Considerations for Appropriate Surplus Accumulation in the Rhode Island Health Insurance Market

Preliminary Findings

March 7, 2006

The LEWIN GROUP

AG EXHIBIT I

Section I

- **Project Background**
- Health Plan Risk, Reserves and Surplus
- Rhode Island Market Risks
- Health Plan Specific Risks
- Conclusions and Recommendations

Overview of Project: The Lewin Group's Role

The Lewin Group was retained to assist the RI Health Insurance Commissioner in assessing the surplus levels of RI health plans pursuant to requirements of the RI Health Care Reform Act of 2004.

Financial Review and Risk Assessment

- Review the financial experience of BCBSRI, UCHNE, and Neighborhood as well as the market and regulatory risks faced by each plan.

Estimate Actuarially Conservative Surplus Ranges

- Develop target surplus ranges reflecting an actuarially conservative assessment of the amount needed to withstand a sustained downturn in the underwriting cycle given actuarial assessment of the risks.

Observations and Recommendations

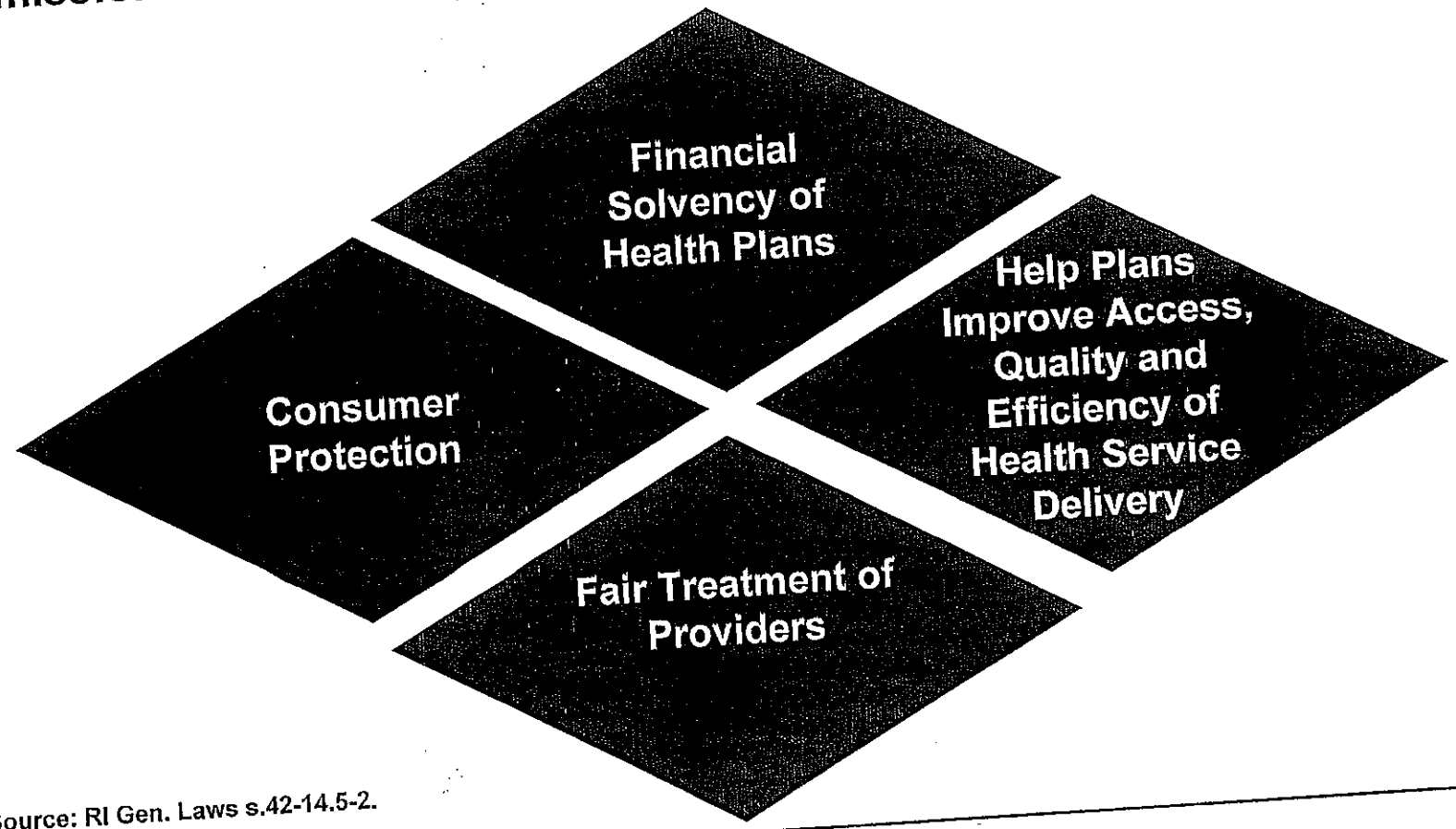
- Document findings in a final written report

Health Care Reform Act of 2004 – Health Insurance Oversight to increase accountability, affordability

- The broader purpose of the legislation is to improve the state of health care delivery in Rhode Island by making health insurance more affordable and available to the public
- Prior to the passage of the legislation, stakeholders argued that BCBSRI should give up some portion of its surplus to help make health coverage more affordable
  - Ensure that BCBSRI, as a non-profit entity, is dedicated to providing affordable health care to the public
- The impetus behind the Reform Act was based on legislative findings which included:
  - "… the power of health care insurers… has become great enough to create a competitive imbalance, reducing levels of competition and threatening the availability of high quality, cost-effective health care."
  - "The power of health care insurers to unilaterally impose provider contract terms may jeopardize the ability of physicians and other health care providers to deliver superior quality health care services…"

Health Care Reform Act of 2004

The Rhode Island Health Care Reform Act of 2004 directs the Insurance Commissioner to focus on four key areas.



Source: RI Gen. Laws s.42-14.5-2.

Section II

- Project Background
- **Health Plan Risk, Reserves and Surplus**
- Rhode Island Market Risks
- Health Plan Specific Risks
- Conclusions and Recommendations

Health plans have multiple mechanisms to offset both known and unknown financial risks

- **Reserves** represent an insurer's funds on hand for which there is a corresponding liability on the company's balance sheet. Reserves are established to offset known future risks and may include:
  - **Claims Reserves:** Reserves held to pay health care providers for services that members have used but for which claims have yet to be paid. Includes IBNR (incurred but not reported claims), IBNP (incurred but not paid claims), contingency reserves, and case reserves.
  - **Premium Reserves:** Includes Premium Deficiency Reserves and Gross Premium Valuation Reserves. Both are intended to offset predictable premium losses for specific products.
  - **Operating Reserves:** Ordinary operating reserves for specific, known liabilities (e.g., taxes, payables, etc.)
- **Reinsurance or Stop Loss Coverage:** Secondary insurance purchased by the insurer to offset potential, extreme losses related to medical claims.
- **Surplus, or unallocated reserves**, represents an insurer's retained earnings or funds on hand for which there is no corresponding liability on the company's balance sheet and which are intended to sustain the insurer through adverse business conditions or to support investment needs.

Reserves ≠ Surplus

This review seeks to develop plan-specific target ranges for surplus.

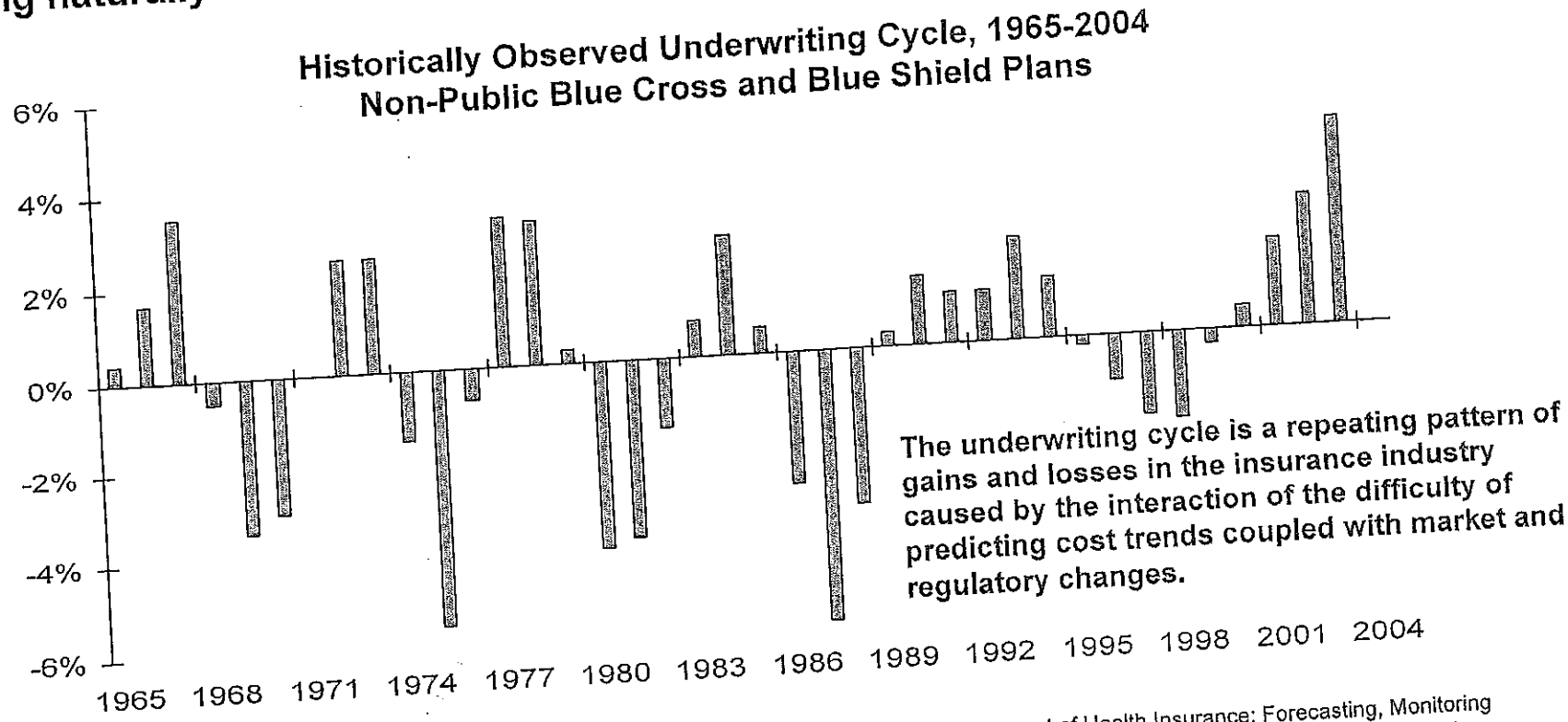
Why is Surplus Needed?

Surplus provides the underpinnings to allow plans to withstand sustained periods of adverse financial results.

- Surplus provides a financial cushion for the risks of unknown outcomes inherent in the delivery of insurance products. Surplus is intended to ensure the plan's solvency and ability to meet long-term contractual obligations.
- Surplus helps companies maintain financial stability during times of unexpected expenses, economic downturns or when costs rise rapidly.
  - Plans are generally not able to immediately respond to adverse conditions due to pricing or cost management inflexibility
  - Most plans provide a 12-month rate guarantee
  - Plans may also have limited pricing flexibility due to regulatory limits
- Surplus also allows companies to make needed investments in infrastructure and technology to serve their customers more efficiently and effectively.
- Non-profit plans are often confused as charities that should not hold any surplus. However, these plans may need higher surplus to offset specific operating constraints.

Underwriting cycles drive surplus demand

Health plans must target surplus levels which will sustain financial performance during naturally occurring downturns in underwriting cycles.



Source: Phyllis A. Doran, FSA, Robert H. Dobson, FSA, and Ronald G. Harris, FSA, "Financial Management of Health Insurance: Forecasting, Monitoring and Analyzing Health Plan Experience," Milliman USA Research Report, December 2001 and based on statutory filings as compiled by Goldman Sachs as of early 2005.

