Report on

CareFirst Premiums and Surplus

January 2010

Executive Summary

The Maryland Insurance Administration ("MIA") reviewed the CareFirst, Inc. ("CFI") group – CareFirst of Maryland, Inc. ("CFMI"), Group Hospitalization and Medical Services, Inc. ("GHMSI") and CareFirst BlueChoice ("BlueChoice") –focusing on premiums and surplus.

Under Maryland law, CFMI and GHMSI make public purpose contributions in lieu of paying the premium tax. The District of Columbia requires GHMSI to pay the premium tax and make other significant public purpose contributions. Assuming federal health reform passes, the General Assembly should give new direction to CFMI and GHSMI about the premium tax exemption.

In 2009, the CFI group requested significant premium increases. The CFI group did not accurately price new high deductible policies qualifying for health savings accounts or health reimbursement accounts ("CDH policies"). This experience reveals that regulators should not automatically embrace low premiums as the short-term benefit to consumers may be followed quickly by painful, unexpected rate increases. Sufficient, but not excessive, surplus provides an insurer an incentive to adequately price products and identify pricing errors quickly.

The MIA engaged the Invotex firm to review the CFI group's surplus. After conducting a thorough quantitative analysis, Invotex recommended a targeted surplus range of 825 to 1075 percent authorized control level risk-based capital ("ACL RBC") for CFMI and 700 to 950 percent of ACL RBC for GHMSI. As of year end 2008, CFMI's actual surplus was 503 percent of ACL RBC, well below Invotex's recommended targeted surplus range; GHMSI's surplus was 845 percent of ACL RBC, and thus is in the middle of Invotex's recommended targeted surplus range. Following a hearing on the Invotex report, the MIA adopts the targeted surplus ranges recommended by Invotex for CFMI and GHMSI and finds that the surpluses for CFMI and GHMSI, respectively, are neither unreasonably large nor excessive.

The District of Columbia Insurance Commissioner is also reviewing the surplus of GHMSI. The two jurisdictions have cooperated throughout their respective reviews, including sharing information and participating in the public hearings held by the respective Commissioners to attempt to avoid an intra-jurisdictional conflict over excess surplus.

Given its current surplus, CFMI must include risk contingency factors in rates. GHMSI's surplus is currently within its targeted range; however, it may still be appropriate to include risk contingency factors in GHMSI's rates, albeit at lesser amounts than would be required if GHMSI's surplus were below the targeted range, as the impact of growth trends on the risk-based capital calculation may nonetheless cause GHMSI's surplus to slip below the targeted range.

The need to increase CFMI's surplus coupled with the CFI group's experience with CDH policies means Maryland policyholders face, for the next few years, premium increases above changes in health care claims costs and administrative costs. This is painful, but unavoidable. The goals need to be to minimize the pain as much as possible, to correct the inadequate pricing, and to learn from this experience to avoid repetition.

The MIA recommends the General Assembly adopt legislation requiring a new working relationship between the CFI group and the Commissioner focused on identifying and keeping surplus within the targeted surplus ranges for CFMI and GHMSI and that the companies and the MIA use these targeted surplus ranges during rate reviews.

Introduction

The CFI group – CFMI, GHMSI and BlueChoice – occupies a singularly important place in Maryland's health insurance market. In 2008, the CFI group accounted for about 54 percent of the total written premium for health care coverage in Maryland. No other carrier or group of carriers approached this market share.[1] Since the 1930s, CFMI has had as its corporate and statutory mission to provide affordable, accessible health care coverage to Maryland residents. The General Assembly has recognized the group's unique place and, accordingly, given the MIA special regulatory responsibilities for the CFI group.[2]

In 2009, the MIA brought together each of the divisions tasked with reviewing one or more aspects of the CFI group's activities to create the CFI Workgroup ("Workgroup"). The MIA formed the Workgroup to better protect the individuals and businesses depending on the CFI group for health care coverage through consistent regulation across divisions as well as to identify any gaps in the tools, processes and procedures employed by the MIA to regulate the CFI group. The Workgroup met (and intends to continue to meet) every two weeks. A focus of the Workgroup was the MIA's regulatory oversight of premiums and surplus.

The CFI Group

CFI was created on January 16, 1998 and holds the Blue Cross and Blue Shield trade marks ("the Mark") for Maryland, the District of Columbia and Northern Virginia. This allows CFI's subsidiaries to market Blue Cross and Blue Shield products throughout this region subject to separate jurisdictional licensing and regulatory requirements.

CFI, CFMI and GHMSI are all licensed nonprofit health service plans in Maryland. CFI and CFMI are domiciled in Maryland; GHMSI is domiciled in the District of Columbia. BlueChoice is a licensed for-profit health maintenance organization domiciled in the District of Columbia. As nonprofit health service plans, CFI, CFMI and GHMSI must:

- Provide affordable and accessible health insurance to their insureds;
- Assist and support public and private health care initiatives for those without health insurance; and
- Promote the integration of a health care system that meets the health care needs of all residents residing in the geographic area served by the companies.[3]

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[1] The carriers owned by Aetna wrote 15.5 percent of the market and UnitedHealthcare 13.7 percent.

