



The LEWIN GROUP

Considerations for Appropriate Surplus Accumulation in the Rhode Island Health Insurance Market As It Relates to: Neighborhood Health Plan

Prepared for:

Office of the Insurance Commissioner

August 11, 2006

STATE OF RHODE ISLAND
OFFICE OF THE HEALTH INSURANCE COMMISSIONER

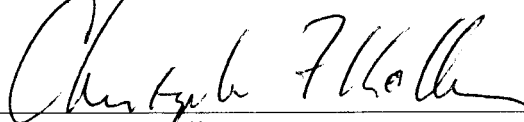
COMMISSIONER'S ORDER

The attached targeted Report of Examination as of December 31, 2005, of the surplus adequacy of NEIGHBORHOOD HEALTH PLAN OF RHODE ISLAND, was recently completed by duly qualified examiners, pursuant to the provisions of the Rhode Island General Laws.

Due consideration has been given to the comments of the examiners regarding the surplus adequacy of the Company, as reflected in the report.

It is therefore ORDERED that said Report be, and it is hereby, adopted and filed and made an official record of this Office as of this date.

OFFICE OF THE HEALTH INSURANCE COMMISSIONER



Christopher F. Koller
Health Insurance Commissioner

ORDER #: **OHIC-2006-03**

DATED: July 25, 2006

Table of Contents

I. INTRODUCTION.....	1
A. Background.....	2
B. Development of this Report.....	3
C. Report Organization	4
II. SURPLUS AND RELATED MEASURES	4
A. Reserves and Surplus	4
B. Risk-Based Capital (RBC).....	9
III. LAWS AND REGULATIONS RELATED TO SURPLUS	10
A. Rhode Island State Laws and Practices	10
B. Target Surplus Levels.....	12
C. How Do Other States Regulate Maximum Surplus?.....	13
IV. RHODE ISLAND’S REGULATORY AND MARKET ENVIRONMENT.....	13
VI. TARGET SURPLUS RANGES FOR THIS STUDY.....	21

APPENDIX A: NEIGHBORHOOD HEALTH PLAN SURPLUS ANALYSIS

APPENDIX B: NEIGHBORHOOD HEALTH PLAN COMPANY RESPONSE

I. INTRODUCTION

The Office of the Health Insurance Commissioner (OHIC) commissioned The Lewin Group (Lewin) to assess the surplus levels of Rhode Island’s three health plans pursuant to requirements of the Rhode Island Health Care Reform Act of 2004.¹ The legislature asked OHIC to provide recommendations for what appropriate insurance surplus reserve levels might be for health insurers in Rhode Island. 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. In recent years, health plan surplus levels have come under intense scrutiny as a result of continued increases in health insurance premiums and profits. Further, public officials and community advocates in a number of states have begun to question whether plans are accumulating surplus levels that exceed prudent protections against adversity. Of paramount concern is access to affordable health care for all Rhode Island residents, with special focus on the uninsured, small business owners, and individual policyholders. Prior to the passage of the Rhode Island Health Care Reform Act, stakeholders proposed that BCBSRI should give up some portion of its surplus to help make health coverage more affordable. Stakeholders wanted to 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 found, among other things, that “... 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....”² Thus, the legislation directs the Rhode Island Insurance Commissioner to focus on four key areas: guarding the financial solvency of health plans, promoting consumer protection, encouraging the fair treatment of providers, and helping plans improve access, quality and the efficiency of health service delivery.³

Lewin conducted this study to assess whether Blue Cross Blue Shield of Rhode Island (BCBSRI), United HealthCare of New England (UHCNE) and Neighborhood Health Plan of Rhode Island (NHP) have surplus levels within appropriate ranges, given the special circumstances of the individual plans and the Rhode Island market. This report is the companion piece to two other reports, *Considerations for Appropriate Surplus Accumulation in the Rhode Island Health Insurance Market As It Relates to: Blue Cross Blue Shield of Rhode Island* and *Considerations for Appropriate Surplus Accumulation in the Rhode Island Health Insurance Market As It Relates to: United HealthCare of New England*.

¹ R.I. Gen. Laws. §§ 42-14.5-1 *et. al.*

² R.I. Gen. Laws. §§ 42-14.5-1.1.

³ R.I. Gen. Laws. §§ 42-14.5-1.2.

A. Background

The Rhode Island health insurance market is a small, heavily regulated, highly concentrated market creating an environment for insurers that may be of greater risk relative to other states.

The major categories of risk addressed by surplus are underwriting risk, portfolio risk, business risk, and the risk of catastrophic events. For each of these risks, each health plan studied faces special challenges engendered by its situation beyond those risks common to all companies offering health insurance in the United States and to regional health plans. In order to categorize and better understand the different sources of risk for each health plan studied, it is useful to view these insurance risks along a continuum, ranging from the risks faced by any insurer in the United States to risks facing a specific health plan. The four layers of this continuum are described below:

- **Risks for all insurers:** There are risks inherent in providing insurance common to all plans offering coverage in the United States. Insurers face both general business risks and risks of underwriting.

Business and underwriting risks include:

- Medical price inflation;
 - New technologies;
 - Pricing accuracy;
 - Changing utilization patterns;
 - Presence and power of competitors;
 - Capital adequacy, which is different for non-profits versus for-profits;
 - Growth strategies, measured through membership and revenue;
 - Regulatory mandates and price controls;
 - Administrative expense management;
 - Litigation and other catastrophic events;
 - The insurer's mix of business;
 - Market concentration and density;
 - Reputation in the marketplace, and relationships with brokers and customers;
 - Provider reimbursement rates, density and comprehensiveness of provider network, degree of risk sharing with providers, and strength of the plan's relationships with providers; and
 - Reinsurance programs and whether retained risk is commensurate with capital level.
- **Risks related to operating in a single region:** Underwriting risk is the largest risk that health plans face, and regional plans are more at risk than national insurers in this regard. Regional insurance companies compete against large national insurers, which

have the ability to absorb excessive claims costs that may occur in a single region, such as a natural disaster or a localized epidemic. Furthermore, national insurers have the wherewithal to maintain and develop technological, actuarial, and financial resources due to economies of scale that are beyond the reach of a localized plan. This increases the likelihood that they will identify and adapt to emerging trends quickly. They can reduce, or even terminate, their participation in the region should market conditions deteriorate sufficiently. National plans may be able to identify centers of excellence for treatment of serious and unusual conditions with better outcomes and efficiencies, while regional plans will be more likely to be constrained to using local providers. National plans also are able to spread administrative costs across a larger base and use their larger size as leverage in contracting. Smaller regional insurers typically do not have these abilities. Finally, a localized economic downturn or catastrophic event would significantly affect a regional plan whereas a national plan could handle the risks associated with such an event.

- **Risks related to operating in Rhode Island:** Health insurers in Rhode Island face a highly regulated environment for certain market segments, including the individual and small group markets. These requirements limit plan flexibility and increase risks. Further, the establishment of the RI Health Insurance Commissioner's office creates regulatory/oversight risks for health insurers in Rhode Island. Additionally, employer based coverage is eroding in Rhode Island (compare 70% in 2000 with 62% in 2004) and those who retain coverage tend to carry higher risk.⁴
- **Plan-specific risks:** Each health insurer carries certain risks related to each insurer's provider reimbursement rates and payment, mix of business, asset investment, density of provider network, local market conditions and amount of counter party risk (ASO business).