Case Study: BCBS of West Virginia Insolvency - 1990

- First Blue Cross and Blue Shield plan to be liquidated by a state insurance commissioner - 1990
- Left thousands of people and numerous health care providers with millions in unpaid claims for years before outside assistance resolved the situation
- The plan was not included in any state guaranty fund and did not have a safety net for subscribers

Source: GAO report, Blue Cross and Blue Shield Experiences of Weak Plans Underscore the Role of Effective State Oversight, April 1994; Letter from BCBSA to Leslie G. Aronovitz, US GAO (Feb. 11, 1994); "Critical Developments in the Blue Cross & Blue Shield System" Session at the Healthcare Financial Management Association Capital Conference, April 1993.

Case Study: HIP Health Plan of New Jersey

- Declared insolvent in November 1998
- HIP was liquidated in March 1999
- Approximately $120 million in unpaid claims to physicians and hospitals
- No state guaranty fund at that time to bail it out
- 190,000 were forced to look for new coverage
- All state insurance carriers were required to have an open enrollment to HIP enrollees during March 1999

Source: The Forums Institute, Public Oversight of Managed Health Care Coverage-Consolidation-Costs, April 1999; Linda R. Brewster, Leslie A. Jackson, Cara S. Lesser, "Insolvency and Challenges of Regulating Providers that Bear Risk" Center for Health System Change Issue Brief No. 26, February 2000.

Case Study: Harvard Pilgrim Health Care of New England (HPHC–RI)

- **Harvard Pilgrim's Rhode Island subsidiary was put into receivership by RI officials in October 1999, ceased operations Dec. 31, 1999, and was liquidated in January 2000.**
  - When it ceased operations, the RI subsidiary was serving 177,000 members
- **Under the March 2000 agreement between MA and RI state officials, HPHC-MA agreed to supplement HPHC-RI's assets with $14.5 million and commit any additional funds necessary to meet HPHC-RI's obligations.**
  - HPHC-MA guaranteed payment of any deficiency in funds necessary to satisfy HPHC-RI's member and provider obligations in full and processed HPHC-RI member and provider claims at cost.
- **Members were forced to seek new health plans with only two months notice.**
  - Approximately 9 percent of patients were uninsured at some point following Harvard Pilgrim's closure.
  - More than one-third of patients (35 percent) reported having no choice of health plan when Harvard Pilgrim was closed.
- **More than one-third of staff model providers (38 percent) experienced a period of unemployment; among mental health providers, that figure was 56 percent.**

Source: Robert Wood Johnson Foundation, "Measuring the Fallout from Shutdown of a Rhode Island Health Care Organization," May 2003; Massachusetts Division of Insurance Press Release, "Governors Cellucci, Almond Announce Agreement: Harvard Pilgrim Receiverships in Both States Will Coordinate Efforts," (March 20, 2000); Office of Massachusetts Attorney General Press Releases, March 20, 2000, May 24, 2000.

Many stakeholders are affected when a plan becomes insolvent

Consumers

- May have to pay for services out-of-pocket
- May experience interruption or reduced access of services
- May need to change physicians
- May experience higher premiums and less product choice given reduced market competition

Providers and Medical Suppliers

- May not get paid
- May experience interruption of services
- May experience insolvency

State

- Loss in tax revenue
- Disruption in the insured process
- Adverse impact on economic climate of the state

Employers

- Lose stable health plan for employees
- May have to cover new health plan costs despite having paid premiums for now-insolvent plan

Plan Employees

- Lose jobs
- May lose retirement funds or other investments

What are examples of health plan risk?

Though not all risks can be known, the types of risks which plans must manage against can be anticipated and effects lessened through appropriate surplus.

General Insurer Risks

- medical price inflation
- new technologies
- public market regulatory risk
- litigation
- catastrophic events
- pricing accuracy
- changing utilization patterns

Regional Plan Risks

- lack economies of scale that national plans enjoy
- cannot spread admin costs across a wider base
- localized economic downturn or catastrophic event

State Risks

- regulatory mandates
- price controls
- local market conditions

Plan-specific Risks

- provider reimbursement rates and payment
- mix of business
- poor asset investment
- density of provider network
- local market conditions
- counter party risk (ASO business)

Increased Layers of Health Plan Risk

How is Surplus Measured?

- Surplus as a Percentage of Annual Revenue (SAPOR)
  measures surplus as a % of insured premium revenue.
- Risk-Based Capital (RBC)
  is a measure used to establish the minimum amount of capital appropriate for a health organization to support its overall business operations during a period of adverse conditions. RBC considers the size, structure and risk profile of the insurer.
- Surplus as Months of Claims
- Surplus as Months of Revenue

Use of RBC

Most states, like RI, have enacted variations of the National Association of Insurance Commissioners (NAIC) model Health Risk-Based Capital Act to regulate surplus minimums.

The Act establishes clear, consistent guidelines for the calculation of RBC. RBC, when developed, assumed the use of reserves and reinsurance as additional offsets to financial risk.

This study primarily uses SAPOR and surplus as months of <u>insured premium revenue</u>.

While RBC is a commonly accepted measure of surplus, it is not amenable to modeling. Since successive annual changes in SAPOR are independent and normally distributed (unlike changes in RBC levels), using SAPOR enables us to extend our analysis from single-year losses to the multi-year losses that can occur during the course of an underwriting cycle. Once the modeling is done, the results are translated back into an estimate of equivalent RBC.

How is minimum surplus regulated in the U.S.?

RI has adopted the NAIC Trigger Points for Intervention Based on NAIC Risk-Based Capital Formula

RBC Level	Company or Regulator Response
Company Action Level (200% ACL)	Under RI law, the company must submit an RBC plan to the Commissioner. This plan includes, among other things, proposals of corrective actions it will take.
Regulatory Action Level (150% ACL)	The company must submit or resubmit a corrective plan of action to remedy the situation. After examining the company, the insurance commissioner will issue an order specifying the corrective actions to be taken.
Authorized Control Level (ACL)	The insurance commissioner is authorized to take regulatory action as may be necessary to protect the interests of the policyholders, including taking control of the company.
Mandatory Control Level (70% ACL)	The insurance commissioner is required to place the company under regulatory control.

The NAIC model only addresses the minimums needed to ensure solvency, and asserts that RBC is not an appropriate tool to use at higher levels of surplus.

BCBSA sets higher thresholds for minimum RBC ratios than the NAIC

The Blue Cross Blue Shield Association (BCBSA) licenses member plans to use the Blue Cross and Blue Shield brand names and trademarks and requires that plans meet specific standards for financial performance.

Association can terminate plan license trigger: < 200% RBC

- If the plan's RBC ratio falls below 200%, it can lose its BCBS license

Association intervention trigger: 375% RBC

- If a plan's surplus falls below this level, it is subject to additional reporting requirements by the Association.
- This gives the Association sufficient warning before a company's surplus is likely to decline to the 200% level

State Guaranty Fund Participation, alternative mechanism or 800% RBC

- BCBSRI currently participates in an alternative mechanism: a pledged asset agreement of $30 million in investment securities
  - Pledged in favor of the BCBSA to cover liabilities for claims administered by out of state BCBS subscribers incurring claims in their respective service areas.

Factors Driving Surplus Demand

Various business factors drive higher requirements for surplus to provide a financial cushion against potential unanticipated risks.

lower SAPOR ⟷ **higher SAPOR**

- **Contracting**
  - Risk-sharing with providers
  - Capitation and risk pools
- **Reinsurance contracts where risk is ceded to another entity**
- **For-profits** – access to capital through stock offerings
- **Large Plan**
  - Larger population to spread cost/risk, impacted less by enrollment fluctuations
  - Lower proportion of admin expenses fixed
  - Economies of scale and cost efficiencies for certain admin functions

- **Contracting**
  - FFS reimbursement
- **No reinsurance contracts ceding risk to another entity**
- **Non-profits** – only source of capital is retained earnings
- **Small Plan**
  - Smaller population to spread cost/risk and more heavily impacted by enrollment fluctuations
  - Higher proportion of admin expenses fixed

Factors Driving Surplus Demand (cont.)

lower SAPOR ← → higher SAPOR

Participate in less risky markets

- **National plan -**
  - Technological, actuarial and financial economies of scale
  - Can absorb excessive claims costs from a single region natural disaster
  - Can spread admin costs across a larger (wider) base
  - Can use its larger size as leverage in contracting
- **Management of Care**
  - High cost case management
  - DM, CM programs
- **Market Intelligence**
  - Longevity of the plan
  - Penetration of the market
  - Historical provider relationships

Participate in riskier markets

- Participate more heavily in the individual and small group markets in which they may be subject to adverse selection
- Higher proportion of business in indemnity or less managed products
- Government markets (Medicare, Medicaid, where premium rates are established earlier and in some cases, set by others)

Regional plan - focused in a single geographic region so the plan cannot spread risk across multiple markets

No Care Management Programs

Market Uncertainties

- New product introduction (Medicare Part D)
- Expansion into a new region
- Entry of a new competitor

Non-profit plans generally have higher surplus requirements

Non-Profit Health Plans

- Have less ready access to capital
- Only source of capital is retained earnings
- Access to, and costs of, other funds are heavily dependent on financial performance and stability

For-Profit Health Plans

- Need to show investors the highest possible return on equity
- Can sell shares in order to raise cash
- Subsidiaries pass profits up the line to the parent company creating the appearance of low surplus

Both for-profit and non-profit health plans have the ability to borrow funds as needed and must comply with the RI-adopted NAIC surplus minimum levels

How do other states regulate maximum surplus?

Given the lack of affordability of health care due to rising health care costs, there has been increasing interest in capping surplus.

- **Most states have adopted the NAIC minimum surplus requirements**
- **Few states have chosen to regulate the upper bounds of surplus capital accumulation:**
  - Pennsylvania set upper limits on surplus on all four of PA's Blue plans (950% RBC for Blue Cross of NEPA and Capital Blue Cross; 750% for Highmark and Independence Blue Cross)
    - Currently none of the PA Blue plans holds excess surplus. If a plan did exceed the surplus upper limit, the plan would have to file a report with the PA Insurance Commissioner justifying its current surplus level or file a plan explaining how it will divest its surplus in a manner that will benefit its policyholders
    - The Pennsylvania Legislative Budget and Finance Committee commissioned Lewin to conduct a study of the regulation and disposition of reserves and surpluses of the four Blue plans. Lewin found that the upper limits on surplus were reasonable.
  - Michigan has capped Blue Cross Blue Shield of Michigan's surplus at an RBC ratio of 1000%.
    - If the cap is reached, BCBSM must file a plan for approval by the Commissioner to adjust its surplus to a level below the allowable maximum surplus. The Commissioner can formulate an alternate plan if it disapproves of the plan filed.
  - Hawaii law requires that if a non-profit health plan's net worth exceeds 50% of the prior year's total health care expenditures plus operating costs, the plan must refund the money to clients.
  - New Hampshire caps a not-for-profit health insurer's contingency reserve funds at 20% of annual premium incomes.
    - NH BCBS plan, which was the state's only not-for-profit plan, is now a for-profit. Prior to this conversion, the state chose not to enforce the limit.

Is there a "right level of surplus"?

Few states have actually capped surplus levels, primarily due to difficulties associated with setting levels which are appropriate for all plans.

- There is no consensus as to the "right" level of surplus for a health insurance company.
- How much surplus is needed to provide an adequate margin of safety is largely a matter of judgment rather than calculation.
- Insurers contend that an insurer wants to provide an adequate margin of safety so that the company can endure periods of adverse experience without triggering any form of regulatory intervention.
  - Non-profits must use their surplus for all capital expenditures
- The "right" level is plan-specific; it is not a single number that can be applied to all plans.