[2] The MIA is charged with ensuring CFI's adherence to the requirements of Title 14, Subtitle 1 of the Insurance Article and to report its findings to the General Assembly. See *Insurance Article* §14-102 (e) These requirements include fulfilling its statutory mission (*Insurance Article* §14-102 (c)); governed by a Board of Directors meeting certain requirements (*Insurance Article* §14-115); maintaining sufficient surplus to protect policyholders (*Insurance Article* §14-117); charging premiums that are not excessive in relation to benefits or offer policy forms that are not unjust, unfair, inequitable, inadequate, misleading, or deceptive (*Insurance Article* §14-126 (b) (3) (i)); investing in or acquiring an affiliate only under certain circumstances (*Insurance Article* §14-133); and compensating officers and directors in a manner meeting certain requirements (*Insurance Article* §14-139)

[3] See *Insurance Article* §14-102 (c).

The CFI Board, along with management, develops goals, objectives and strategies for carrying out this statutory mission.

The CFI group was created pursuant to the Business Combination Agreement ("Agreement") between the precursor of CFMI and GHMSI.[4] The Agreement promised to make it easier for the companies to meet their mission across the areas historically served by CFMI (all of Maryland, except Montgomery and Prince George's counties) and GHMSI (the District of Columbia, Montgomery and Prince George's counties in Maryland and Northern Virginia) through:[5]

- Economies of scale
- A regional provider network
- Unified products

Since concluding the Agreement, progress has been made to bring the advantages of a regional company to those served by CFMI, GHMSI and BlueChoice:

- Administrative costs are shared between all companies
- Technology investment has improved administrative capabilities
- A regional provider network supports CFMI and GHMSI
- GHMSI and BlueChoice offer products across the entire region

In the early years of the last decade, the General Assembly considered whether CFMI and GHSMI should be required to help support public and private health care initiatives for those without insurance and pay the premium tax. Legislation passed in 2001 continued CFMI's and GHMSI's exemption from the premium tax:

> "It is the public policy of this State that the exemption from taxation for nonprofit health service plans under §6-101 (b) (1) of this article is granted *so that funds which would otherwise be collected by the State and spent for a public purpose shall be used in a like manner and amount by the nonprofit health service plan*." *Insurance Article* §14-106 emphasis added.

The statute specifies the initiatives CFMI and GHMSI must support in lieu of paying premium tax. These include the Senior Prescription Drug Assistance Program, the Maryland Pharmacy Discount Program and the Community Health Resources Commission Fund. In 2007, CFMI and GHMSI collectively transferred $22,705,990 to these programs and in 2008, $23,825,033.

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[4] The Agreement, dated March 27, 1997, was approved by the Maryland Insurance Commissioner ("Commissioner") on December 23, 1997 in Case No. MIA-240-12/97.

[5] Over time, the Commissioner reasoned in 1997, the Agreement would result in the integration of business operations and asset transfers, with the relative value of CFMI and GHMSI becoming skewed. For this reason, the Agreement sought to quantify and protect Maryland's public interest in CFMI's value as of the date of the affiliation by requiring a "snapshot".

Additionally, CFI is required to transfer $4 million to the Senior Prescription Drug Assistance Program if the CFI group has a surplus that exceeds 800 percent of the consolidated risk-based capital ("RBC") requirements. See *Insurance Article* §14-106.2(b).

In the District of Columbia, GHMSI is required to pay premium tax. In addition, the District of Columbia authorizes GHMSI to enter into a public-private partnership with the District. In 2010, GHMSI is expected to contribute approximately $5 million to support Healthy DC (a public program offering health care to low income individuals and families). GHMSI will also continue an open enrollment program for the medically uninsurable residing in the District of Columbia.[6]

Over and above these requirements, the CFI group supports a number of health related initiatives throughout the region. These are summarized in its publication *CareFirst Commitment 2008 Community Report* available on the CFI group's website, www.carefirst.com.

It is difficult to make a precise "apples to apples" comparison of the CFI group's "public purpose contribution" to Maryland as compared to the District of Columbia. Nevertheless, it is noteworthy that in the District of Columbia GHMSI must pay premium tax *and* make contributions for health care while in Maryland CFMI and GHMSI are exempt from state premium tax and make payments in lieu of taxes which are counted as their "public purpose contribution." Maryland would appear to be disadvantaged by what is, in effect, "double public purpose contributions" in the District of Columbia — that is tax payments plus additional "public purpose contributions." On the other hand, it may disadvantage GHMSI in the market and increase premiums to pay premium tax in the District of Columbia and make contributions for health care.

