions will be passed on to members and GHMSI's surplus requirements would remain unchanged. Mr. Shaw's treatment of this item implies that he believes that any reduction in expense level that might occur for GHMSI would be kept by the company year after year as profit This obviously would not be the case, either as a matter of GHMSI policy or of DISB oversight.

Moreover, Mr. Shaw's comparison of the administrative expenses incurred by GHMSI's supposed "peer" companies is skewed. Many of those companies are part of large insurer holding companies, and even large for-profit families of insurers, which have access to capital markets and can spread operating efficiencies across much larger entities. Mr. Shaw makes no effort to adjust his analysis for those differences. Mr. Shaw also makes no effort to adjust for variables among companies that would be expected to affect expense levels, including issues such as self-funded business, market segment mix, taxes and fees, or in-kind contributions. In sum, his analysis does not support any conclusion that GHMSI is less efficient than other carriers.

E. Other Risk Factors

1. ***Provision for Catastrophic Events:*** Mr. Shaw argues that there should be no additional provision for catastrophic events, on the presumption that they would already be reflected in historical underwriting results and hence to include them separately would amount to double counting. But this statement reflects a failure to understand, or at least to acknowledge, that Milliman's development of assumptions for the rating adequacy and fluctuation component of our risk assessment involved looking at historical underwriting results for GHMSI and peer companies. This is a completely false premise by Mr. Shaw; as we described previously, our approach did not consider historical underwriting results for any individual company.

The occurrence of catastrophic events is expected to be infrequent. Should they occur,

however, the effect could be truly devastating medically, operationally, and financially – to the community and to GHMSI. We believe it is critically important to ensure adequate provision for such events in surplus, for the benefit of these parties. The probability assumptions that have been used by Milliman and those that have been used by Rector are not intended to reflect a prediction of the frequency with which such events will occur in the short term. Rather, they are intended to reflect a minimal level of financial protection that a prudent company should reasonably maintain in order to withstand a potential catastrophic event along with the other risks that it faces and retain financial viability.

2. ***Changes in Interest/Discount Rates:*** Mr. Shaw makes three errors with respect to the interest/discount rates. First, he misinterprets the probabilities in Milliman's development, which reflect a 55% probability of increase in bond interest rates over three years, not a 90% probability as asserted by Mr. Shaw. The Milliman assumptions are supported by an analysis of historical interest rate patterns, and they are consistent with and reasonable in view of today's very low interest-rate environment. Second, his assertion, or at least clearly implied position and treatment in his analysis, that rates would not change over three years is contradicted by actual experience, which shows that rates are continually changing. Third, Mr. Shaw simply ignores the fact that interest rates in 2011 were historically low and thus more likely to go up than down.

3. ***Overhead Expense Recovery and Fee Income Risks -- Commercial Business:*** The assumptions related to overhead expense recovery and fee income risks for commercial business represent the likelihood of unanticipated fluctuation in the level of administrative expense recoveries. Mr. Shaw erroneously eliminated the impact of this risk component, claiming that the impact of any adverse fluctuation in expense levels due to, for example, an unexpected large group termination would already be reflected in historical underwriting results and hence to include them separately would amount to double counting. Contrary to this presumption, our rating adequacy and fluctuation assumptions do not reflect any shortfall in expense recovery, and the assumptions for this risk component should be appropriately incorporated separate and apart from those assumptions.

4. ***Overhead Expense Recovery and Fee Income Risks -- FEP Indemnity Business and FEP Operations Center:*** Mr. Shaw erroneously assumes that GHMSI has "unfettered access" to a reserve fund held by the OPM, and that GHMSI would be able to recoup any shortfalls in expenses due to FEP from that fund. That demonstrates a fundamental misunderstanding of the purpose of the OPM reserve fund and how it works. GHMSI does not have "unfettered access" to the special reserve fund. Rather, the BCBSA negotiates a contract expense limitation with OPM each year, and allocates a portion of that to each plan. If GHMSI were to experience a material reduction in FEP membership, it could expect the expense allocation to decline accordingly, resulting in a reduction in reimbursement for a portion of overhead expense that could not be immediately eliminated.