Development of target surplus range

- For this study, we developed surplus levels reflecting what we believe represent prudent and conservative target ranges
- The target ranges can be justified to protect against underwriting swings based on each plan's circumstances
  - Surplus levels below the lower end of ranges do not reflect <u>insufficient</u> surplus

Section III

- Project Background
- Health Plan Risk, Reserves and Surplus
- **Rhode Island Market Risks**
- Health Plan Specific Risks
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RI's health insurance market is highly concentrated

Rhode Island Fully-insured Commercial Enrollment (Enrollment in 1,000s)

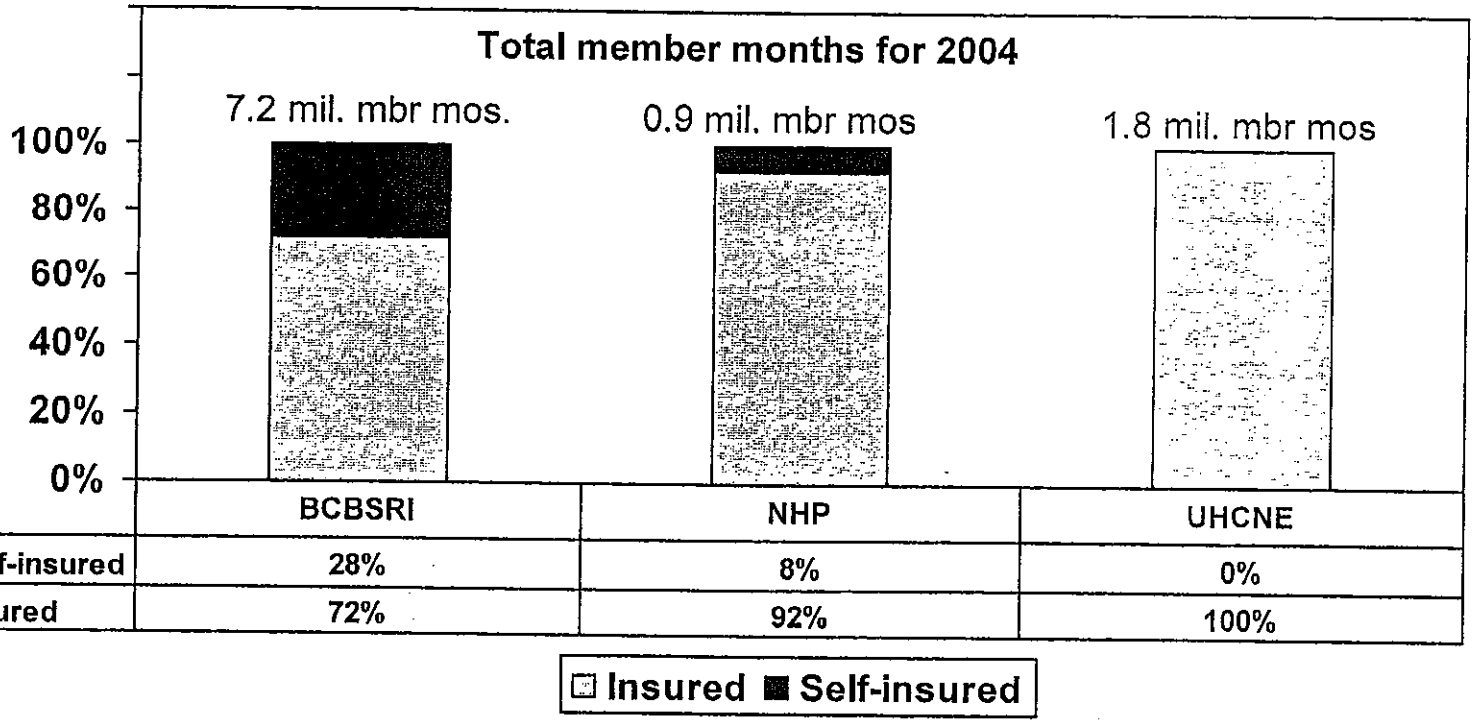
	2002	2003	2004
Plans Domiciled in RI			
BCBSRI (including BlueCHIP)	65%	64%	65%
UHCNE	15%	18%	19%
All Other Plans	20%	19%	16%
Total Commercial Enrollment	100%	100%	100%

Rhode Island is a very small, highly concentrated market

- -RI Population: 1M
- -Commercially insured: 380,000 (2004)
- -High degree of population density
- -Lack of market competition
  - -Two RI domiciled health plans in the commercial market with market dominance by BCBSRI

Source: Cryan, Bruce. *RI Commercial Health Plans' Performance Report (2004)*, Rhode Island Department of Health, December 2005, p.4. Available at www.health.ri.gov.

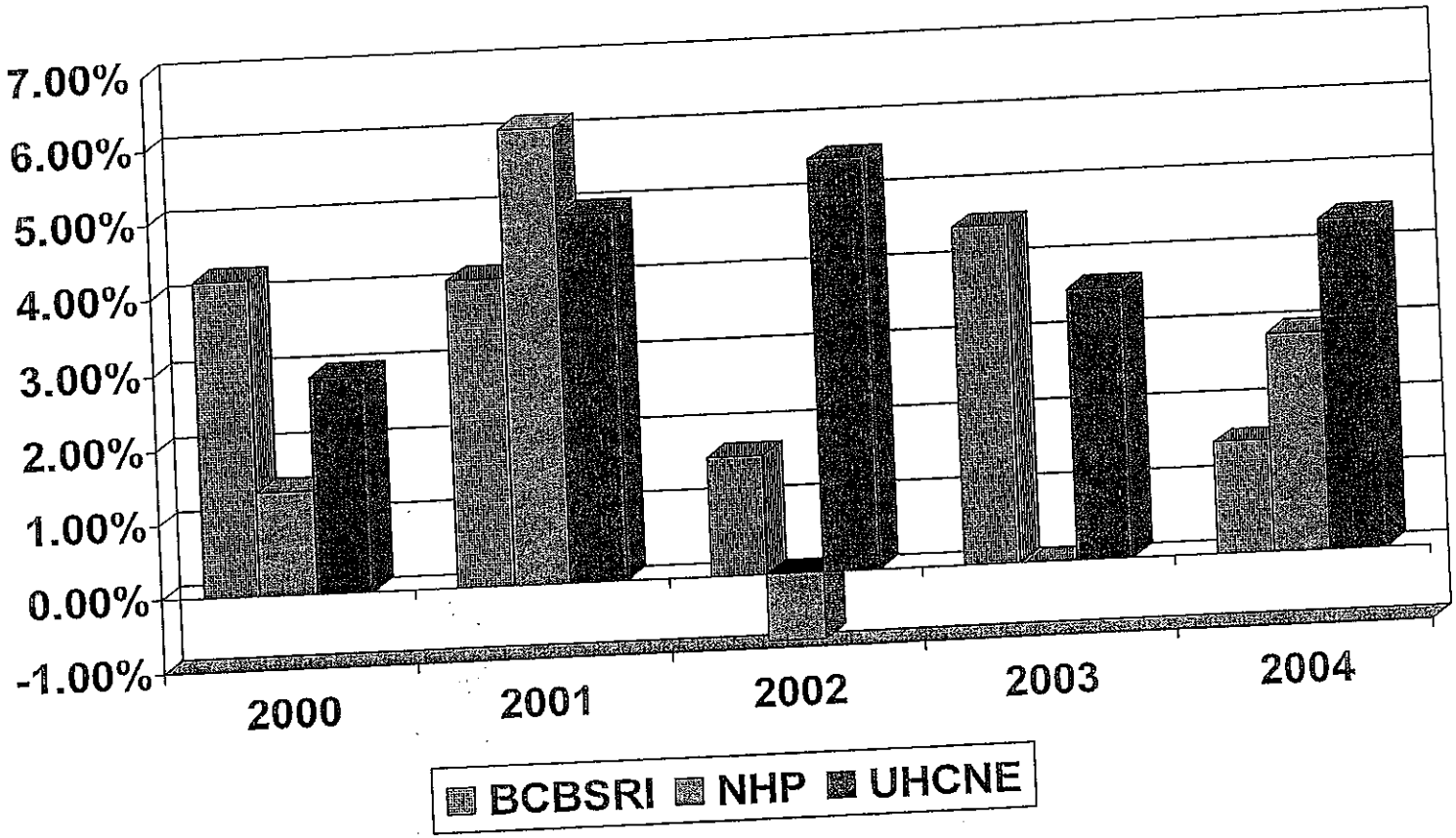
BCBSRI has the majority of total insured members and most self-insured business



	BCBSRI	NHP	UHCNE
Self-insured	28%	8%	0%
Insured	72%	92%	100%

United's self-insured contracts in Rhode Island and Massachusetts are written through another UHC affiliate and consequently are not reflected in UHCNE's business lines.

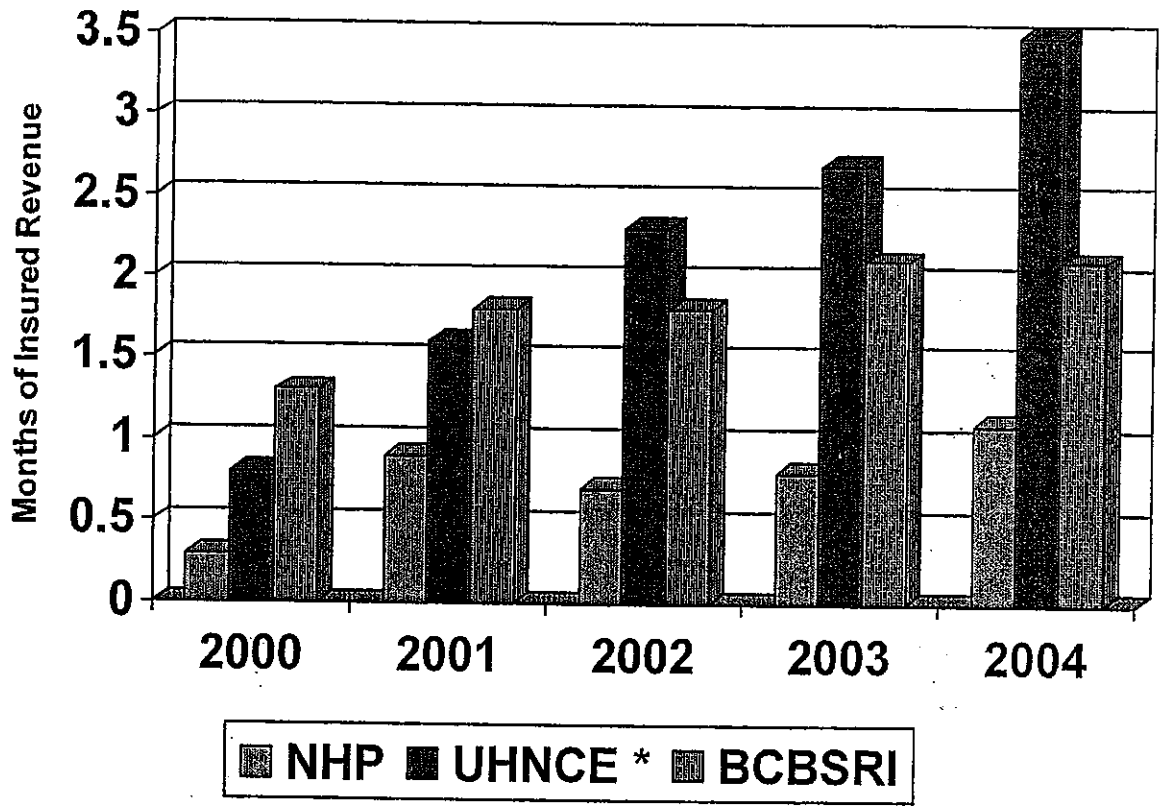
Rhode Island plans have generally experienced positive net profit margins over the last five years



BCBSRI numbers for all years include financial results of Coordinated Health Plan.

Source: Statutory filings to Rhode Island Department of Business Regulation.

Rhode Island plans' surplus as months of revenue has varied from 0.3 months to 3.5 months in recent years



* UHCNE's months of revenue reflect total revenue plan-wide.

Source: Statutory filings to Rhode Island Department of Business Regulation.

What risks do plans face with significant enrollment in the RI Medicaid market (RIteCare) requiring increased surplus?

- Changes in enrollment, benefits and rates
- State changes to the structure of the program
  - Governor's Budget eliminates RIteCare eligibility for parents in families with incomes >133% FPL (previously 185% FPL)
  - Removes RIteCare benefit for all undocumented children
  - Establish an asset test for RIteCare eligibility
  - Governor's Budget calls for a restructuring of contracts with Rite Care managed care providers
- Expansion to new populations such as SSI
  - Currently, TANF population risk is fairly stable and predicable
    - Hospital and pharmaceutical utilization and prices are risks
- Unavailability of NICU beds at Women and Infants Hospital in RI creates additional costs incurred out of network
- Potential Changes to risk-sharing agreement and other DHS stop loss
  - Currently each plan participates in a risk share agreement with DHS that transfers 70% of expenses in excess of 89% MLR to DHS
  - DHS also provides stop loss protection (90/10 reinsurance) for organ transplants

Current Medicaid Risk-Share (Gain/Loss) Agreement Risk Corridor

	<86% MLR	>89% MLR
Plan Risk	50%	30%
DHS Risk	50%	70%

All three RI insurers participate in RiteCare: NHP at 56.5%, UHCNE at 32.8% and BCBSRI at 56.6% (Enrollment as of June 30, 2004).