B. Development of this Report

Lewin's task consisted of qualitative and quantitative information gathering and expert analysis on the subject of appropriate surplus levels and accumulation for BCBSRI, UHCNE and NHP. Our major activities included:

- In-depth interviews with each health plan's executives representing the financial planning and actuarial departments, government affairs, and marketing. These interviews provided information on each plan's market position relative to competitors, as well as the ways in which Rhode Island's market differs from other states. We also took into account regional and national market trends that may affect each plan.
- Primary and secondary source research on laws, regulations, and practices governing (a) the accumulation of surplus capital and (b) regulation of the Rhode Island health insurance market.

⁴ Rhode Island State Planning Grant on Access to Health Insurance, HRSA Final Report, September 2005 (citing to US Census Bureau, Current Population Survey).

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- Assessment of Rhode Island’s health insurance market with particular attention to business risks, insurance risks, and the competitive nature of the market.
 - Assessment of each plan’s financial performance and formulation of an appropriate surplus range.

To assess the sufficiency of each plan’s surplus levels, Lewin conducted a series of analyses in early 2006 in which we applied existing models for assessing health plan solvency. For BCBSRI and NHP, we performed a detailed analysis of each plan’s financial experience and compared current surplus levels with the amounts necessary to withstand a potential sustained downturn in the underwriting cycle. This analysis allows us to recommend an appropriate range for amounts of surplus for these two plans. For UHCNE, we determined that developing a target surplus range was not feasible without a thorough review of all financial relationships between the parent company, United Health Group, Inc., and its affiliates. Such an extensive undertaking would require resources far beyond those available for this review and a much longer time period to accomplish. Instead, we developed a target range for a hypothetical for-profit insurer domiciled in Rhode Island with *some* of the characteristics of UHCNE. Although this hypothetical case study does not provide an appropriate range for UHCNE, per se, it does provide context for the impact of key characteristics (most notably, the for-profit status) of UHCNE on an appropriate surplus range as compared to those developed for BCBSRI and NHP.

C. Report Organization

After providing some background information on measuring surplus, the main body of this report is divided into two sections. First we discuss the insurance market in Rhode Island, including both the regulatory and competitive environments. We then analyze each plan’s need for surplus in light of the risks posed by these environmental factors.

II. SURPLUS AND RELATED MEASURES

Reserves and surplus are important and distinct terms that are sometimes mistakenly used interchangeably. Risk-based capital, or RBC, is a measure adopted by the National Association of Insurance Commissioners for use in assessing reserve adequacy. To ensure clarity in the discussion and analysis provided in this report, the terms are defined below.

A. Reserves and Surplus

Claims reserve, often shortened to “**reserves**,” is a term for the estimate of the amount of money that a health care insurer needs in order to pay health care providers for services that members have used but for which claims have yet to be submitted and/or processed and paid, to make retroactive cost adjustments to providers, and to build specific case reserves for high-cost medical cases or for legal costs for cases with unpaid claims. On an insurer’s balance sheet, claims reserves have both asset and liability characteristics. There is an asset (typically cash or other highly liquid funds) in place to cover a liability, that being the foreseeable debt owed to health care providers who are currently caring for plan members. The reserves an insurer holds

do not represent disposable funds because there is an asset with a directly offsetting liability. **Premium reserves** include premium deficiency reserves and gross premium valuation reserves. Both are intended to offset predictable premium losses for specific products. **Operating reserves** includes ordinary operating reserves for specific, known liabilities (e.g., taxes, payables, etc.). This report does not assess reserves.

Reinsurance or stop loss coverage is secondary insurance purchased by the insurer to offset potential, extreme losses related to medical claims.

Surplus, or unallocated reserves, in contrast, 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 is intended to sustain the insurer through adverse business conditions or to support investment needs. In other contexts, surplus, also referred to as "surplus capital," would be interchangeable with such terms as "retained earnings," which is typically used in non-profit organizations such as hospitals, or "net worth," which is common in for-profit companies.

How is surplus measured?

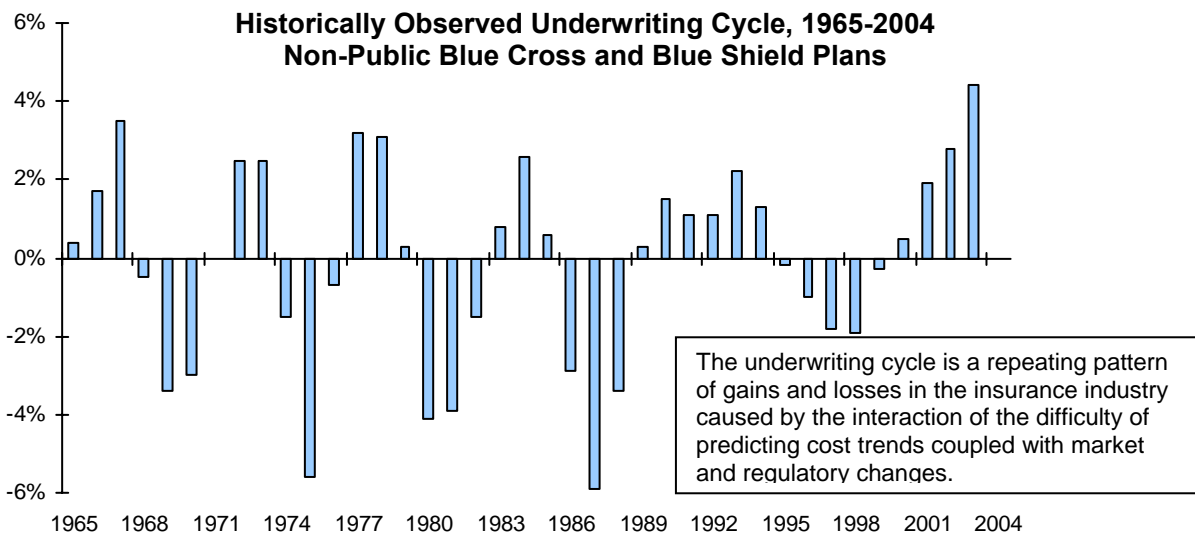
Surplus may be measured in several ways, including months of premium, risk-based capital (RBC) ratio, and surplus as a percent of revenue (SAPOR). SAPOR measures capital and surplus ("surplus") as a percentage of insured premium revenue net of reinsurance ("total revenues"). SAPOR is easily converted to a RBC level, which is described below, and which is a widely accepted method of measuring surplus adequacy.

This study primarily uses SAPOR in its review of historic surplus levels and target surplus ranges. 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.

Why is surplus needed?

Surplus provides the underpinnings to allow plans to withstand sustained periods of adverse financial results. Surplus is intended to serve as a cushion against adverse circumstances, reduce financial risk and serve as a capital resource. Adverse circumstances include unplanned medical expenses, declining enrollment, inadequate premiums to cover medical expenses, adverse selection risks, financial exposure associated with new mandates and regulatory controls and investment risks. For instance, plans are generally not able to immediately respond to adverse conditions due to pricing or cost management inflexibility. This is especially the case since most plans provide a 12-month rate guarantee. Further, plans may also have limited pricing flexibility due to regulatory limits. Finally, surplus also allows companies to make needed investments in infrastructure and technology to serve their customers more efficiently and effectively. Thus, surplus is intended to ensure the plan's solvency and ability to meet long-term contractual obligations.

An example of how underwriting cycles drive surplus demand is shown in the graph below. 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.