If enacted, federal health reform which expands access to affordable health care coverage and improves Medicare Part D coverage for seniors will raise questions about the premium tax exemption for CFMI and GHMSI in Maryland.[7] If federal health reform eliminates or diminishes the need for the programs specified in Maryland's current statutes, policymakers should give new direction to CFMI and GHMSI about the premium tax exemption, modifying the contributions qualifying for the premium tax exemption or requiring a premium tax payment plus a more modest contribution to public and private health care initiatives that does not harm CFMI or GHMSI in the market or result in higher premiums for their policyholders.

Premiums

In response to the CFI group's unsuccessful attempt to become a for-profit insurer owned by a national Blue Cross and Blue Shield plan, the CFI Board embraced in 2005 the "CareFirst Commitment." Underwriting changes made health care coverage more accessible to individuals

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[6] GHMSI expects to experience a $4 million to $8 million loss stemming from GHMSI's open enrollment program for the medically uninsurable.

[7] Federal health reform may also place substantial new financial and regulatory burdens on the companies that could affect their respective surplus levels. This should also be examined after the passage of federal health reform.

and general premium reductions made health care coverage more affordable to individuals and employer groups.[8]

Independent of this, between 2006 and 2007, the CFI group began to offer new high deductible plans qualifying for health savings accounts or health reimbursement accounts ("CDH policies"). Based on the then prevailing actuarial judgment, the CFI group assumed CDH policies would decrease consumer demand for health care.

Between 2005 and 2008, the CFI group's market share increased, individuals and employers benefited from lower premiums, and enrollment in CDH policies significantly increased. Today, in Maryland, over half of the small employer groups insured by the CFI group and about 20 percent of all individuals purchasing health care coverage directly from the CFI group have a CDH policy.

By 2008, the actual claims data revealed that the assumed decrease in demand for health care had not materialized. The data showed little significant difference in overall health care utilization for CDH policies and non-CDH policies. This meant that CDH policies were underpriced and, consequently, the CFI group requested premium rate increases. In the individual and small employer group market, the MIA limited the increases to 24 percent during 2009. The CFI group continues to experience losses and has requested rate increases for 2010.[9]

The MIA now requires the CFI group to submit claims and revenue data about CDH policies quarterly. The MIA and the CFI group anticipate adequate pricing for CDH policies in 2010, thereby allowing the rate of premium increase to primarily reflect the underlying changes in health care costs and administrative costs.

The CDH experience has caused the MIA to reflect seriously on the anomaly that rates which are too low, meaning insufficient to match actual losses plus administrative costs, provide only a short-term benefit to consumers which is then followed by painful rate increases. Regulators tend not to question rates which appear too low because no one seems to be hurt by them and certainly no consumer complains. Again, however, the short-term benefit of low rates can be outweighed by the longer-term pain of the inevitable substantial rate increases which follow if the rates are too low in the first place.

Each time an insurer or health maintenance organization introduces a new product in the market, the assumptions used to determine the premium may turn out, in practice, to be incorrect. The challenge for the company, and the regulator, is to determine, as early as possible, any variance between pricing assumptions and actual experience in order to assure that prices are reasonable, yet sustainable (i.e., not producing losses). Companies, particularly a non-profit like the CFI group, have an increased incentive to more closely scrutinize pricing models when surplus levels are in appropriate ranges.

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[8] In 2005, CareFirst dedicated $60 million to premium reductions.

[9] Under the law, the Insurance Commissioner ("Commissioner") may deny a premium rate for CFMI or GHMSI if, among other reasons, the rate "appears by statistical analysis and reasonable assumptions to be excessive in relation to benefits." See *Insurance Article* §14-126 (b) (3) (i) 1.

Surplus Review

The MIA issued a Request for Proposal ("RFP") in January 2009 requesting consulting services to:

- Recommend the appropriate amount of surplus for CFMI and GHMSI on an individual and consolidated basis, addressing how surplus earned in more than one jurisdiction should be apportioned to ensure that subscribers of a health benefit plan issued or delivered in Maryland are adequately protected
- Develop an analytical framework, methodology and/or identify additional criteria the Commissioner may use to evaluate whether surplus is excessive
- Recommend whether the evaluation of the surplus levels of CFMI and GHMSI should be made on an individual or consolidated basis
- Recommend the appropriate risk based capital requirements for CFMI and GHMSI on an individual and consolidated basis

The MIA engaged the Invotex firm to carry out this task. Invotex submitted its report to the MIA in October. The Commissioner held a public hearing on the Invotex report in November.[10]

One of the principal findings of the MIA's review of the CFI group's surplus is that the structure of the group -- while more advantageous from a business perspective than stand-alone, independent companies -- has inherent inefficiencies for managing risk and surplus. Principally,