The FEP Operations Center also contributes to the offset of certain overhead expenses for CareFirst, which would be forfeited if GHMSI were to lose the Operations Center contract. Under the circumstance of a significant reduction in GHMSI surplus of the nature simulated in Milliman's analysis, there is the risk, which cannot be ignored, that the Operations Center contract with GHMSI would be terminated by BCBSA.

5. ***Provision for Unidentified Development and Growth****:* Mr. Shaw erroneously asserts in his report that any excess expenses for unidentified development and growth would have been reflected in underwriting results and therefore are already included in Milliman's provision for rating adequacy and fluctuation. As described previously, this reflects an incorrect premise by Mr. Shaw that Milliman looked at historical underwriting results for GHMSI and peer companies in order to develop assumptions for the rating adequacy and fluctuation component of our risk assessment. Therefore, his claim that any excess expenses for unidentified growth and development are imbedded in these assumptions is false.

Mr. Shaw also miss-characterizes and apparently misunderstands the treatment of expenses associated with non-admitted assets. Under statutory accounting principles a company does not charge the entire expense for such assets in the first year. Rather, the expense is amortized, and the company reflects the change in non-admitted assets directly in a change to surplus. In subsequent years the company charges amortization to underwriting gain/loss and releases the corresponding portion of the non-admitted asset.

IV. Mr. Shaw dramatically underestimates the downward pressure the Affordable Care Act will impose on GHMSI's surplus.

Mr. Shaw's discussion of the ACA's impact is inappropriately limited to those provisions intended to mitigate risk, and Mr. Shaw makes mistakes in how he applies those provisions.

Mr. Shaw downplays the potential effects of the ACA's guaranteed issue requirements by assuming that they would be completely offset by reinsurance and risk adjustment. The reinsurance program is temporary, and its effects will diminish each of the next two years before it terminates. The risk adjustment program is completely new, and the extent to which it will benefit or harm GHMSI is unknown. As previously noted by CareFirst, there is a risk that there will be more carriers with losses than carriers with gains, and there may not be sufficient appropriated funds to cover the full needs of the program, in which case the protections intended by this feature of the ACA would not be fully available.

In addition, Mr. Shaw fails to acknowledge the changes to GHMSI's distribution channels wrought by the ACA, and the individual and employer mandates, all of which increase GHMSI's risks and costs, particularly in the short-term, while at the same time increasing enrollment in the long term. These are fundamental components of the ACA, which cannot be reasonably ignored as Mr. Shaw has done.

Even where Mr. Shaw attempts to account for specific features of the ACA, his assessment contains errors and/or makes "simplifying assumptions" that bias his results. In applying the MLR rules, Mr. Shaw effectively assumes that every segment of GHMSI's business will achieve a gain if GHMSI achieves an overall gain. That is not correct; between GHMSI and BlueChoice, there are 18 different market segments in which GHMSI may suffer a loss or be required to pay rebates *independent* of the results in any other of its market segments. Mr. Shaw also erroneously or inappropriately applied the risk corridors to all market segments, even though the risk corridor program only applies to Qualified Health Plans sold in the individual and small group markets.

V. Mr. Shaw's assertion that Milliman failed to comply with Actuarial Standards of Practice is baseless.

Finally, I note that Mr. Shaw's assertion that Milliman failed to explain its work in accordance with Actuarial Standard of Practice 41 has no basis in fact. Milliman provided extensive documentation of its model to GHMSI, its client and intended user, which is consistent with Standard of Practice 41. Moreover, it is our understanding that Rector and the DISB provided Mr. Shaw extensive information regarding Milliman's model. Mr. Shaw has indicated that he was able to run his own simulations and largely replicate Milliman's analysis.

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