Surplus is often a subject of public policy debate. While inadequate surplus can result in contracted benefits not being paid and a company's insolvency, policymakers or insurers may pursue alternative uses of surplus for purposes such as providing additional benefits for enrollees, additional payments to providers, lower premiums for consumers and capital investments. In an era of increased concern over the price of health care and the conduct of health insurers, surplus levels are subject to much discussion by insurance regulators and state legislatures across the country. Determining appropriate surplus levels is somewhat subjective, however, requiring not only financial analysis but also judgment and experience, given the complexity of measuring the risk of loss facing an insurer and the unique business characteristics facing each insurer.

What factors drive demand for surplus?

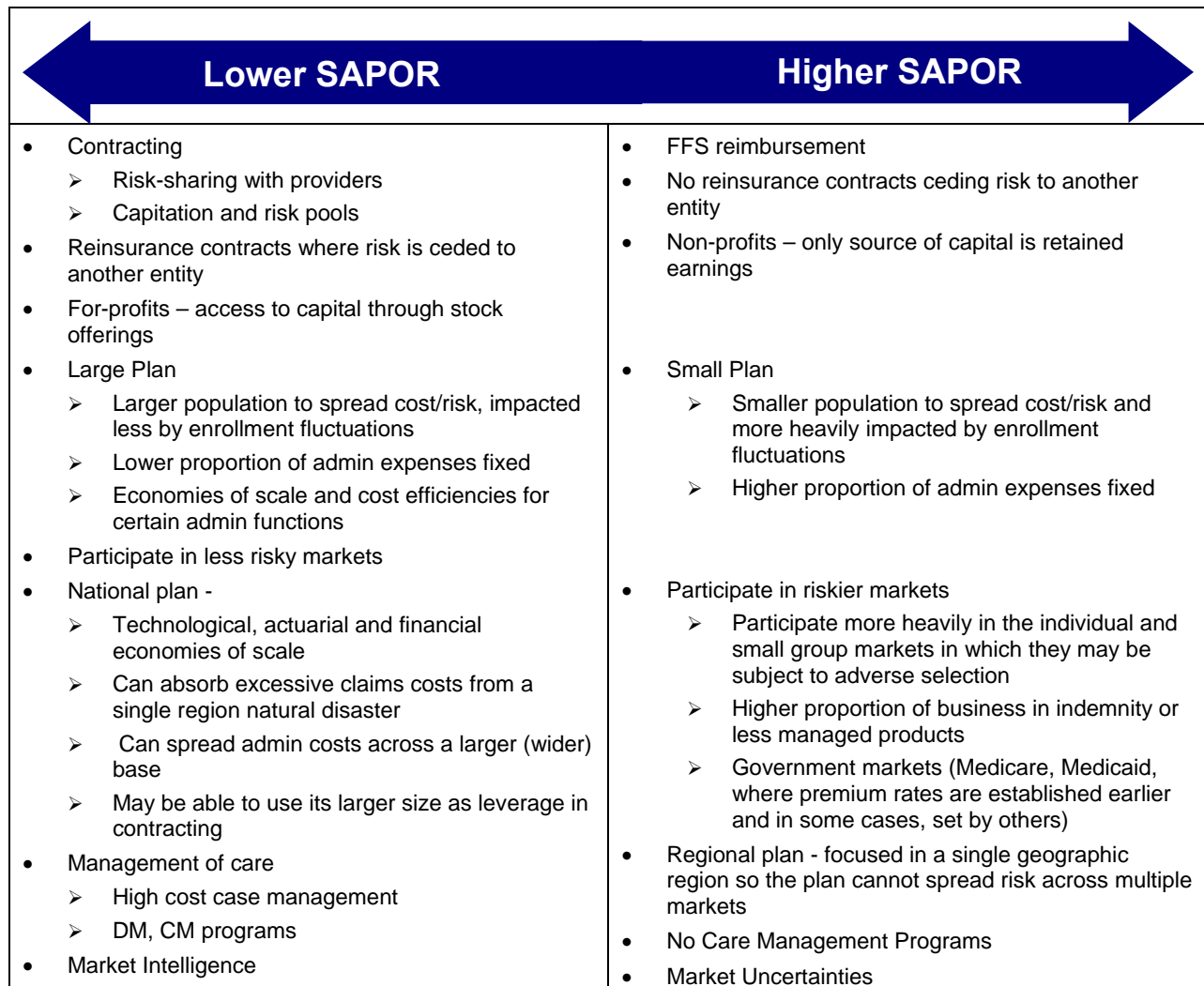
Various business factors drive higher requirements for surplus to provide a financial cushion against potential unanticipated risks as shown in the chart below. For instance, non-profit plans are often confused as charities that should not hold any surplus. However, these plans may need higher surplus to offset specific operating constraints. This is because non-profit plans have less ready access to capital since their primary source of capital is retained earnings. Access to, and costs of, borrowed funds are heavily dependent on financial performance and stability.

In contrast, for-profit insurers tend to retain surplus at lower levels than non-profit plans. Generally, for-profit health insurers, especially the larger publicly traded firms, find less advantage in having big surpluses. First, these insurers must demonstrate to investors the

highest possible return on equity. By converting surpluses to other uses – such as buying back shares – they lower the denominator in the return-on-equity formula and raise the result.

Second, for-profit insurers have access to external equity capital and can sell shares in order to raise cash, while non-profit insurers do not have this option, requiring them to retain sufficient capital for contingencies along a long time horizon.⁵ Further, for-profit insurers are typically structured as holding companies; the entities holding state insurance licenses are wholly owned subsidiaries, and those subsidiaries usually pass their profits up the line quickly. This action creates the appearance of low surplus held by the entity that files reports with state regulators. However, it is important to note that both for-profit and non-profit health plans have the ability to borrow funds as needed and must comply with the Rhode Island-adopted NAIC surplus minimum levels.

The following chart provides the various business factors that drive higher requirements for surplus and those business factors that drive lower requirements for surplus.



⁵ Sherlock Company, Report to Pennsylvania Insurance Commissioner, Responses to Commentors, October 6, 2004.

<ul style="list-style-type: none"> ➤ Longevity of the plan ➤ Penetration of the market • Historical provider 	<ul style="list-style-type: none"> ➤ New product introduction (Medicare Part D) ➤ Expansion into a new region ➤ Entry of a new competitor
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What happens if a plan does not hold enough surplus?

Many stakeholders are affected when a plan becomes insolvent. For instance, consumers may have to pay for services out-of-pocket, may experience interruption or reduced access of services, may need to change physicians and may experience higher premiums and less product choice given reduced market competition. Similarly, providers and medical suppliers may not get paid, may experience interruption of services and may experience insolvency. The State may suffer a loss in tax revenue, disruption in the insured process and experience an adverse impact on its economic climate. Employers may lose a stable health plan for employees and may need to cover new health plan costs despite having paid premiums for a now-insolvent plan. Finally, plan employees lose jobs and may lose retirement funds.

Three case studies provide a more detailed understanding of what happens when a plan does not hold enough surplus:

- **Blue Cross Blue Shield of West Virginia** became the first Blue Cross and Blue Shield plan to be liquidated by a State Insurance Commissioner in 1990, leaving 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.⁶
- **HIP Health Plan of New Jersey**, declared insolvent in November 1998 and liquidated in March 1999, left approximately \$120 million in unpaid claims to physicians and hospitals. As with BCBS of West Virginia, there was no state guaranty fund at that time to bail out the plan. Approximately, 190,000 were forced to look for new coverage and all state insurance carriers were required to have an open enrollment to HIP enrollees during March 1999.⁷
- **Harvard Pilgrim’s Rhode Island subsidiary** was put into receivership by Rhode Island officials in October 1999, ceased operations Dec. 31, 1999, and was liquidated in January 2000. When it ceased operations, the Rhode Island subsidiary was serving 177,000 members. Under the March 2000 agreement between Massachusetts and Rhode Island 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. Further, 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

⁶ 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.