What risks requiring increased surplus does BCBSRI face given its enrollment in the RI Medicare market?

Product restructuring under MMA, combined with expansion into new products, increases plan risks and surplus demand relative to premium dollars.

- **The Nature of the risk in the Medicare market is still not yet well understood**
  - Effective Part D marketing may result in significant shifts in enrollment patterns across plans in the Medicare market
  - The Medicare Part D Program is new and most pricing could not be developed using historical information.
  - June 2006 Deadline for Medicare 2007 bidding process prevents use of 2006 experience
    - The nature and outcome of competitive bidding increases uncertainty about the adequacy of supplemental premiums.
  - Both MA and PDP products will have premiums dependent on the reported risk status of the enrollees, which is dependent on the quality of coding of the providers
  - Budget neutrality requirement adds uncertainty to rate setting process
  - Although the premiums received are adjusted for health status, there is still uncertainty about who will enroll and how successful the new offering will be given that the product is new.
  - Subsequent years of premium increases may depend not only on the actual underlying cost trends, but the availability of funding.
  - Entering the market will be easier than exiting for regional plans.
- **Introducing or expanding Medicare products means a sudden large need for surplus to back the product given the new enrollment.**

Section IV

- Project Background
- Health Plan Risk, Reserves and Surplus
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- **Health Plan Specific Risks**
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BCBSRI corporate structure

License Held	Non-profit, hospital and medical service corporation founded in 1939 and is Rhode Island's largest locally based, nonprofit health plan. BCBSRI is an independent licensee of the Blue Cross and Blue Shield Association.
Corporate Structure	◆ 16 member board of directors with 6 board members appointed by the State (2 by the Governor, 2 by the Speaker of the House and 2 by the Senate President) ◆ Effective January 1, 2005, BCBSRI merged with its for-profit wholly owned HMO subsidiary, Coordinated Health Partners to streamline operations. BlueCHiP Coordinated Health Plan, BlueCHiP for Medicare, and BlueCHiP for RIteCare continue to be offered under those product names.

BCBSRI's surplus experience

	Key Issues
Surplus History	◆ BCBSRI had a net loss of $73.2 million between 1996 and 1998 ◆ By the end of 1998, BCBSRI's contingency reserves had declined to a level of $76.6 million, representing 68% of its capital benchmark with a corresponding RBC ratio of 402% and surplus equal to 1.1 months of insured revenue, causing concern for its use of the Blue Cross and Blue Shield Association trademark since the required minimum level to use the BCBSA name and trademark was 60%.
Governor's Agreement on Surplus (now expired)	◆ To control costs, BCBSRI entered into a one-year agreement with the Governor of RI to work to manage its surplus to $277 million. This agreement ended August 1, 2005.

Source: Phyllis A. Doran, FSA, Robert H. Dobson, FSA, and Ronald G. Harris, FSA, "White Paper: Reserves for Subscriber Protection," Milliman and Robertson, August 9, 2000; BCBSRI Quarter 3 2005 Corporate Overview.

BCBSRI risk assessment

BCBSRI's structure, characteristics, and position in the market influence its surplus needs.

lower SAPOR ← → **higher SAPOR**

- Favorable facility contracting for high cost cases, historically
- Reinsurance contracts where extensive risk is ceded to another entity
  - Organ Transplant Reinsurance Agreement
  - Reinsurance Agreement between BCS Insurance Co and BCBSRI for Medicaid HMO business

- Contracting
- Non-profit
  - Surplus is the primary source of capital
- Small Plan
  - Smaller population to spread cost/risk and more heavily impacted by enrollment fluctuations
  - Growth potential limited due to size of Rhode Island market and BCBSRI's high penetration
  - Higher proportion of admin expenses fixed

BCBSRI risk assessment (cont.)

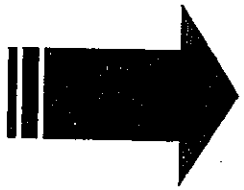
lower SAPOR ← → **higher SAPOR**

- Market Intelligence
  - Long history and deep market understanding reduces surprises

- Participate in riskier markets
  - participate more heavily in the individual and small group markets in which they may be subject to adverse selection
  - higher proportion of business in indemnity or less managed products
  - Government markets (Medicare, Medicaid, where rates are more fixed and set by others)
    - Losses in Medicare Supplement (Plan 65 Individual)
- Regional plan - focused in a single geographic region so cannot spread risk across multiple markets
  - Blues Limitations
    - Cannot sell product lines other than health insurance
    - Cannot use the Blues brand to sell health insurance outside of RI
- Faces unique regulatory requirements

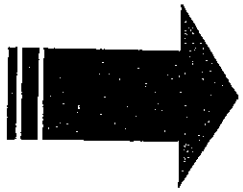
Mandated RI regulatory requirements lead to inherent risks for BCBSRI

Required to participate in the individual market



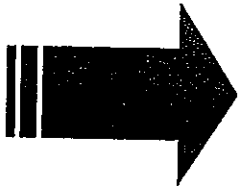
- Must have a 30 day open enrollment period every 12 months
- Serves as the insurer of last resort

Required to employ pricing strategies that "enhance the affordability of health care coverage"



- Direct pay and Plan 65 rate increases are subject to rate hearings and approval
  - "File and approve" not "file and use"
  - Statutory language affects BCBSRI's rate increase approval in the direct pay market despite actuarial soundness of proposed rates

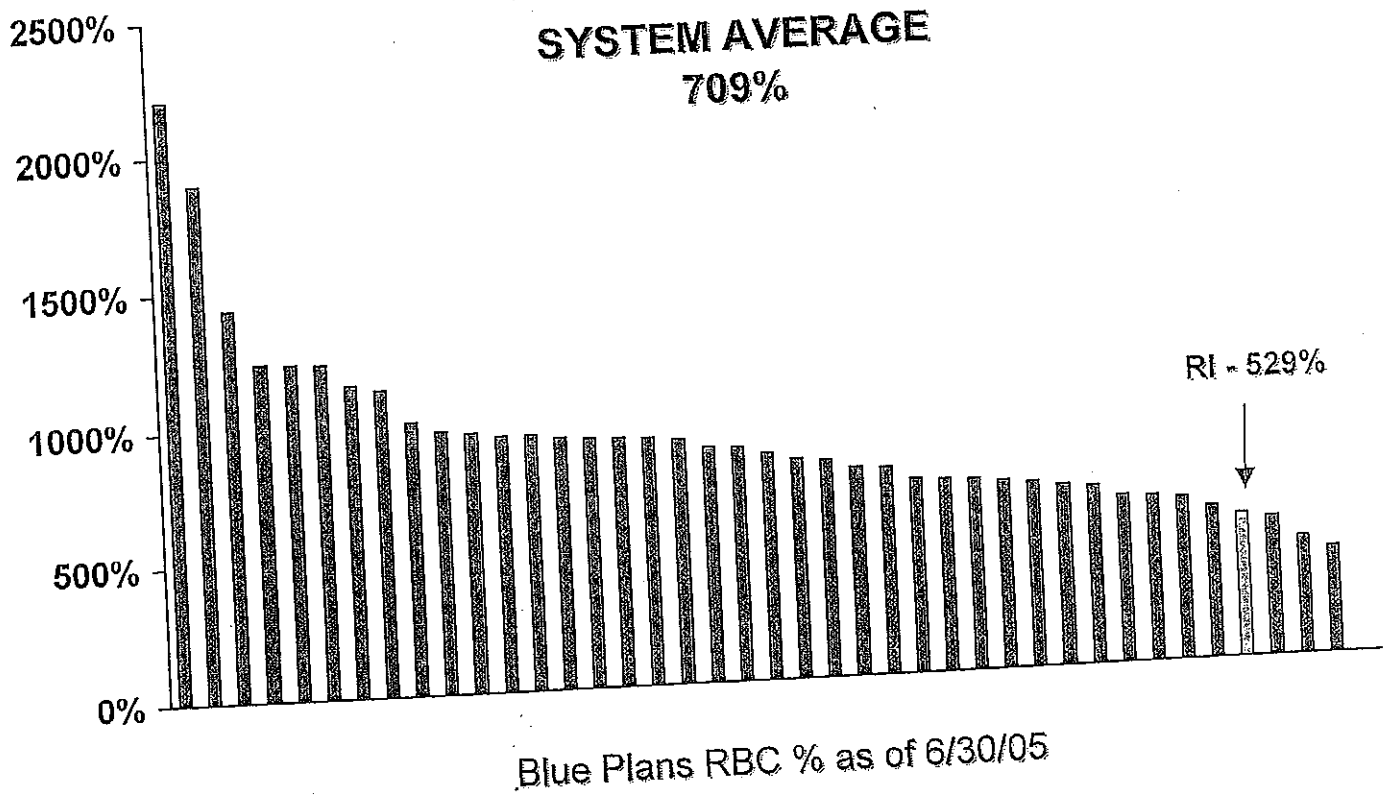
Required to participate in the small group market



- Small group requirements spread risk more broadly by bringing all insured small employers into one insurance risk pool, and limits premium rate variability among small employers with adjusted community rating but could lead to adverse selection in the small group market

Source: Lautzenheiser & Associates, Report on the Effectiveness of Rhode Island General Laws ss. 27-50-1 et seq. Small Employer Health Insurance Availability Act in Promoting Rate Stability Product Availability and Coverage Affordability (2002); RI Gen. Laws s. 27-19.2-10.

BCBSRI's RBC ratio is lower than most Blue plans nationally



Source: BCBSA, as provided by BCBSRI.

Lewin Blues RBC model was used to analyze BCBSRI's surplus needs

- The Lewin Blues RBC model follows a four-step process
  - Identify similar BCBS plans - similar total and average revenue levels and similar growth in revenue as BCBSRI
  - Assess the distribution of annual changes in surplus as a percentage of revenue (SAPOR) to validate the plan sample
  - Determine the validity of number of years in expected downturn
  - Assess RBC required to withstand such downturn using two benchmarks for minimum surplus levels
    - BCBSA's Early Warning Level of 375% of ACL
    - NAIC's Company Action Level and BCBSA absolute minimum of 200% of ACL

Methodology, data input, and model results are summarized in Appendix A

Implications of Lewin RBC model for BCBSRI

- Based on our model, surplus levels that produce RBC ratios in the range of 554% to 853% can be justified to protect against underwriting swings or unfavorable events.
  - This range reflects a 95% confidence interval and a down cycle from two to six years in length.
- This analysis supports a target surplus range of 2.2 – 3.3 months of insured consolidated revenue (including CHP)
- As of 2005, BCBSRI has a surplus equal to 2.4 months of insured revenue.

Neighborhood Health Plan of RI

	Background
License	Non-profit HMO, founded in 1993 by 13 community health centers to participate in the State's Medicaid managed care program, RIteCare, received HMO license in 1994.
Corporate Structure	◆ Neighborhood is a 501(c)(3) organization with a 15 member board.
Population Served	◆ TANF (Insured: moms and kids in Medicaid managed care) ◆ Foster care children (ASO) ◆ Children with special health care needs (ASO)
Surplus History	NHPRI's surplus has increased over time: ➢2005 (333% RBC) ➢2004 (240% RBC) ➢ 2003 (180% RBC) ➢ 2002 (154% RBC) The State may waive the RBC requirements for NHPRI in accordance with RI Insurance laws s.27-4.7-10 given the nature of the company as a provider for 2/3 of RI's Medicaid population, risk share agreement in place that limits the possibility of material loss and the financial results of the plan's Medicaid line over past years

Neighborhood Health Plan risk assessment

RIteCare's risk sharing agreement provides a crucial offset to the risks NHP faces as a Medicaid-only plan in a small market.

lower SAPOR ← → **higher SAPOR**

- Reinsurance contracts where risk is ceded to another entity
  - Excess Loss Reinsurance Agreement on Medicaid business
- Market Intelligence
  - Strong expertise in RI Medicaid
- Plan Size
  - Although small, NHP dominates the Medicaid RIteCare market and has 2/3's of Medicaid members
  - Market dominance provides NHP with leverage within RIteCare program

- Limitations of reinsurance
  - Per diem cap applied to inpatient costs
  - Excludes drugs not provided in an inpatient setting, putting NHP at risk most notably for outpatient drugs for hemophilia patients
- Contracting
  - Less leverage in negotiating with providers given Medicaid-only line of business
- Non-profit
  - Surplus is the primary source of capital
  - Impaired position in the capital market (Bond Rating of C- affects Neighborhood's leverage in capital markets)
- Small Plan
  - Smaller population to spread cost/risk and more heavily impacted by enrollment fluctuations
  - Higher proportion of admin expenses fixed

Neighborhood Health Plan risk assessment (cont.)