- The Inter-Company Agreement provides that the entities within the CFI Group will support each other in the event that a member company has insufficient funds to pay claims or has a deficiency in surplus. It specifies that a transfer of funds must be in the form of a loan that is subordinate to all other claims and obligations of the company. Further, the repayment of the loan could only be made upon regulatory approval as well as approvals by companies within the CFI group.
- Much of the surplus for CFMI (62 percent) is attributable to its equity investment in BlueChoice; for GHMSI, about one-quarter. To that extent, their respective surplus is illiquid and is not readily available for payment of claims or other obligations.
- The financial strength within the CFI group arises from the assets of CFMI, GHMSI and BlueChoice rather than the assets of the parent (CFI). CFI does not have the financial wherewithal to provide support to the operating subsidiaries as needed.[11]

Either a loan or an extraordinary dividend payment from BlueChoice to CFMI or GHMSI would require regulatory approval by regulators in both Maryland and the District of Columbia. A regulator in one jurisdiction may be reluctant to approve a loan to a nonprofit health service plan domiciled in another jurisdiction due to the uncertainty of repayment. A regulator may not approve an extraordinary dividend payment from BlueChoice to CFMI and GHMSI to bolster

[10] A copy of the Invotex report, the hearing transcript and the documents submitted by interested parties are posted on the MIA's website, www.mdinsurance.state.md.us.

[11] This is a stark contrast to other insurers and health maintenance organizations that belong to a group. For these companies, the parent typically has financial strength available to support the parent's operating subsidiaries.

their capital position. Because it is not certain that the CFI group could provide sufficient timely financial assistance should the need arise for CFMI or GHMSI, Invotex recommended the MIA review CFMI's and GHMSI's surplus on an individual basis only.

The CFI group engaged actuaries at Milliman, Inc. ("Milliman") to perform an independent assessment of the surplus levels of CFMI and GHMSI. Milliman recommended a targeted surplus range of 900 to 1200 percent of authorized control level risk based capital (ACL RBC) for CFMI and 750 to 1050 percent of ACL RBC for GHMSI.[12]

Invotex challenged and modified certain assumptions used by Milliman and arrived at ranges modestly lower than those recommended by Milliman. Specifically, Invotex recommended a targeted surplus range of 825 to 1075 percent ACL RBC for CFMI and 700 to 950 percent of ACL RBC for GHMSI.

While Invotex was conducting its analysis, the CFI group retained The Lewin Group to review Milliman's work and to conduct an independent review of GHMSI's appropriate RBC range. Based on that review, The Lewin Group concluded, similar to Invotex, that the appropriate targeted surplus range for GHMSI is 750 to 1000 percent ACL RBC. [13]

All three independent reviews essentially arrived at similar conclusions, with only minor differences, for the appropriate surplus levels to be held by GHMSI. Invotex and Milliman also reached similar conclusions for CFMI.[14] As of year end 2008, CFMI's actual surplus was 503 percent of ACL RBC, falling below Invotex's recommended targeted surplus range; GHMSI's was 845 percent of ACL RBC, falling within Invotex's recommended targeted surplus range.

Invotex recommended the MIA adopt the following procedure, generally based on the procedure used in Pennsylvania:

- Every three to five years, CFMI and GHMSI identify a targeted surplus range
- The targeted surplus range is subject to regulatory review and approval
- When the surplus is within the targeted surplus range, CFMI and GHMSI may include risk contingency factors in rate filings, to maintain the companies within their

[12] Insurers, nonprofit health service plans and health maintenance organizations are all required to report their risk-based capital (RBC). There are four RBC levels that trigger intervention: company action level, regulatory action level, authorized control level (ACL), and mandatory control level. If a company reports RBC at or below the ACL RBC level, the Commissioner must take significant action, which may include placement under conservation, rehabilitation or liquidation. Maintaining surplus to diminish the likelihood of ACL is a company and regulatory priority.

[13] Lewin was not retained to do the same with respect to CFMI's surplus.

[14] Notably, the Invotex figures are also in line with surplus targets adopted by other jurisdictions. In particular, Pennsylvania's Insurance Commissioner in 2005 adopted a target range of 750 to 950 percent of ACL RBC for an insurer close in size to GHMSI. And the only other jurisdiction to set upper-level ACL RBC targets – Michigan – chose an upper boundary of 1000 percent.

respective appropriate surplus range given their unique risk profiles, growth trends and other factors[15]

- When the surplus falls below the targeted surplus range, CFMI and GHMSI should include risk contingency factors in rating filings
- When the surplus exceeds the targeted surplus range, CFMI and GHMSI would propose a plan to bring the surplus down to the targeted surplus range

This procedure allows the CFI group to maintain sufficient financial stability to protect policyholders and maximize its ability to provide affordable health care coverage.

Following the completion of the Invotex report, the Commissioner held a public hearing to solicit public comment on the targeted surplus range and recommendations. Only DC Appleseed questioned Invotex's report.