⁷ 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.

provider claims at cost. Members were forced to seek new health plans with only two months notice with approximately 9 percent of patients 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. Further, more than one-third of staff model providers (38 percent) experienced a period of unemployment - among mental health providers, 56 percent.⁸

B. Risk-Based Capital (RBC)

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.

RBC was introduced as a concept by insurance industry regulators to refine the definition of surplus funds of insurers taking into account the nature of the risks that different companies face, as well as varying degrees of volatility that arise with alternative sets of risks.

RBC is an approach to determining the minimum level of capital cushion needed for protection from insolvency, based on an organization's size, structure, and retained risk. Factors in the RBC formula are applied to assets, premium, and expense items. The factors vary depending on the level of risk related to each item. The higher the risk related to the item, the higher the factor, and vice versa.⁹

The National Association of Insurance Commissioners (NAIC) set forth a standard formula for the computation of RBC, taking into account the risk characteristics of an insurer's investments and products. The RBC of any insurer is said to be unique to that insurer, because no two insurers have exactly the same mix of assets and risks. The NAIC also created a model RBC law for states to adopt for the purpose of regulating health insurers' minimum surplus levels. The RBC Model Act establishes the formula for calculating the RBC requirements. The law requires increasing regulatory oversight and intervention as an insurance company's RBC declines. The level of regulatory oversight ranges from requiring the insurance company to inform and obtain approval from the insurance commissioner of a comprehensive financial plan for increasing its RBC to mandatory regulatory intervention requiring an insurance company to be placed under regulatory control in rehabilitation or liquidation proceeding. Rhode Island is one of the many states that have adopted the NAIC's RBC Model Act.

The NAIC's RBC formula was not originally developed with health insurance in mind but was later adopted in recognition of the complicated nature of this particular insurance market. Health insurance has special characteristics that make successful competition more capital intensive than in a traditional insurance setting. Health insurance is technologically complex; carriers must maintain claims payment systems, produce frequent member communications,

⁸ 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.

⁹ Audrey Halvorson and Craig Keizur, "Risk-Based Capital Requirements for Managed Care Organizations," Milliman & Robertson, Inc. Research Report, December 1998.

keep data repositories for analysis, reporting, and audit, and attract and retain employees of sufficient talent to use the data effectively. In addition, care and disease management functions are now a routine and expected part of the services provided by health insurers. This requires clinical management expertise and continuous monitoring of best practice developments to keep up with new medical technologies. All of these activities related to health coverage have significant capital requirements, including constant upgrades and training to keep up with emerging technologies.

As health insurance is very competitive and produces small margins, full recovery from any long period of substantial downturns takes a long period of time, even for a very well-managed insurer. Surplus provides the source of capital to recover from adverse experience, as well as resources to invest in the company's business to maintain competitive service levels.

III. LAWS AND REGULATIONS RELATED TO SURPLUS

Health insurers' surplus levels are regulated through various mechanisms, including state laws, and internal plan actions. Blue Cross Blue Shield plans are also subject to oversight by the Blue Cross Blue Shield Association. This section provides an overview of Rhode Island's requirements regarding RBC ratios as well as requirements from other states in this area.

A. Rhode Island State Laws and Practices

State insurance regulators have broad discretion to regulate health insurers. The majority of the states have adopted the NAIC's Model Health Organization Risk-Based Capital Act. State laws concerning reserves and surpluses and insurance commissioners' uses of their authority aim to ensure that sufficient capital is available to health insurers in order to weather adverse events and protect consumers. Very little state regulation exists that is designed to limit the amount of reserves and surpluses that health insurers for that matter, can accumulate.

In Rhode Island, a domestic insurance company cannot begin operation until the capital stock of the company is at least equal to one million dollars (\$1,000,000) and the gross paid in and contributed surplus of the company is at least equal to two million dollars (\$2,000,000), or, if a mutual company, its net assets over all liabilities amount to not less than three million dollars (\$3,000,000), or, if a single line business company, has a combined capital and surplus of two million dollars (\$2,000,000). For domestic insurance companies which have undergone a change in control subsequent to August 1, 1995, the Insurance Commissioner may require lesser capital and surplus, but in no event less than one million dollars (\$1,000,000).¹⁰

Further, to protect against insolvency, Rhode Island HMOs must deposit securities with the general treasurer of the state of Rhode Island to be held for the benefit and protection of all the enrollees of the health maintenance organization in the following amounts described below. For an organization that is applying for initial licensure the amount is the greater of:

¹⁰ R.I. Gen. Laws. §§ 27-1-37, 27-35-1.

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- (i) Five percent (5%) of its estimated expenditures for health care services for its first year of operation; or
 - (ii) Twice its estimated average monthly uncovered expenditures for its first year of operation; or
 - (iii) One hundred thousand dollars (\$100,000).

Further, the organization must also, at the beginning of each succeeding year, unless not applicable, deposit four percent (4%) of its estimated annual uncovered expenditures for that year.¹¹

For UHCNE, which was licensed as an HMO on May 17, 1983, other rules apply. The required deposit amount instead was the larger of (i) One percent (1%) of the preceding twelve (12) months of uncovered expenditures; or (ii) One hundred thousand dollars (\$100,000), within six (6) months of May 17, 1983. Also, on the first day of the organization's first fiscal year beginning six (6) months or more after May 17, 1983, the organization was required to make an additional deposit equal to two percent (2%) of its estimated annual uncovered expenditures. In the second fiscal year, the rules stipulated that the additional deposit was equal to three percent (3%) of its estimated annual uncovered expenditures for that year, and in the third fiscal year and subsequent years, the additional deposit was equal to four percent (4%) of its estimated annual uncovered expenditures for each year. Each year's estimate, after the first year of operation, must reasonably reflect the prior year's operating experience and delivery arrangements.¹²

It is important to note, however, that the State may waive any of the above deposit requirements whenever satisfied that the organization has sufficient net worth and an adequate history of generating net income to assure its financial viability for the next year, or its performance and obligations are guaranteed by an organization with sufficient net worth and an adequate history of generating net income, or the assets of the organization or its contracts with insurers, hospital or medical service corporations, governments, or other organizations are sufficient to reasonably assure the performance of its obligations.¹³ Further, when an organization has achieved a net worth not including land, buildings, and equipment of at least one million dollars (\$1,000,000), or has achieved a net worth including plan related land, buildings, and equipment of at least five million dollars (\$5,000,000), the annual deposit requirement shall not apply. In addition, the annual deposit requirement will not apply to an organization if the total amount of the deposit of securities is equal to twelve percent (12%) of the HMO's estimated annual uncovered expenditures for the next calendar year, or the capital

¹¹ R.I. Gen. Laws. §§ 27-41-13(a),(b).

¹² R.I. Gen. Laws. § 27-41-13(c).