- Uniformity of population increases predictability
- Small population permits immediate detection of issues.

- Participate in riskier markets
  - Medicaid-only plan
  - Significantly affected by changes to Medicaid
  - Must accept rates offered by DHS which may not reflect the most current experience
- Regional plan - focused in a single geographic region with a focus on urban areas so cannot spread risk across multiple markets
- Philosophy is to interpret benefit requirements more generously

Neighborhood Health Plan's risk protection under current conditions is adequate, yet has gaps

- While NHP is insulated from claim fluctuation risk, underwriting cycle risk, and catastrophic risk via its reinsurance and state risk sharing agreement, they are not entirely immune.
  - Reinsurance: there remains the risk that the per diem costs will exceed the maximums in the reinsurance contract or that significant drug costs will be incurred for cases not confined to an inpatient facility (a hemophiliac child)
  - Risk Sharing: NHP receives 70% of medical costs incurred above an 89% medical loss ratio. However, NHP must accept the rates offered by the State and the State's contracting terms. In addition, the risk sharing corridor is not a statutory requirement but can be modified by the State in future contract periods.

Neighborhood Health Plan's recommended surplus level reflects its unique combination of risks

Estimated percent of current premium needed to cover specific risks, estimated using standard actuarial techniques based on percent of premium as a measure.

- Claims Risk: 10-11% of premium
  - Increased accrual of surplus is needed to prepare for the *potentiality* of a reduction in the State's risk sharing coverage
  - Claims risk would increase beyond 10-11% if the risk sharing corridor were to change unfavorably
- Risk of Fluctuation in Asset Values: 5% of premium
- Risk of loss of business to the other two Medicaid insurers: 4% of premium
  - Competitor growth in the market could lead to NHP losing business creating the need to cover fixed expenses from surplus
  - This scenario estimates 60% of expenses being variable with12% of premium as expense and the possibility of 50% erosion in plan membership

Continued

Neighborhood Health Plan's recommended surplus level reflects its unique combination of risks

Estimated percent of current premium to cover specific risks

- Business interruption caused by catastrophe: 2% of premium
- Litigation risk: .5% of premium
- Capital outlay: 1% of premium
- External Factors: 1-2.5% of premium
  - Competitor withdrawal from the market and subsequent enrollment in NHP would strain its surplus
  - Need to maintain the financial well being of providers or increased contracting to keep providers solvent
  - Modest changes in the Medicaid program or changes to the Risk Sharing Agreement.

Implications for Neighborhood's surplus needs

- We estimate NHP's surplus needs to be between 20 and 25% of insured revenue (2.4 – 3.0 months of insured premium revenue).
  - This range assumes no change to the risk sharing corridor in the near term.
  - Significant changes to the RIteCare program would require immediate re-evaluation.

- As of 2005, Neighborhood had surplus equal to 1.4 months of total insured revenue.

United HealthCare of New England

	Key Issues
License Held	For-profit HMO; Licensed to operate in RI and portions of MA. Incorporated in 1983, under the name of Ocean State Master Health Plan. In 1993, as a result of regional growth and the affiliation with UHC, the name was changed to United Healthcare of New England. Operates statewide and also in Bristol County, MA with 119,694 RI members and 26,063 MA members as of Dec. 31, 2004.
Corporate Structure	Wholly-owned subsidiary of the United HealthCare Services, Inc (UHS), an HMO management corporation that provides services to UHCNE. UHS is a wholly owned subsidiary of United Health Group, Incorporated. Net premium revenue reported in 2004: $303 million Total 2004 Premium revenue for corporate parent, United Health Group: $33.5 billion
Surplus in 2004	Entered into a reinsurance agreement with a sister corporation, United Healthcare Insurance Company (UHIC), a Connecticut domestic insurer where United HealthCare of New England ceded 60% of its commercial business and attendant risk to UHIC; In 2004, UHCNE transferred $26.5 M: 10M to its parent company United Healthcare Services, Inc. to pay back a surplus note and $16.5M as dividends to United HealthCare Services, Inc.

Source: United States Securities and Exchange Commission Form 10-K, United Health Group Incorporated 2004 Filing; Rhode Island Dept. of Health, Office of Health Insurance Commissioner, "The Health of Rhode Island's Health Insurers: A Financial Analysis" (2005)

United HealthCare of New England risk assessment

UHCNE's reinsurance contract with another United subsidiary and the operational contributions of its corporate parent insulate it from many of the risks inherent in the Rhode Island market.

lower SAPOR ⟷ **higher SAPOR**

- Reinsurance contracts where risk is ceded to another entity
  - Reinsurance contract with a sister corporation, United Healthcare Insurance Company (UHIC)- ceded 60% of its commercial business and attendant risk to UHIC
  - Parent Company guarantee at 275% RBC
  - Excess loss Reinsurance Agreement for Medicaid business

United HealthCare of New England

lower SAPOR ← → **higher SAPOR**

- Lower levels of participation in riskier markets
  - Individual market
- For-profit
- Large Plan/National plan
  - Larger population to spread cost/risk, impacted less by enrollment fluctuations
  - Lower proportion of admin expenses fixed
  - Dedicated risk analysis group
  - Economies of scale and cost efficiencies for admin functions
- Market Intelligence
  - Market research
  - New product developments

- Participate in riskier markets
  - Participate in small group market
  - Participate in Government markets (Medicare, Medicaid, where rates are more fixed and set by others)

UHCNE's surplus needs are closely tied to the financial strength of its corporate parent

- The financial strengths of UHCNE's parent company offers some protection against short term financial downturns.
  - Parent Company guarantee at 275% RBC
- The substantial reinsurance provided to UHCNE by UHIC means that most if not all of the risks are covered by the reinsurance provisions or reduced by using other United subsidiaries to administer the plans (Medicare).
- Beyond the NAIC minimum, the State sought and received from UHCNE a parental guarantee of 275% RBC to ensure solvency for Rhode Island insured lives.
  - We would need to do a more extensive review of the risk sharing provisions and surplus history throughout all affected companies within UHC in order to determine a suggested maximum surplus level in light of UHCNE's reinsurance coverage. The private agreement with the State provides a minimum surplus level.
- However, there should remain a concern that resides outside the scope of this study or of the scope of authority of the Department: are the reinsurance surplus amounts adequate to cover the risk and further, how would Rhode Island fare in a competition among UHC subsidiaries for surplus funds?

Implications for UHCNE

- The minimum RBC level of 275%, equivalent to approximately 0.8 months of insured premium revenue for 2005, was negotiated by the State as a means of addressing adequate surplus levels beyond the NAIC Model requirements.
- As of 2005, UHCNE's surplus was equal to 2.1 months of insured gross premium revenue plan-wide.
- Developing a target surplus range for UHCNE is not feasible without a thorough understanding of the financial relationships between the UHC affiliates and the parent organization.

UHCNE's characteristics reduce SAPOR needed relative to target ranges for others

- Several characteristics diminish UHCNE's need for surplus as a % of revenue as compared to BCBSRI or NHP
  - UHCNE's affiliates provide geographic diversity
  - UHCNE's corporate parent provides centralized administrative functions and expertise, reducing capital requirements for administrative infrastructure at the plan level
  - UHCNE has extensive reinsurance coverage
  - UHCNE's for-profit status provides alternative sources for capital
  - UHCNE's diversification across lines of business, relative to NHP, provides some protection

Analysis of surplus needs for a regional for-profit insurer can offer some context

- Although we cannot evaluate UHC and UHC-affiliated risks within the timeframe and scope of this study, we can create and evaluate a hypothetical insurer with *some* of the characteristics of UHCNE
- A case study of a hypothetical for-profit insurer domiciled in Rhode Island allows us to eliminate some of the key differences noted between UHCNE and NHP and BCBSRI

Hypothetical For Profit Health Insurer: The Better Health Insurance Company

- The *Better Health Insurance Company* was created to illustrate the potential surplus target range for a for-profit insurance company operating in the state of Rhode Island.
- The hypothetical company operates in the same concentrated market place as current Rhode Island carriers and participates in commercial and government markets.
- Very broad assumptions regarding the financial condition, business arrangements, and enrollment statistics were made to assess the target surplus range for BHIC.

Business statistics for Better Health Insurance Company reflect participation in all major markets

BHIC's 2005 Experience Reflects a Medical Loss Ratio of 80 percent for its 1.5 million member months.

Lines of Business Statistics	Member Months	Premium Revenue
Medium and Large Group, Insured	372,000	$ 101,000,000
Small Group	168,000	$ 46,000,000
Individual	4,000	$ 650,000
Government Plans	300,000	$ 83,000,000
Medicaid	470,000	$ 77,000,000
Medicare Advantage	180,000	$ 120,000,000
Total	1,494,000	$ 427,650,000

BHIC cedes $164 million of premium to its reinsurer for a net premium of $264 million.

Additional risk protection provided to BHIC's Medicaid business is covered by the RIteCare risk sharing mechanism.

The Better Health Insurance Company's Corporate Structure (BHIC)

License Held	◆ For-profit HMO domiciled in RI; Licensed to operate in RI. Operates statewide.
Reinsurance	◆ Maintains extensive reinsurance coverage with a third party non-affiliate
Product Mix	◆ Participates in the individual, small, mid, and large group commercial markets, and Medicare market ◆ Participates in RIteCare with risk sharing

Development of BHIC risk profile reflects many broad assumptions

Type of Risk	Description	Risk Management in Place
Claim Fluctuation	Foremost risk: that premium may be inadequate for costs that occur. Can be due to underestimation of trend or exposure to high cost claims	Extensive Reinsurance on a Aggregate Level; Specific Stop Loss, Reputable Reinsurer
Asset/Liability Fluctuation	The assets will not produce income as expected or be worth what is expected; The assets may not be as liquid as necessary when needed	Solid Investment Policy
Business Loss	Loss of large customers leaves fixed costs to be covered	Contingency Reserves
Catastrophe	Natural Disaster, Terrorist Attack, Epidemic, Industrial Accident; Claims extraordinarily high, provider supply severely restricted.	Contingency Reserves
Business Interruption	Extensive costs due to interruption from natural or man-made disasters	Contingency Reserves, Business Interruption Policy, Contingency Plan
Litigation	Class action lawsuits due to enforcement of benefit provisions or provider reimbursement	Contingency Reserves, Consistent and Documented Methods

Development of BHIC risk profile reflects many broad assumptions, cont.