DC Appleseed urged the Commissioner to set the targeted surplus range at the lowest possible level. DC Appleseed commissioned a consultant to assess GHMSI's targeted surplus range. Based on this, DC Appleseed concludes GHMSI's targeted surplus range should be 450 to 525 percent ACL RBC. Because GHMSI's surplus exceeds the targeted surplus range developed by DC Appleseed, DC Appleseed maintains, a plan should be developed to bring the surplus within this range.

DC Appleseed's proposed range is well below the ranges recommended by Invotex, Milliman, and The Lewin Group. While the MIA appreciates and acknowledges DC Appleseed's contributions to this proceeding (as well as the proceeding in the District), the MIA is unconvinced that the substantial adjustments DC Appleseed's analyst made to the Milliman approach – resulting in a target surplus range out of line with those of other analysts – are warranted. The overwhelming weight of the evidence supports Invotex's target surplus range, not that proposed by DC Appleseed.

While there certainly is a highly respected field of knowledge called "actuarial science" and it is also true that some fine practitioners in that field have been involved in this matter, it is fair to note that "actuarial science" is, in the end, actuarial judgment, not actuarial fact. Judgments, by their very nature, can prove to be incorrect. The risk that judgments in this context may turn out to be incorrect counsels an element of cautious conservatism in reducing the cushion of protection that is the purpose of surplus.

In sum, based on the information received at the hearing, the MIA has concluded there is no reason to deviate from the targeted surplus range recommended by Invotex for CFMI and GHMSI. For all the above reasons, the MIA adopts Invotex's recommendations as the appropriate surplus ranges for CFMI and GHMSI, respectively.

[15] See page 86 of Invotex's report. Today, the rate filings submitted by the CFI group identifies "contribution to surplus" as a factor. This is essentially synonymous with "risk contingency factors."

District of Columbia surplus review

The District of Columbia Insurance Commissioner is also reviewing GHMI's surplus. Although Maryland law and the District of Columbia law are not identical with different standards and processes for review, the two jurisdictions have shared information and participated in the public hearings held by the respective Commissioners. This collaborative effort is indicative of the importance of GHMSI in both jurisdictions.

In financial matters, it is the practice that the Insurance Commissioner of the jurisdiction where the insurer is domiciled is primarily responsible for monitoring the insurer's financial condition. Because GHMSI also operates in Maryland and the majority of its enrollment is in Maryland, GHMSI is very important to Maryland individuals and employer groups. GHMSI is also important to the CFI group. Accordingly, it is appropriate for the Maryland Insurance Commissioner to independently review GHMSI's targeted surplus range.

The District of Columbia Insurance Commissioner is reviewing the surplus of GHMSI attributable to the District of Columbia to determine if it is unreasonably large and inconsistent with GHMSI's community health reinvestment obligation under the District's laws. The problem of surplus allocation or attribution is related to the organizational structure of the CFI group and the fact that GHMSI is domiciled in the District of Columbia while doing business in the District of Columbia, Maryland and Virginia. [16]

Under the District of Columbia law pursuant to which the District of Columbia Insurance Commissioner is reviewing GHMSI's surplus range, the so-called "attribution" issue is not reached unless the entirety of GHMSI's surplus is unreasonably large. The MIA sees no reason to reach the difficult issue of attribution given that GHMSI's surplus is in the middle of the ranges established by Invotex, Milliman and The Lewin Group.

The MIA notes, however, that it is fundamentally unfair for policyholders in one jurisdiction to be compelled to subsidize policyholders in another jurisdiction or the government of another jurisdiction. Avoiding intra-jurisdictional conflict over excess surplus (again assuming there is any excess) must remain a priority.

CFMI and GHMSI

CFMI's and GHMSI's similarities and differences must be considered to put Invotex's recommendation into practice. Some of these are noted here.

The Agreement allows CFMI and GHMSI to share the same provider network, administrative policies and procedures, and staff. Much of what shapes premiums – unit costs and administrative costs – are the same for CFMI and GHMSI. But the business mix for each company and the geographic distribution of the business also impact other factors shaping premiums such as utilization and margins.

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[16] The Invotex report argues persuasively that the notion of trying to attribute a portion of GHMSI's surplus (assuming it is excessive) to the policyholders in one or another jurisdiction is deeply flawed.

Over 50 percent of the CFI Group's written premium in 2008 came from large employer groups (employers with 51 or more employees), over a third from small employer groups, and less than 10 percent from individuals. CFMI wrote most of the CFI group's premium to large employer groups and individuals while BlueChoice wrote mostly to small employer groups.

Looking just at CFMI, over three-quarters of its written premium in 2008 came from large employer groups and over 15 percent from individuals. For GHMSI, close to half came from small employer groups and about half from large employer groups.

The CFI group has significant non-risk business. However, this business comprises a much greater percentage of CFMI's entire book of business (over 70 percent) than that of GHMSI (less than half). The CFI group does not recoup all its administrative costs assumed for its non-risk business. These losses must be made up by gains in the risk business, essentially individuals, small employer groups and large employer groups.