¹³ If the organization has a guaranteeing organization which has been in operation for at least five (5) years and has a net worth not including land, buildings, and equipment of at least one million dollars (\$1,000,000), or which has been in operation for at least ten (10) years and has a net worth including plan related land, buildings, and equipment of at least five million dollars (\$5,000,000), the annual deposit requirement shall not apply; provided, that if the guaranteeing organization is sponsoring more than the one organization, the net worth requirement shall be increased by a multiple equal to the number of organizations. This requirement to maintain a deposit in excess of the deposit required of an accident and health insurer shall not apply during any time that the guaranteeing organization maintains a net worth at least equal to the capital and surplus requirements for an accident and health insurer. R.I. Gen. Laws. §§ 27-41-13(d),(e)

and surplus requirements for the formation and admittance of an accident and health insurer in Rhode Island, whichever is less.¹⁴

B. Target Surplus Levels

The level of surplus required to provide an adequate margin of safety is a matter of judgment, and experts do not agree on a “correct” target surplus level for a health insurer. The NAIC, as one interested party, only addresses the minimums needed to ensure solvency, and further asserts that RBC is not an appropriate tool to use at higher levels of surplus. Most states, like Rhode Island, have enacted variations of the NAIC model Health Risk-Based Capital Act to regulate surplus minimums. The Act establishes clear, consistent guidelines for the calculation of RBC. As shown below, Rhode Island has adopted the NAIC trigger points for intervention based on the NAIC risk-based formula.

Exhibit 1
NAIC Trigger Points for Intervention Based on 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 Insurance 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.

Surplus represents the financial cushion that an insurer needs to safeguard against unanticipated circumstances that could cause extraordinary losses. But protecting against catastrophe is only part of the picture. Even under normal conditions, it is notoriously difficult to predict health care costs accurately, and it is especially difficult to do so consistently. Moreover, competition leads health insurers to quote premiums that provide only a narrow margin for error, so that a small under-estimation (in percentage terms) of health costs can swing the plan’s underwriting results from a modest gain to a big loss. Thus, some cushion is needed just to protect an insurer from the ordinary vagaries of the health care and health insurance markets. It is in the public’s interest to protect both plan members and the broader community from the undesirable consequences of a plan’s insolvency. Beyond protecting against adverse claims experience, insurers also require capital for competitive, service, and regulatory response purposes.

¹⁴ R.I. Gen. Laws. § 27-41-13,(e).

The target surplus ranges presented in the appendices are expressed as surplus as a percent of total net revenue (SAPOR), where revenue represents revenue net of reinsurance.

C. 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. However, while 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 its Blue plans (950% RBC for Blue Cross of NEPA and Capital Blue Cross; 750% for Highmark and Independence Blue Cross). Currently none of the Pennsylvania Blue plans holds excess surplus given these upper limits. If a plan did exceed the surplus upper limit, the plan would have to file a report with the Pennsylvania 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.¹⁵
- **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 non-profit health insurer's contingency reserve funds at 20% of annual premium incomes. However, the law is moot since the New Hampshire BCBS plan, which was the state's only non-profit plan, is now a for-profit. Prior to this conversion, the state chose not to enforce the limit.

IV. RHODE ISLAND'S REGULATORY AND MARKET ENVIRONMENT

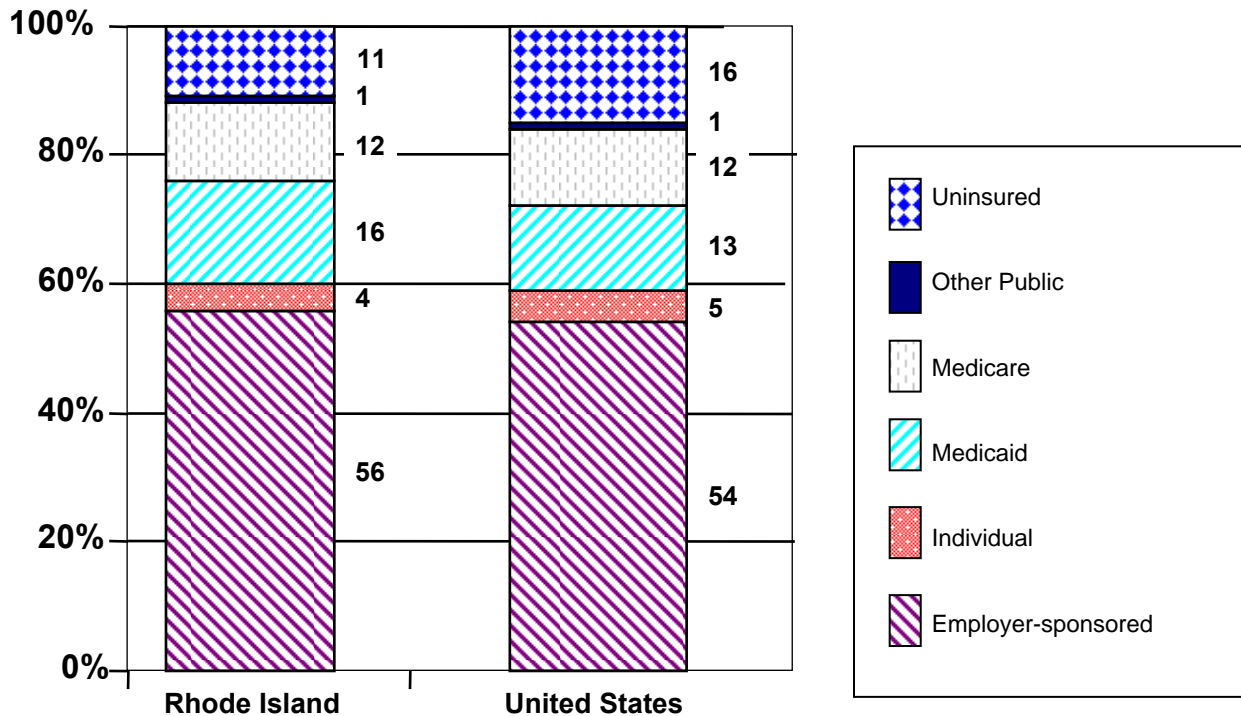
As a practical matter, assessing the sufficiency of current surplus levels depends on an understanding of Rhode Island's insurance market (both regulatory and competitive) and not simply on an actuarial assessment. This assessment of the adequacy of BCBSRI, UHCNE and NHP surplus was driven in part by an evaluation of the business and market risks that each

¹⁵ 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. The Lewin Group, Considerations for Regulating Surplus Accumulation and Community Benefit Activities of Pennsylvania's Blue Cross and Blue Shield Plans, prepared for The Pennsylvania General Assembly Legislative Budget and Finance Committee (June 13, 2005), available at <http://www.lewin.com/NR/rdonlyres/empv7jjik2vp4b6bq5bcslqmiq6fjezjrrbkdficmnzinnvcodrj3nlcpdukuf7vzfzpigbibip/3193.pdf>

plan faces. This section provides an overview of Rhode Island’s regulatory and market environment.

The main sources of health insurance coverage in Rhode Island mirror national trends. As the chart indicates below, Rhode Island’s population reflects a slightly lower proportion of uninsured individuals and slightly higher Medicaid enrollment rate than nationally.

Population Distribution by Primary Insurance Source



Source: 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 *available at* www.statecoverage.net/profiles/rhodeisland.htm.

Further, Rhode Island’s health insurance market is highly concentrated. With a population of one million, and only 380,000 commercially insured¹⁶, Rhode Island also lacks market competition with only two Rhode Island domiciled health plans participating in the commercial market and strong market dominance by BCBSRI as shown below.