Type of Risk	Description	Risk Management in Place
Growth	Growth causes surplus stress, particularly with Medicare	Contingency Reserves; note that with a premium increase of 10%, need a 2-3% margin to maintain garget surplus level
Anti-selection	Competition for members may produce a poorer risk profile than expected	Contingency Reserves
Business Management Risk	Management will not have the experience or capacity to manage the risk	Very sharp management team
Provider Network	Limited choice of providers; provider financial health	Wide provider network to the extent possible
Regulatory	Regulations restrict or preclude, in the case of Medicaid, the plan from setting premiums at the level expected	Contingency Reserves
Capital Access	Plans to upgrade systems or add buildings	Bond ratings and stock offering, but need some capital too

Assumptions for financial profile and insurer risks drive BHIC's target surplus

- With an estimated ACL of $13 million, a written premium of $428 million, and a net premium (net of reinsurance) of $264 million:
  - We estimate a conservative range for BHIC's surplus to be between 1.7 – 2.1 months of insured premium revenue (or SAPOR of 20% to 25%), or 462 -577% of RBC
  - Surplus range applicable to 2005: $60 - $75 million
  - The surplus target reflects extensive reinsurance, current RIteCare risk sharing, and risk adjustment payment mechanism for Medicare Advantage and sole operations

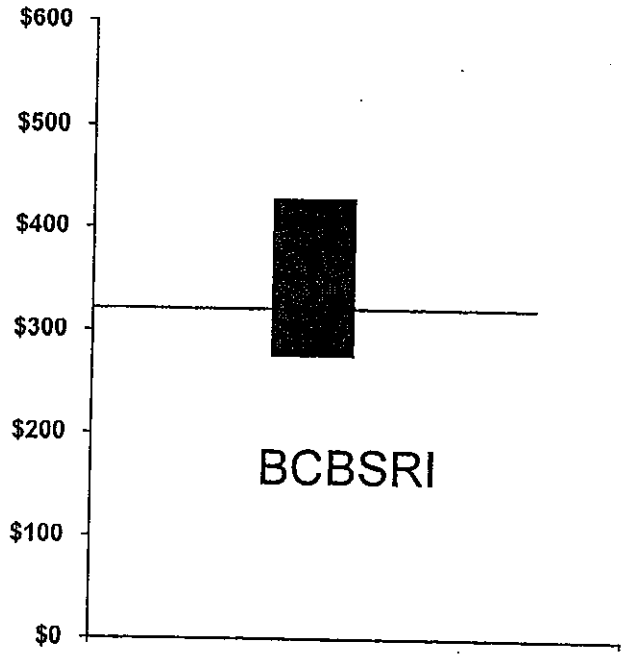
BHIC's situation does not mirror UHCNE's

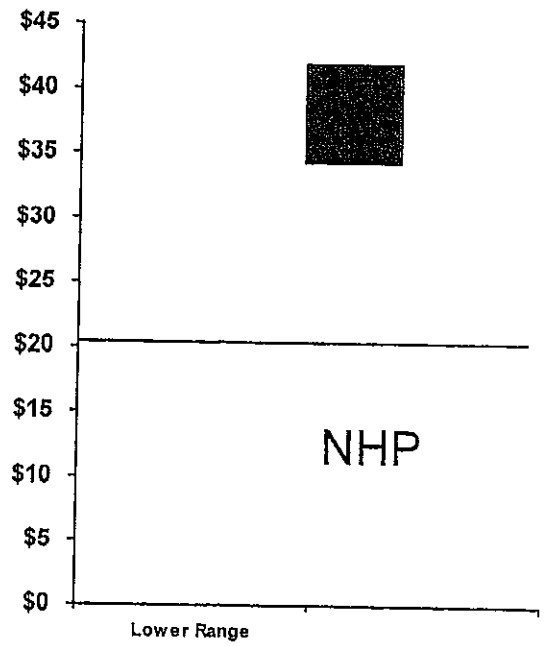
UHCNE Compared to BHIC	UHCNE's SAPOR needs relative to BHIC's
UHCNE's for-profit status, size and mix of business similar to BHIC's	No impact
UHCNE's reinsurance coverage has a more advantageous loss ratio than available commercially	Lower
UHCNE benefits from its status as a subsidiary of UHC ◆ Centralized administrative functions and actuarial/financial support ◆ Economies of scale for management information systems	Lower

Section V

- Project Background
- Health Plan Risk, Reserves and Surplus
- Rhode Island Market Risks
- Health Plan Specific Risks
- **Conclusions and Recommendations**

The recommended surplus ranges reflect the unique characteristics of the three carriers





BCBSRI
Actual 2005 surplus:
$316 million
Surplus range applicable to 2005:
$285 - $439 million

NHP
Actual 2005 surplus:
$20 million
Surplus range applicable to 2005:
$34 - $43 million

Final observations for BCBSRI

- Strengths
  - Strong market share (in excess of 60%)
  - Strong infrastructure to support its expanding managed care business
  - Long history and brand identity provide marketing advantage
- Weaknesses
  - Regulatory environment that limits rate/premium increases while increasing physician fee reimbursement
  - Typically prices its products with small margins
  - Not open to capital markets
  - Past conflicts over reimbursement levels with providers
  - Individual market rate increase denials could put BCBSRI in an unprofitable cycle creating material decrease in surplus
  - Geographically limited: Cannot use the Blues brand to sell health insurance outside of RI
  - Statutorily defined as a charitable corporation and an incorporated public charitable institution.
- Recommend targeting 2.2 to 3.3 months of insured revenue for surplus

Final observations for Neighborhood

- The plan's net worth has certain protection due to the risk share with DHS. However, the plan is dependent on DHS to provide an adequate premium and assume risk through its risk share arrangement. If this does not occur, a material strain on the plan's capital and surplus will occur.
- RI should consider a target surplus range of 2.4 to 3.0 months of insured revenue to provide for the risks enumerated earlier, with a review upon resolution of the impacts on RIteCare resulting from State budget shortfall. NHP's ability to maintain this target depends on the adequacy of capitation rates in future periods.
  - NHP needs to increase its surplus in recognition of the eventuality of the degradation of the risk sharing protection.

Final observations for United HealthCare of New England

- United
  - Surplus was equal to 3.2 months of insured premium revenue in 2005
  - Strong capital position of its parent company combined with the parental guarantee of a minimum of 275% RBC, protects against short-term downturns
  - The organization has shown its ability to react quickly to industry trends of higher than average medical costs with pricing adjustments and aggressive medical management initiatives
  - The company's market position (one of 2 main commercial insurers in RI) provides competitive advantage in provider negotiations and cost controls
  - Developing a target surplus range for UHCNE would require an analysis of UHC and all affiliates

Source: UHCNE 2004 Financial Analysis Completion Summary, 10/30/05

Appendix A
Results of Lewin Blues RBC Model for BCBSRI

The Lewin Blues RBC model

There are four basic steps to the Lewin RBC model.

Step 1: Identify Similar BCBS Plans	■ We looked at plans that had total and average insured revenue levels over time that were similar to BCBSRI
Step 2:Analyze Validity of Selected Plans	■ We calculated surplus as a percent of revenue (SAPOR) for each year (1992-2004) ■ We analyzed this data to see how the changes are distributed and to validate our plan sample.
Step 3: Determine Validity of Number of Years in Expected Downturn	■ We looked at the cumulative changes in SAPOR for each company, found the maximum cumulative loss of surplus that occurred during this timeframe and noted the number of years over which this loss took place
Step 4: Assess RBC Required To Withstand Downturn	■ We considered two benchmarks for minimum surplus levels: BCBSA's "Early Warning Level" of 375% of ACL and NAIC's "Company Action Level" of 200% of ACL ■ We considered two confidence levels: 90% and 95%.

Step 1: BCBS Plans Chosen For Lewin Model

BCBS plans used for comparisons were chosen based on objective criteria. The overall sample included 15 plans including BCBSRI.

	2004 Revenue	Avg Revenue, 1998-2004	Ratio of Avg Revenue
Plan 1	$ 902	$ 795	124%
Plan 2	$ 1,139	$ 904	115%
Plan 3	$ 635	$ 529	114%
Plan 4	$ 746	$ 602	123%
Plan 5	$ 937	$ 659	123%
Plan 6	$ 1,793	$ 1,647	117%
Plan 7	$ 642	$ 493	109%
Plan 8	$ 981	$ 705	123%
Plan 9	$ 1,947	$ 1,386	131%
Plan 10	$ 809	$ 549	123%
Plan 11	$ 381	$ 294	118%
Plan 12	$ 2,062	$ 1,392	113%
Plan 13	$ 1,063	$ 873	108%
Plan 14	$ 1,869	$ 1,309	132%
Plan 15	$ 262	$ 216	99%
Average	**$1,078**	**$824**	**118%**
BCBSRI	**$1,063**	**$873**	**108%**

Notes: Plans are either non-profit or mutual BCBS plans

Criteria for Inclusion

Select a group of plans that, on average, have insured revenue levels similar to BCBSRI

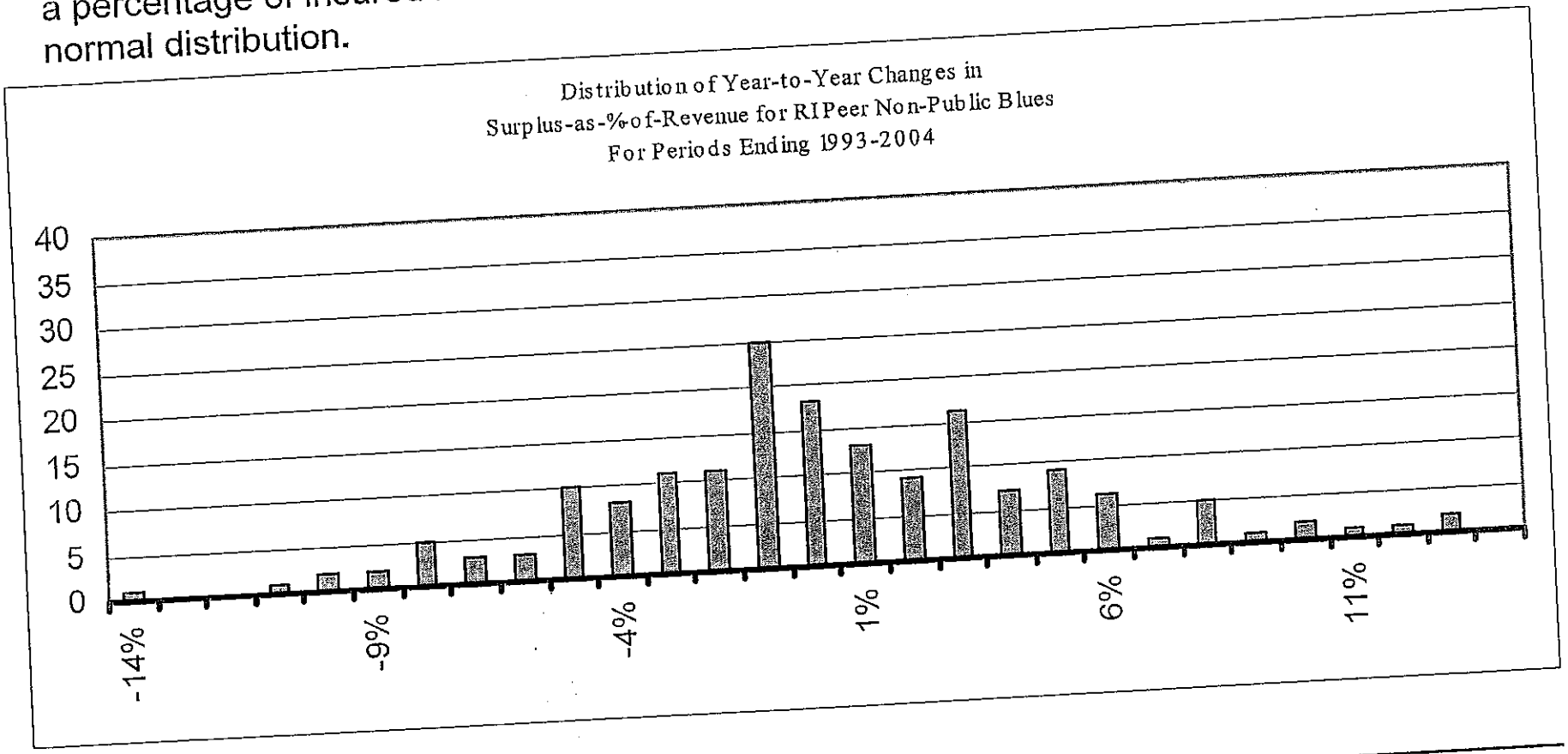
- 2004 insured revenue is between $262M and $2,062M with an average slightly above BCBSRI

Select a group of plans that, on average, have similar growth in insured revenue as BCBSRI

- Average insured revenue 1998-2004 is slightly below BCBSRI
- Ratio of Average Insured Revenue 1998-2004 to Average Insured Revenue 1992-2004 is similar to BCBSRI