The CFI group's risk business benefits from the size and scope of the non-risk business. The non-risk business significantly increases the presence of the CFI group within the region, thereby enabling its subsidiaries to obtain greater provider discounts. These discounts, in turn, allow the CFI group to offer lower premiums to individuals, small employer groups and large employer groups. Nonetheless, while the benefits of the non-risk business accrue to both CFMI and GHMSI, the losses accrue primarily to CFMI.

Based on these business differences, allowing risk contingency factors in CFMI's rate filings to bring its surplus to the targeted surplus range will increase premiums above changes in health care claims costs and administrative costs primarily for Maryland residents purchasing health care coverage on their own and employer groups. This process should eventually result in CFMI's surplus level reaching the targeted surplus range adopted by the MIA. Once within the targeted surplus range, CFMI's product price increases should be based more on changes in health care claims costs and administrative costs.

However, the amount of time required to build up the surplus for CFMI to its targeted surplus range based on premiums paid primarily by individuals and employer groups could be quite long. This is because CFMI loses money on its primary block of business – the non-risk business.

Conclusions and recommendations

Sufficient surplus to withstand anticipated and unanticipated risks furthers the CFI group's mission. Surplus within the targeted surplus range adopted by the MIA allows the CFI group to moderate risk and contingency factors to just those amounts necessary to maintain surplus in the targeted ranges, thus keeping the rate increases as restrained as possible over the long-term. It allows the CFI group to introduce new products to the market. Keeping the CFI group focused on maintaining surplus within a targeted range incentivizes the company to quickly identify any pricing variations from expectations and adjust accordingly.

It is the responsibility of the CFI group – the various Boards and management – to identify the targeted surplus ranges going forward to withstand anticipated and unanticipated risks and support the CFI group's mission. The MIA's task is to make sure the targeted surplus ranges identified by the company are reasonable and that premium rates maintain surplus within the targeted surplus ranges. Invotex's recommendations to the MIA provide a framework for accomplishing this goal.

However, as Invotex notes, the targeted surplus ranges for CFMI and GHMSI could be lower, and thus premiums lowered by some amount, if the structure of the CFI group facilitated the movement of capital within the CFI group. In effect, a fully integrated company with capital resources either at the parent level (CFI) or combined through a merger of CFMI and GHMSI into one entity would provide the most efficacious back-bone for the furtherance of the CFI group mission. The CFI group, regulators and policymakers should explore the impediments to a fully integrated company, including modifications, as necessary, of applicable legislation and original regulatory orders that accompanied the affiliate structure that now governs the CFI group. Finding ways to move the CFI group closer to this model would likely benefit each jurisdiction and their respective policyholders and subscribers within the CFI group's service area. Until then, the MIA must look at CFMI and GHMSI as separate, independent companies.

As indicated above, CFMI's surplus is below the appropriate targeted surplus range. To further promote CFMI's mission, the MIA and CFMI must work together to increase the company's surplus. Rate filings for CFMI should include risk contingency factors in order to grow and maintain CFMI's surplus to within the targeted surplus range.

GHMSI's surplus is currently within its targeted range. However, it may still be appropriate to include risk contingency factors in GHMSI's rates, albeit at lesser amounts than would be required if GHMSI's surplus was below the targeted range, as the impact of growth trends on the risk-based capital calculation may nonetheless cause GHMSI's surplus to slip below the targeted range.

To put this new regulatory framework into place, the MIA recommends the General Assembly consider legislation requiring that CFMI and GHMSI establish updated targeted surplus ranges at least every 5 years and annually report to the MIA the status of each company's surplus. The MIA should have the authority to require more frequent intervals if the business climate significantly changes. Based on this review, the MIA will determine whether and to what extent to allow risk contingency factors in premium rate filings for CFMI and GHMSI. The MIA includes suggested draft language for the General Assembly's consideration.

The need to increase CFMI's surplus coupled with the CFI group's experience with CDH policies means Maryland policyholders should expect continued rate increases above changes in health care claims costs and administrative costs for the next few years.

Appendix 1: Suggested statutory changes

§14–117.

(a) (1) In this section the following words have the meanings indicated.

(2) (i) "Assets" means assets that are:

1. authorized under § 14-120 of this subtitle; and

2. determined by the Commissioner to be admitted assets under the guidelines issued by the National Association of Insurance Commissioners.

(ii) "Assets" does not include:

1. cash, notes, or receivables that result from the sale of an asset of a nonprofit health service plan or its affiliate or subsidiary if the purchaser may require the plan to repurchase the asset; or

2. stock of an affiliate or subsidiary of the plan if the stock has not been issued in accordance with a public offering or is not publicly traded on a recognized stock exchange.

(iii) Notwithstanding subparagraph (ii)2 of this paragraph, "assets" includes stock of an affiliate or subsidiary of a nonprofit health service plan to the extent that the Commissioner determines that the stock has a value that could be made available for the payment of claims and losses.