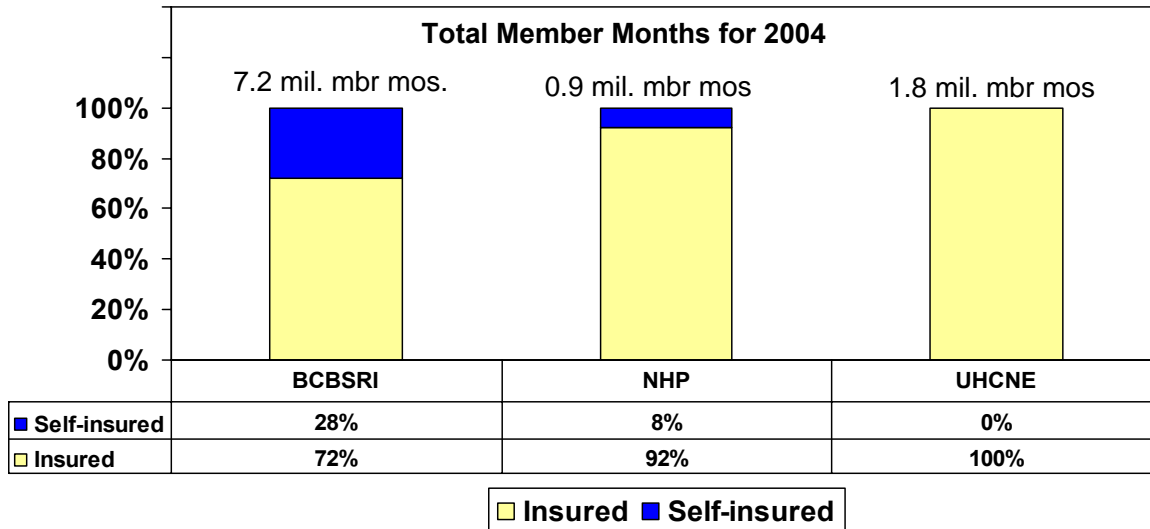
¹⁶ Rhode Island Department of Health, “Rhode Island Commercial Health Plans’ Performance Report” (December 2005).

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%

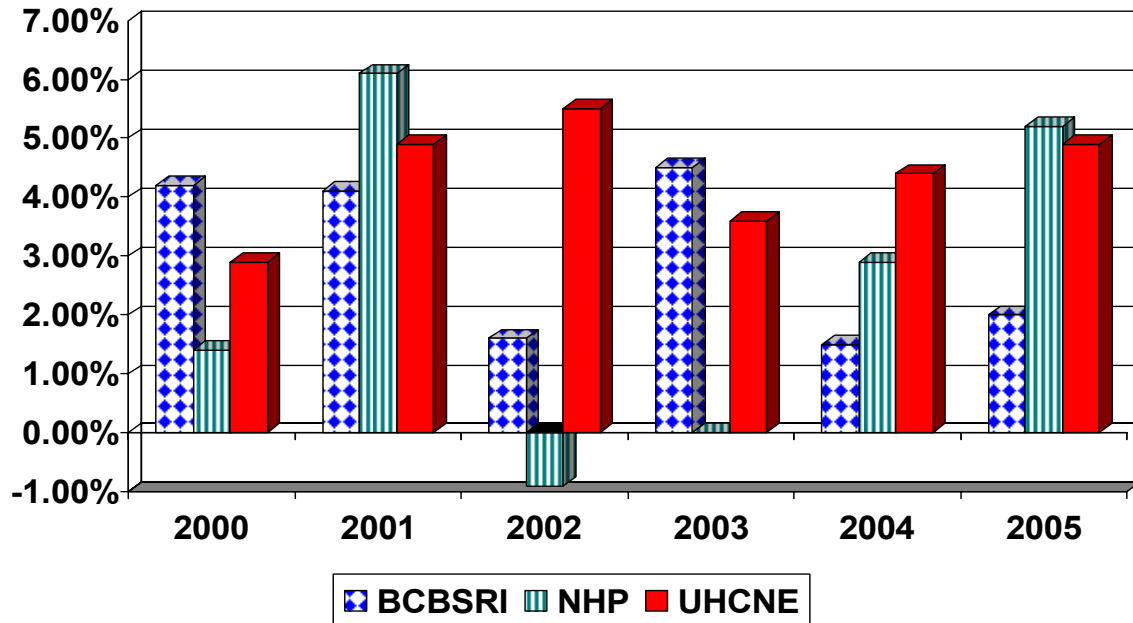
Source: Cryan, Bruce. RI Commercial Health Plans' Performance Report (2004), Rhode Island Department of Health, December 2005, p.4. Available at www.health.ri.gov.

Additionally, BCBSRI has the majority of total insured members and most self-insured business. It is important to note that 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.



As shown in the chart below, Rhode Island plans have generally experienced positive net profit margins over the last six years.

Net Profit Margins, 2000 to 2005

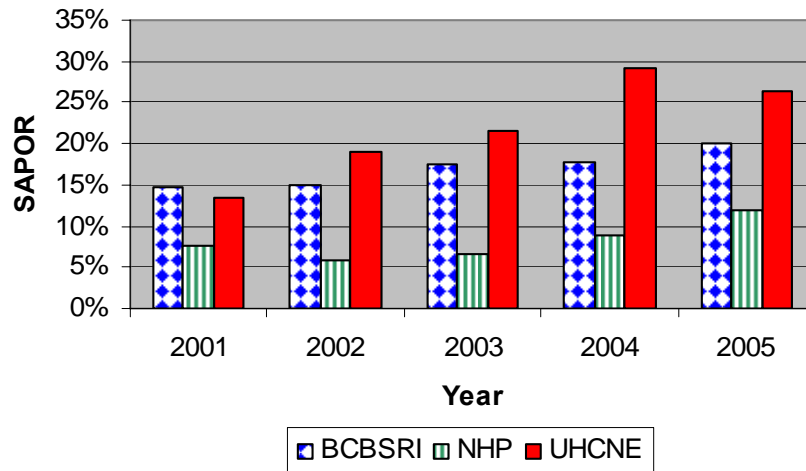


Note: BCBSRI numbers for all years include financial results of Coordinated Health Partners.

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

Rhode Island plans' SAPOR has varied from 6 to 29 percent in recent years.

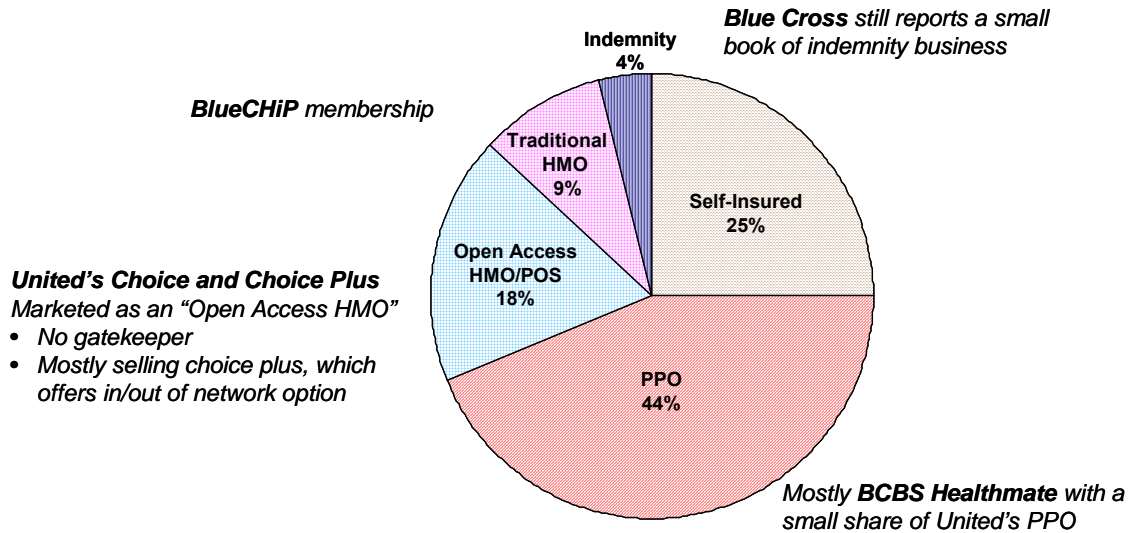
Surplus as a Percent of Revenue 2001 - 2005



Source: Derived from statutory filings to Rhode Island Department of Business Regulation.
 Note: BCBSRI SAPOR is calculated based on consolidated revenues including BlueCHIP revenues for all years.