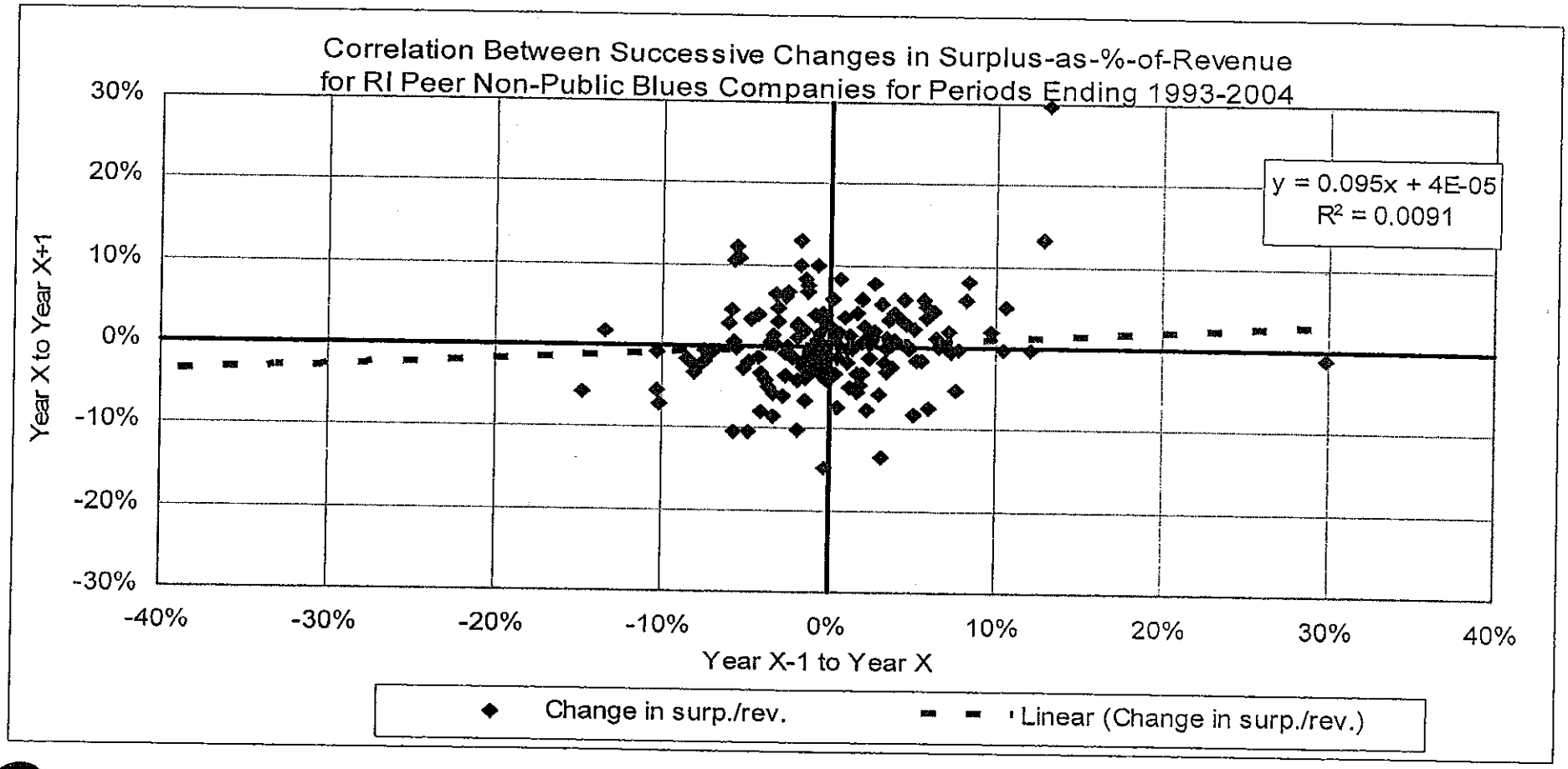
Step 2: Analysis of Comparative Plans

To validate the plan sample, we assessed the distribution of annual changes in surplus as a percentage of insured revenue (SAPOR) for the sample to ensure that it was close to a normal distribution.



Step 2: Analysis of Comparative Plans, cont.

We also ensured that the successive changes in SAPOR for an individual company are independent, as shown by the analysis below, which has an insignificant R-squared.



Steps 3 & 4: Years in Downturn to Arrive at BCBSA Early Warning Levels

Historical Number of Years in a Cumulative Downturn

Number of Years	Number of Plans
1	1
3	4
4	2
5	2
6	2
7	3

Range Used

Definitions of BCBSA Early Warning Level and Company Action Level

RBC Level	Company Response
BCBSA Early Warning Level (375% ACL)	The company must notify the BCBSA.
Company Action Level (200% ACL)	The company must notify the insurance commissioner of the corrective actions it plans to take to increase capital.

Additionally, under RI statute, a plan that is at the company action level must submit an RBC plan to the Commissioner. This plan includes, among other things, proposals of corrective actions the plan will take.

Target RBC Range Identified

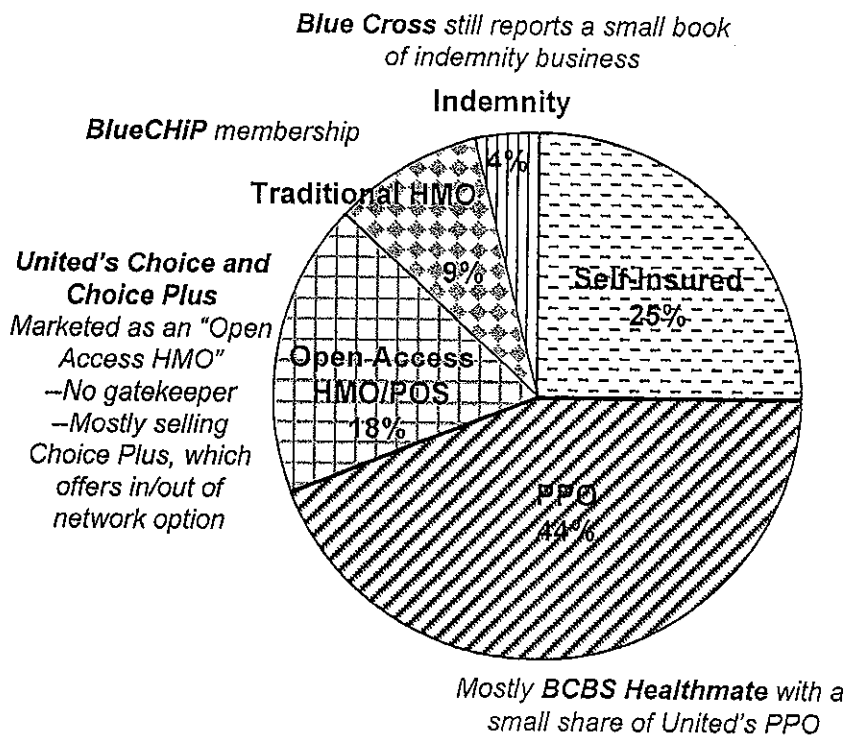
Based on our model, surplus levels that produce RBC ratios in the range of 554% to 853%, or 2.7 to 4.1 months of insured revenue, can be justified to protect against underwriting swings or unfortuitous events.

	Number of Years in Potential Down Cycle				
	2	3	4	5	6
Standard Deviation in Cumulative Change in SAPOR	8.7%	10.6%	12.2%	13.7%	15.0%
Requirements to Stay Above BCBSA Early Warning Level with 90% confidence					
Incremental SAPOR requirement	11.1%	13.6%	15.7%	17.5%	19.2%
Total SAPOR	26.2%	28.7%	30.8%	32.6%	34.3%
RBC Equivalent	651%	713%	765%	811%	853%
Requirements to Stay Above BCBSA Company Minimum Level (CAL) with 95% confidence					
Incremental SAPOR requirement	14.2%	17.4%	20.1%	22.5%	24.7%
Total SAPOR	**22.3%**	**25.5%**	**28.2%**	**30.6%**	**32.7%**
RBC Equivalent	**554%**	**634%**	**701%**	**760%**	**814%**

Appendix B
Health Insurance Coverage in Rhode Island

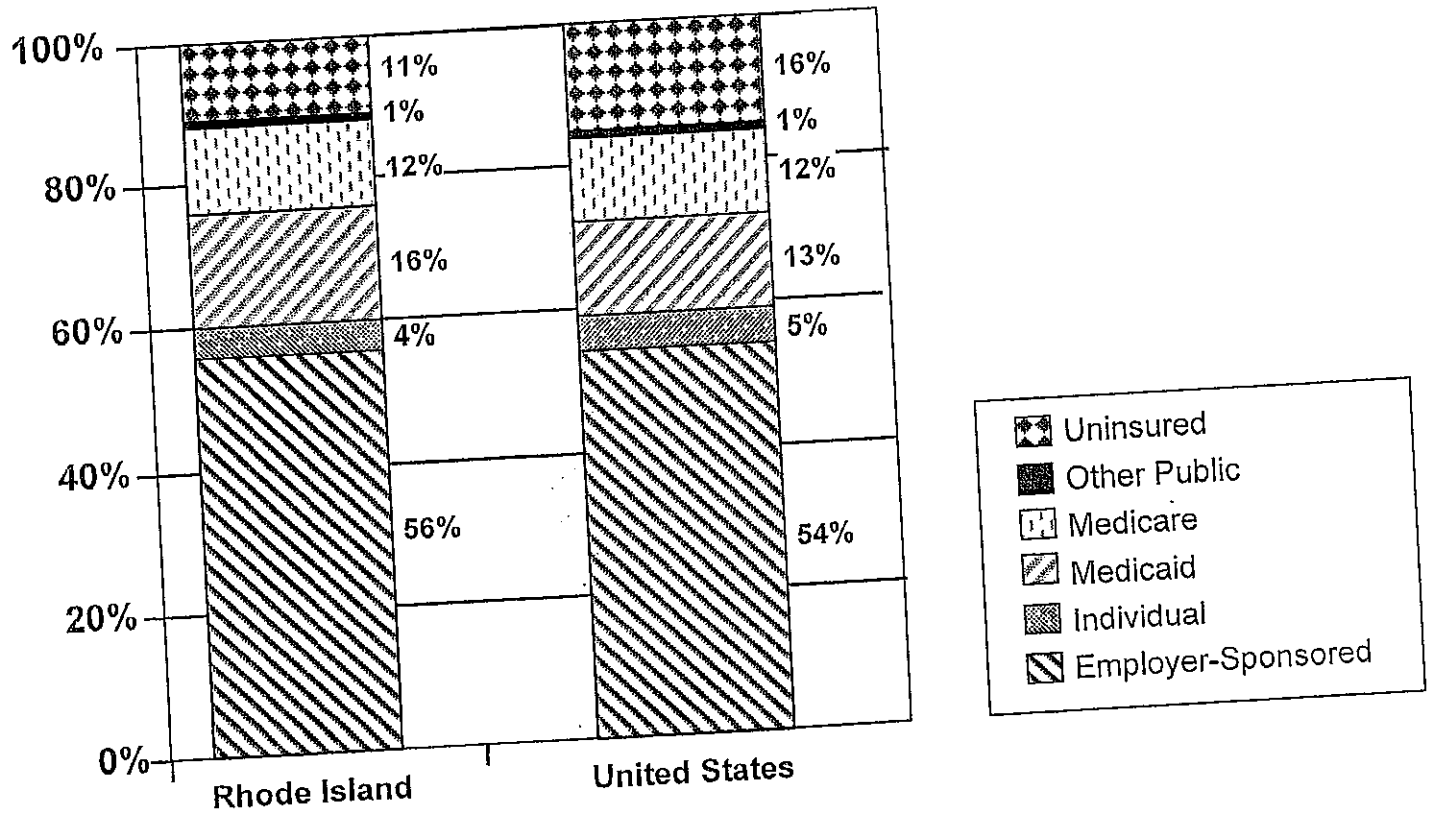
Rhode Island Commercial Membership by Product

- Unlike most other New England states (with the exception of Maine), RI is a relatively unmanaged, PPO dominant environment.
- Although there are plans marketed as an HMO, the vast majority have no gatekeeper and the networks are fairly broad, covering most providers in the state.



Source: Department of Human Services, Rhode Island State Planning Grant on Access to Health Insurance, HRSA Final Report, September 2005. Based on Q1 2004 financial filings from BCBS, United and NHP; does not include TPA business.