(3) "Earned premium" means earned premiums under:

(i) insurance contracts and policies; and

(ii) the insured part of other contracts.

(4) "Surplus" means the amount by which assets exceed liabilities described in § 5-103 of this article.

(b) Except as provided in subsection (d) of this section, a corporation authorized under this subtitle shall maintain a surplus in an amount equal to the greater of:

(1) $75,000; and

(2) 8% of the total earned premium received by the corporation in the immediately preceding calendar year.

(c) If the size and structure of the corporation requires, the Commissioner may require the differentiation of the corporation's activities into risk and nonrisk business for the purpose of determining the corporation's income that is derived from earned premium and other sources.

(d) **SUBJECT TO §14-117.1 OF THIS SECTION, [**If**] IF** the Commissioner determines after a hearing that a larger surplus is necessary for the protection of subscribers to a nonprofit health service plan, the Commissioner may require a corporation authorized under this subtitle to maintain a surplus in an amount greater than the amount required by subsection (b) of this section.

(e) (1) **SUBJECT TO §14-117.1 OF THIS SECTION, [**The**] THE** surplus of a corporation authorized under this subtitle may be considered to be excessive only if:

(i) the surplus is greater than the appropriate risk based capital requirements as determined by the Commissioner for the immediately preceding calendar year; and

(ii) after a hearing, the Commissioner determines that the surplus is unreasonably large.

(2) After the Commissioner has determined the surplus of a corporation authorized under this subtitle to be excessive, the Commissioner:

(i) may order the corporation to submit a plan for distribution of the excess in a fair and equitable manner; or

(ii) if the corporation fails to submit a plan of distribution within 60 days, may compile a plan and order the corporation to implement it.

(3) A distribution ordered under paragraph (2) of this subsection may be made only to subscribers who are covered by the corporation's nonprofit health service plan at the time the distribution is made.

(f) The Commissioner may not order a distribution or plan for distribution under subsection (e) of this section if the distribution would render the corporation impaired or insolvent under the laws of its domiciliary state or any other state in which the corporation is authorized to do business.

§14–117.1

A. (1) IN THIS SECTION, THE FOLLOWING WORDS HAVE THE MEANINGS INDICATED.

(2) "AUTHORIZED CONTROL LEVEL RBC" HAS THE MEANING STATED IN §4-301 (N) (3).

(3) "TARGETED SURPLUS RANGE" MEANS THE OPTIMAL SURPLUS RANGE EXPRESSED AS A PERCENTAGE OF AUTHORIZED CONTROL LEVEL RBC NEEDED FOR A NONPROFIT HEALTH SERVICE PLAN TO WITHSTAND ANTICIPATED AND UNANTICIPATED RISKS.

B. THIS SECTION APPLIES TO A NONPROFIT HEALTH SERVICE PLAN THAT INSURES MORE THAN 10,000 COVERED LIVES IN MARYLAND AND OFFERS COMPREHENSIVE MEDICAL BENEFITS.

C. SUBJECT TO PARAGRAPH D OF THIS SECTION, A NONPROFIT HEALTH SERVICE PLAN SUBJECT TO THIS SECTION SHALL:

(1) ESTABLISH A PROPOSED TARGETED SURPLUS RANGE AT LEAST EVERY FIVE YEARS; AND

(2) NOTIFY THE COMMISSIONER OF THE PROPOSED TARGETED SURPLUS RANGE WITHIN 60 DAYS OF ESTABLISHING THE PROPOSED TARGETED SURPLUS RANGE.

D. THE COMMISSIONER MAY REQUIRE A NONPROFIT HEALTH SERVICE PLAN TO ESTABLISH A PROPOSED TARGETED SURPLUS RANGE.

E. WITH THE ANNUAL STATEMENT FILED WITH THE COMMISSIONER UNDER §14-121 OF THIS ARTICLE, THE NONPROFIT HEALTH SERVICE PLAN SHALL SPECIFY THE:

(1) TARGETED SURPLUS RANGE APPLICABLE TO THE CALENDAR YEAR FOR WHICH THE ANNUAL STATEMENT IS FILED; AND

(2) ACTUAL SURPLUS AS A PERCENT OF AUTHORIZED CONTROL LEVEL RBC AT THE CLOSE OF THE CALENDAR YEAR FOR WHICH THE ANNUAL STATEMENT IS FILED.

F. THE NONPROFIT HEALTH SERVICE PLAN MAY NOT ADOPT THE PROPOSED TARGETED SURPLUS RANGE UNTIL THE COMMISSIONER HAS REVIEWED AND APPROVED THE PROPOSED TARGETED SURPLUS RANGE.