Unlike most other New England states (with the exception of Maine), the Rhode Island health insurance market is a relatively unmanaged, PPO dominant environment. Although there are plans marketed as an HMO, the vast majority has no gatekeeper and the networks are fairly broad, covering most providers in the state.¹⁷

Rhode Island Insured Members by Plan Model

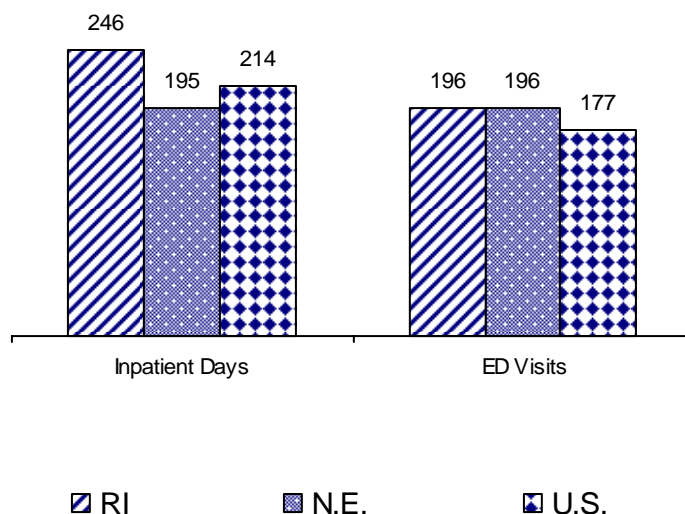


Source: Department of Human Services, Rhode Island State Planning Grant on Access to Health Insurance, HRSA Final Report, September 2005. Based on Q1 2004 financial filings from BCBS, United and NHP; does not include TPA business.

Further, Rhode Island's high hospitalization utilization rates increase volatility for carriers. For instance, Rhode Island has a higher than national average ER use and medical costs with inpatient days significantly above both New England (N.E.) and national rates (+26% and +15%, respectively). Further, Rhode Island's emergency department utilization is 10% greater than the U.S. rate.

¹⁷ 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.

Hospital Utilization per 1,000 Members (2004)



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.

Health insurers in Rhode Island face a highly regulated environment for certain market segments, including the individual and small group markets. These requirements limit plan flexibility and increase risks. For instance, the Rhode Island individual market requirements are broader than the federally mandated Health Insurance Portability and Accountability Act (HIPAA) requirements. Rhode Island insurers in the individual market (BCBSRI) must guarantee issue some products continuously to HIPAA-eligibles and individuals with 12-months of continuous prior coverage.¹⁸ Only fourteen other states do so as well.¹⁹ Further, the small group requirements pursuant to the Rhode Island Small Employer Health Insurance Affordability Act spread risk more broadly by bringing all insured small employers into one risk pool, and limits premium rate variability among small employers with adjusted community rating. However, this can lead to adverse selection in the small group market.²⁰ Further, the small group market size is defined as 1-50 in Rhode Island. Only 12 states in addition to Rhode

¹⁸ HIPAA requires all health insurers operating in the individual health insurance market to offer coverage to all eligible individuals and prohibits them from placing any limitations on preexisting conditions. Kaiser Family Foundation, State Health Facts, Individual Market Guarantee Issue (2005) and Lewin analysis; RI Gen. Laws s.27-18.5-3.

¹⁹ Five 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; four other states are similar to RI and require all insurers in the individual market to guarantee issue some products continuously for some individuals; in three states including Michigan, only certain insurers must guarantee issue some products periodically for all individuals while Ohio requires all insurers to guarantee issue some products periodically for all individuals. Kaiser Family Foundation, State Health Facts, Individual Market Guarantee Issue (2005) and Lewin analysis

²⁰ Small Employer Health Insurance Affordability Act allows only four adjustment factors: age, gender, family composition, health status (4-1 rate compression) with 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 carrier. 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).

Island 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.²¹

Medicaid and Medicare: Risks Related to Participating in Government Markets

There are both advantages and disadvantages for a health plan to participate in government markets. While these markets offer a large pool of beneficiaries and represent a disproportionately large share of total health care spending, they are also constrained by the inflexibility inherent in heavily regulated markets. Earnings from government sources are more vulnerable than those of commercial segments because the government imposes controls over premium levels and precludes a company's ability to control pricing fully or affect selection through benefit redesign. Therefore, when operating and pricing in government markets, health plans are less able to react to and meet market demands. Plans that participate heavily in government markets benefit from their large populations and revenue stream, but bear more risk from the stiff premium constraints and less flexible benefit design inherent in these programs.

Medicaid

All three Rhode Island insurers participate in RItCare, Rhode Island's Medicaid managed care program covering the Medicaid TANF population (Temporary Assistance for Needy Families). NHP has the largest enrollment at 56.5% with UHCNE at 32.8% and BCBSRI at 10.7% (Enrollment as of June 30, 2004).²² Key areas of risk for plans in the Medicaid RItCare market include:

- Insufficient capitation rates,
- Anti-selection,
- Changes in enrollment procedures, eligibility determination processes, benefits, or other changes to the structure of the program,²³
- Expansion to new populations such as SSI (currently, RItCare only covers the TANF population where risk is fairly stable and predictable albeit there are inherent hospital and pharmaceutical utilization risks), and
- Potential access barriers to NICU beds at Women and Infants Hospital, requiring plan payment for services not captured in capitation rates.

²¹ Kaiser Family Foundation, State Health Facts, Small Group Health Insurance Market Guaranteed Issue (2005); Rhode Island Association of Health Underwriters.

²² Rhode Island Department of Human Services, Annual Report on the Department of Human Services' Implementation of Programs to Address Uninsurance Among Rhode Islanders, submitted to Permanent Joint Committee on Health Care Oversight (Feb. 15, 2005).

²³ For example, the Governor's proposed Budget for FY 2007 eliminates RItCare eligibility for parents in families with incomes greater than 133% FPL (previously 185% FPL), removes RItCare benefit for all undocumented children, establishes an asset test for RItCare eligibility, and calls for a restructuring of contracts with Rite Care managed care providers Rhode Island. Department of Human Services, "FY2007 Budget Impacts: Medical Assistance."