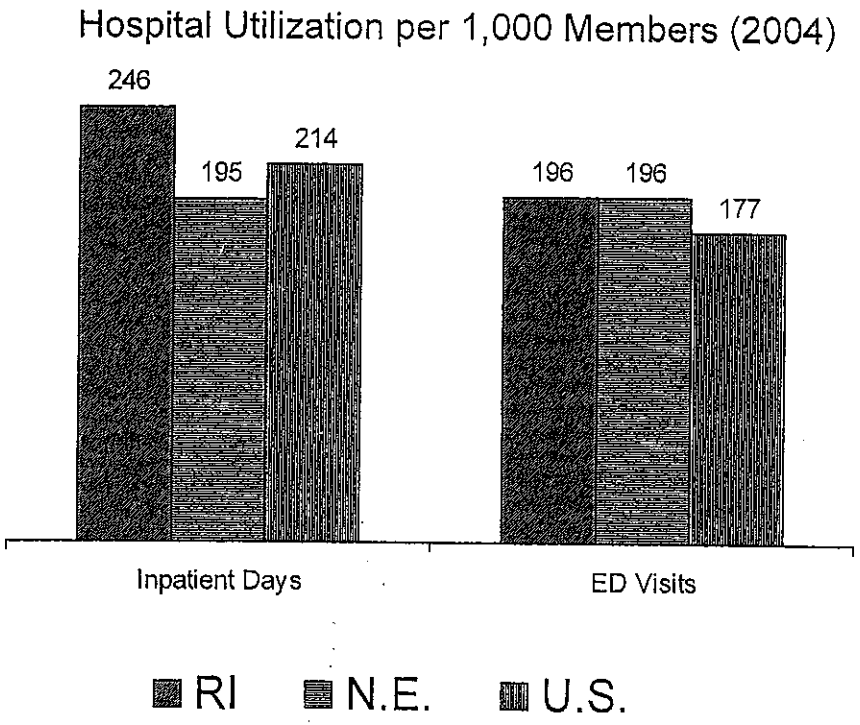
Sources of Health Insurance Coverage in RI mirror national trends



State Data 2003-2004; U.S. data 2004; Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2004 and 2005 Current Population Survey available at State Coverage Initiatives www.statecoverage.net/profiels/rhodeisland.htm

RI's High Hospitalization Utilization Rates Increase Volatility for Carriers

- **Higher than national average ER use and medical costs**
  - Inpatient days were significantly above both New England (N.E.) and national rates (+26% and +15%, respectively).
  - Emergency Department utilization is 10% greater than the U.S. rate



Source: Rhode Island Commercial Health Plans Performance Report, Health Quality Performance Measurement, 2004; RI Dept. of Human Services, Rhode Island State Planning Grant on Access to Health Insurance, HRSA Final Report, September 2005.

The Rhode Island regulatory environment limits plan flexibility and introduces risks.

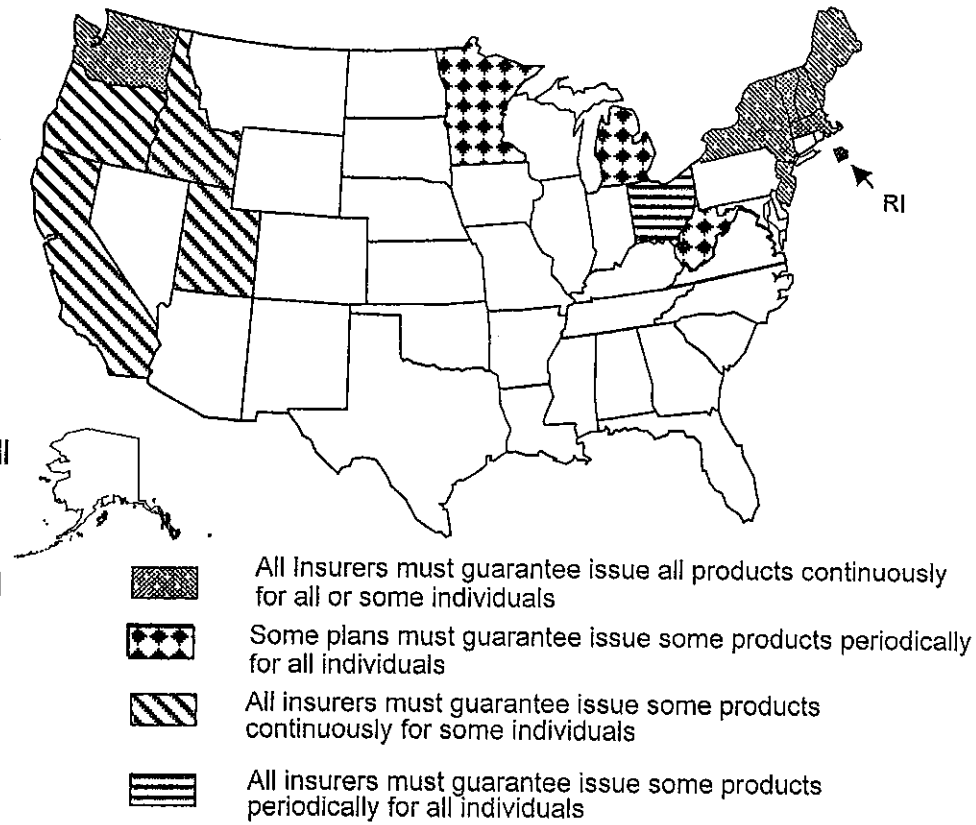
RI is heavily regulated in the individual and small group markets

- **"File and approve" not "file and use" for the individual market affects BCBSRI**
  - Most other states have moved away from file and approve for regulating rate changes and simply require carriers to file rate changes with the state before implementing them.
- **Small Group requirements: Small Employer Health Insurance Affordability Act (1-50) affects BCBSRI and UHCNE**
  - Four allowed adjustment factors: age, gender, family composition, health status (4-1 rate compression)
  - A health status adjustment of +/-10% around the base rate.
    - Prior to the Act, health status adjustments ranged from 40% for one carrier, 60% for the other
  - Only 12 states in addition to RI count self-employed people as "groups of one" and permit them to buy health insurance in the small group market on a guaranteed issue basis.

Source: Lautzenheiser & Associates, Report on the Effectiveness of Rhode Island General Laws ss. 27-50-1 et seq. Small Employer Health Insurance Availability Act in Promoting Rate Stability Product Availability and Coverage Affordability (2002); Kaiser Family Foundation, State Health Facts, Small Group Health Insurance Market Guaranteed Issue (2005); Rhode Island Association of Health Underwriters.

RI's requirements for the individual market exceed federal requirements

- **RI Individual market requirements move beyond HIPAA requirements**
  - RI insurers in the individual market must guarantee issue some products continuously to HIPAA-eligibles and individuals with 12-months of continuous prior coverage (must apply no later than 63 days following termination of the previous coverage)
- **14 other states do so as well**
  - 5 states including New York, require all insurers to guarantee issue all products for all individuals year-round beyond HIPAA-eligibles
    - WA requires this for some individuals
  - 4 other states are similar to RI and require all insurers in the individual market to guarantee issue some products continuously for some individuals
  - In 3 states including Michigan, only certain insurers must guarantee issue some products periodically for all individuals
  - Ohio requires all insurers to guarantee issue some products periodically for all individuals



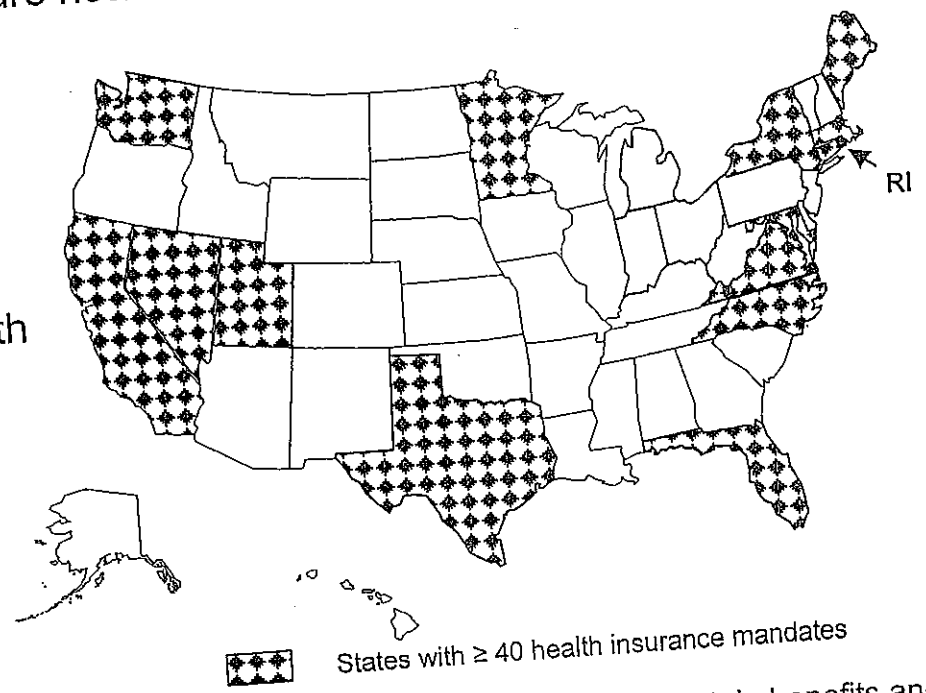
Health insurers that sell on a guaranteed issue basis cannot turn applicants down based on health or risk status.

Source: Kaiser Family Foundation, State Health Facts, Individual Market Guarantee Issue (2005) and Lewin analysis; RI Gen. Laws s.27-18.5-3.

How does RI compare to other states in health insurance mandates?

The Rhode Island health insurance market has a relatively high number of mandates which is one indicator of the level of legislative activism by the state legislature that leads to greater uncertainty for RI insurers of future health insurer requirements.

- RI currently has 40 health insurance mandates
  - 25 benefit mandates
  - 10 provider mandates
  - 5 eligibility mandates
- Only 15 states have 40 or more health insurance mandates
- Only 13 states have 25 or more benefit mandates
- 32 states have 10 or more provider mandates
- 43 states have 5 or more eligibility mandates



These health plan mandates are broken down into 3 categories: benefit mandates (plans must provide certain benefits and treatments), provider mandates (plans must include certain providers in their coverage such as chiropractors), and eligibility mandates (plans must cover certain eligibility groups such as adopted children).

Source: Council for Affordable Health Insurance, "Health Insurance Mandates in the States, 2005" and Lewin analysis.

Where is the market heading?

- **Establishment of RI Health Insurance Commissioner's office which creates regulatory/oversight risks**
- **Employer based coverage is eroding (70% in 2000 and 62% in 2004)**
  - **Those who retain coverage tend to carry higher risk**
- **Small number of uninsured (11.4% in 2004 – eight lowest rate of uninsured in the nation) but this number is growing at a greater rate than nationally**
  - Nearly two-thirds of Rhode Island residents without health coverage are in the labor force, and over half are working
  - Rate of growth of uninsured from 1999-2002 in RI (3.4%) compared to US (.7%)
- **Increasing cost of health care coverage far surpasses the increase in inflation and wages in the past five years.**
  - New treatments and technologies contribute to rapid increase
  - Average group medical costs for RI employers increased by 46% over the last 3 years
  - RI Employers paid 22% more than the national average and 20% more than the Northeast regional average for HMO coverage for their employees
  - RI Employers paid 17% more than the national average and 12% more than the region for PPO products
- **SNPs, created by the MMA serve primarily dual-eligible Medicare-Medicaid enrollees in RI and consequently carry high risk**
  - BCBSRI and Neighborhood currently offer the BlueCHiP for Medicare Optima SNP to the state's 28,000 dual eligibles jointly
  - Neighborhood will provide customer service and medical and case management
    - BCBSRI will handle sales and marketing, enrollment, claims, provider contracts, network management and underwriting
  - United offers a SNP for dual eligibles through Evercare, a subsidiary of UnitedHealth Group

Source: The Rhode Island Health Care for Families Act 2004: Report to the General Assembly (Jan. 2005); Rhode Island State Planning Grant on Access to Health Insurance, HRSA Final Report, September 2005 (citing to US Census Bureau, Current Population Survey). Rhode Island Health Care: Symptoms, Causes and Solutions, Rhode Island Medical Society Report Presented to the Rhode Island General Assembly Joint Legislative Committee on Health Care Oversight (2004) (citing Bluff Head Enterprises, Inc. "RI Area Employer-Sponsored Medical and Dental Benefits Survey 2004"), HealthLeaders-InterStudy.