G. IN REVIEWING THE PROPOSED TARGETED SURPLUS RANGE, THE COMMISSIONER SHALL CONSIDER:

(1) THE RISKS IDENTIFIED BY THE NONPROFIT HEALTH SERVICE PLAN;

(2) THE AVAILABILITY OF CAPITAL WITHIN THE INSURANCE HOLDING COMPANY GROUP, IF APPLICABLE;

(3) THE DISTRIBUTION OF THE NONPROFIT HEALTH SERVICE PLAN'S BUSINESS, INCLUDING RISK AND NON-RISK BUSINESS;

(4) THE MISSION OF THE NONPROFIT HEALTH SERVICE PLAN;

(5) WHETHER THE SURPLUS IS ADEQUATE FOR THE PROTECTION OF SUBSCRIBERS; AND

(6) ANY OTHER FACTOR THE COMMISSIONER DEEMS RELEVANT.

§14–126.

(a) (1) A corporation subject to this subtitle may not amend its certificate of incorporation, bylaws, or the terms and provisions of contracts issued or proposed to be issued to subscribers to the plan until the proposed amendments have been submitted to and approved by the Commissioner and the applicable fees required by § 2-112 of this article have been paid.

(2) A corporation subject to this subtitle may not change the table of rates charged or proposed to be charged to subscribers for a form of contract issued or to be issued for health care services until the proposed change has been submitted to and approved by the Commissioner.

(3) The Commissioner shall approve an amendment to the articles of incorporation or bylaws under paragraph (1) of this subsection unless the Commissioner determines the amendment is contrary to the public interest.

(b) (1) (i) An amendment may not take effect until 60 days after it is filed with the Commissioner.

(ii) If an amendment is not accompanied by the information needed to support it and the Commissioner does not have sufficient information to determine whether the filing meets the requirements of this section, the Commissioner shall require the nonprofit health service plan to provide the needed information.

(iii) If the Commissioner requires additional information, the waiting period under this paragraph shall begin again on the date the needed information is provided.

(iv) On written application by the nonprofit health service plan, the Commissioner may authorize an amendment that the Commissioner has reviewed to become effective before the expiration of the waiting period or any extension of the waiting period or at a later date.

(2) A filing is deemed approved unless disapproved by the Commissioner within the waiting period or any extension of the waiting period.

(3) (i) The Commissioner shall disapprove or modify the proposed change if:

1. the table of rates appears by statistical analysis and reasonable assumptions to be excessive in relation to benefits; or

2. the form contains provisions that are unjust, unfair, inequitable, inadequate, misleading, or deceptive or encourage misrepresentations of the coverage.

(ii) In determining whether to disapprove or modify the form or table of rates, the Commissioner shall consider:

1. past and prospective loss experience within and outside the State;

2. underwriting practice and judgment to the extent appropriate;

3. **FOR A NONPROFIT HEALTH SERVICE PLAN SUBJECT TO §14-117.1 OF THIS ARTICLE**, a reasonable margin for reserve needs **TO MAINTAIN SURPLUS WITHIN THE TARGETED SURPLUS RANGE APPROVED BY THE COMMISSIONER UNDER §14-117.1 OF THIS ARTICLE**;

4. past and prospective expenses, both countrywide and those specifically applicable to the State; and

5. any other relevant factors within and outside the State.

(4) On the adoption of an amendment or change, after approval by the Commissioner, the corporation shall file with the Commissioner a copy of the amendment or change that has been certified by at least two executive officers of the corporation.

(c) At any time, the Commissioner may require a nonprofit health service plan in the State to demonstrate that its filings, including the terms and provisions of its contracts, its table of rates, and its method for setting rates, comply with subsections (a) and (b) of this section, notwithstanding that the Commissioner had previously approved the filings.

(d) (1) If, after the applicable review period established under subsection (b) of this section, the Commissioner finds that a filing does not meet the requirements of this section, the Commissioner shall issue to the filer an order that specifies the ways in which the filing fails to meet the requirements of this section and states when, within a reasonable period after the order, the filing will no longer be effective.

(2) (i) The Commissioner shall hold a hearing before issuing an order under paragraph (1) of this subsection.

(ii) The Commissioner shall give written notice of the hearing to the filer at least 10 days before the hearing.

(iii) The written notice shall specify the matters to be considered at the hearing.

(3) An order issued under paragraph (1) of this subsection does not:

(i) affect a contract or policy made or issued before the expiration of the period set forth in the order; or

(ii) directly affect an existing contract or policy between a nonprofit health service plan and a subscriber established in accordance with a collective bargaining agreement.

(e) (1) The Commissioner may adopt regulations to allow a type or kind of form to be effective upon receipt of the filing by the Commissioner.

(2) If a nonprofit health service plan uses a form which becomes effective in accordance with the provisions of subparagraph (i) of this paragraph and the form would be subject to disapproval under subsection (b)(3) of this section, the Commissioner may:

(i) subsequently disapprove the form; and

(ii) impose on the nonprofit service plan a penalty under § 4-113 of this article.

(3) If a nonprofit health service plan files a form with the Commissioner which becomes effective in accordance with paragraph (1) of this subsection, the nonprofit health service plan shall pay the applicable filing fee provided in § 2-112 of this article.