In addition, changes to the current RItCare risk sharing agreement is a significant potential risk for each plan. The Rhode Island Department of Human Services (DHS) has entered into risk-share agreements with all three RItCare health plans. Under the risk-sharing methodology, risk is shared according to whether the plan's actual medical loss ratio (MLR) is within agreed-upon ranges or risk corridors. Currently, each plan that participates in the risk share agreement with DHS 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	87-88.9% MLR	≥ 89% MLR
Plan Risk	50%	100%	30%
DHS Risk	50%	0%	70%

Medicare

Currently, BCBSRI participates in the Medicare managed care market. This year, NHP and BCBSRI were approved by CMS to offer the BlueCHiP for Medicare Optima SNP (Special Needs Plan) to the state's 28,000 dual eligibles jointly. Further, United offers a SNP for dual eligibles through Evercare, a subsidiary of UnitedHealth Group.²⁴

Recent changes in Medicare create new business opportunities and risks for plans participating in this market. The enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) has ensured that Medicare Advantage plans will play a significant role in the future in covering people on Medicare and in providing the new drug benefit. Specifically, MMA created a comprehensive voluntary prescription drug plan for Medicare beneficiaries, known as Medicare Part D. Medicare Part D is delivered through private risk-bearing entities under contract with the Centers for Medicare & Medicaid Services (CMS). Part D coverage for beneficiaries enrolled in a prescription drug plan began on January 1, 2006. The drug benefit is offered to beneficiaries through both Part D Prescription Drug Plans (PDPs) and Medicare Advantage Prescription Drug Plans (MA-PDs). PDPs are stand-alone drug only plans for beneficiaries enrolled in Medicare. MA-PD plans are offered to MA beneficiaries in conjunction with MA plans; these MA-PD plans may serve to increase enrollment in Medicare managed care. While risk corridors help mitigate the risk, the Part D Program is completely new and most pricing could not be developed using historical information. Furthermore, 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. Thus, it will take several years for the impact of this offering to be well understood, as evidenced by the vastly differing estimates of the cost of Part D presented to Congress during the development of the MMA legislation. In addition to claims uncertainty, the timing and amounts of payments are also uncertain in government products such as Medicare, which adds to the risk of offering these products.

²⁴ Neighborhood will provide customer service and medical and case management. BCBSRI will handle sales and marketing, enrollment, claims, provider contracts, network management and underwriting. Ric Gross. "Special Needs Plans Rolling Out in New England" HealthLeaders-InterStudy (Winter 2006).

In sum, the nature of the risk in the Medicare market is still not yet well understood. Product restructuring under MMA, combined with expansion into new products, increases plan risks and surplus demand relative to premium dollars.

Key areas of risk to consider in the Medicare market include:

- 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.
- Introducing or expanding Medicare products means a sudden large need for surplus to back the product given the new enrollment.

VI. TARGET SURPLUS RANGES FOR THIS STUDY

While 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. Thus, the “right” level is plan-specific; it is not a single number that can be applied to all plans.

For this study, we developed surplus levels, expressed in terms of percentages of total net revenue or SAPOR, reflecting what we believe are prudent and conservative target ranges. The targets reflect the surplus range for each plan within which we believe the plan is sufficiently capitalized to withstand financial downturns of some significance. Each insurer sets its own surplus target level, reflecting its own assessment of the risks they face and their sensitivity to these risks; expectations regarding competitive pressures; marketing and expansion intentions;

capital investment plans; and stockholder pressures. Because this analysis is as much an art as a science, the insurers' targets may fall outside of the range we have developed. Because total revenue is net of reinsurance, any significant change in the proportion of premiums ceded to a reinsurer will impact the actual SAPOR level.

Our assessment of the risks faced by NHP along with our analysis of its surplus needs is presented in Appendix A of this report. Our assessments of the risks faced by BCBSRI and UHCNE along with our analysis of their surplus needs are presented in the companion reports to this report. The target surplus ranges presented for BCBSRI and NHP can be justified to protect against underwriting swings based on each plan's circumstances. We note that surplus levels below the lower end of the ranges do not reflect insufficient surplus.

As discussed in *Considerations for Appropriate Surplus Accumulation in the Rhode Island Health Insurance Market As It Relates to: United HealthCare of New England*, developing a target surplus range for UHCNE is not feasible without a thorough review of the financial relationships between the UHC affiliates and the parent organization. Such a review would be an enormous undertaking and would require the cooperation of the parent organization and its affiliates. However, providing target surplus ranges for BCBSRI and NHP might lead some readers to make assumptions regarding an appropriate surplus range for UHCNE. Because of the many differences in organizational structure, market participation, profit status, risk sharing and reinsurance arrangements, and other characteristics across the three plans, applying recommendations for NHP or BCBSRI to UHCNE is wholly inappropriate. To characterize how some of the characteristics of UHCNE influence the surplus level necessary to provide reasonable protection to the plan and its customers, we developed the hypothetical case study of a for-profit insurer based in Rhode Island, which is presented in *Considerations for Appropriate Surplus Accumulation in the Rhode Island Health Insurance Market As It Relates to: United HealthCare of New England*.

The discussion and recommended surplus ranges included in the appendices reflect our analysis of the external regulatory and market conditions and the internal financial, operational, and market penetration characteristics along with the competitive pressures and capital needs faced by the insurers as of the spring of 2006. Because these all influence surplus needs, both insurers' and regulators' surplus policies must recognize and accommodate significant changes in the environment that materially impact the risks faced by insurers.

Appendix A
Neighborhood Health Plan
Surplus Analysis

Table of Contents

- I. NEIGHBORHOOD HEALTH PLAN 1
 - A. Background..... 1
 - B. Surplus History..... 1
 - C. Neighborhood Health Plan Risk Assessment..... 2
 - D. Actuarial Analysis of Surplus Levels 3
- II. TARGET SURPLUS RANGE..... 4

I. NEIGHBORHOOD HEALTH PLAN

A. Background

Neighborhood Health Plan (NHP) is a non-profit HMO, founded in 1993 by 13 community health centers to participate in the State's Medicaid managed care program, RItCare. NHP received its HMO license in 1994 and currently has a 15-member board. NHP is a Medicaid-only plan that serves the following populations: Temporary Assistance for Needy Families (TANF) (which is comprised of insured moms and kids in Medicaid managed care), foster care children (Administrative Services Only, or ASO) and children with special health care needs (ASO). Although all three Rhode Island insurers participate in RItCare, NHP holds the largest enrollment at 56.5% with UHCNE at 32.8% and BCBSRI at 10.7% (Enrollment as of June 30, 2004).²⁵

The Rhode Island Department of Human Services (DHS) has entered into risk-share agreements with all three participating RItCare health plans (NHP, UCHNE and BCBSRI). Under the risk-sharing methodology, risk is shared according to whether the plan's actual medical loss ratio (MLR), is within agreed-upon ranges or risk corridors. Currently, each plan that participates in the risk share agreement with DHS 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	87-88.9% MLR	≥ 89% MLR
Plan Risk	50%	100%	30%
DHS Risk	50%	0%	70%

B. Surplus History

Most states, like Rhode Island, have enacted variations of the NAIC model Health Risk-Based Capital Act to regulate surplus minimums. The Act establishes clear, consistent guidelines for the calculation of RBC. As shown below, Rhode Island has adopted the NAIC trigger points for intervention based on the NAIC risk-based formula.

²⁵ Rhode Island Department of Human Services, Annual Report on the Department of Human Services' Implementation of Programs to Address Uninsurance Among Rhode Islanders, submitted to Permanent Joint Committee on Health Care Oversight (Feb. 15, 2005).

NAIC Trigger Points for Intervention Based on 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 Insurance 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.

Over the past few years, NHP's RBC ratio and SAPOR have steadily increased:

Year	NHP RBC Ratio	Surplus as a Percent of Revenue (SAPOR) ²⁷
2005	333 %	12 %
2004	240 %	8%
2003	180 %	7 %
2002	154 %	6 %

²⁷ Note: SAPOR is calculated as capital and surplus as a percent of total revenues as reported in NHP's 2005 annual financial statement.

In 2002 and 2003, when NHP's surplus was at the NAIC Company Action Level, the State temporarily waived the RBC requirements for NHP in accordance with RI insurance laws §27-4.7-10 in recognition of the company's position as a provider for 2/3 of RI's Medicaid population, the 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.²⁶

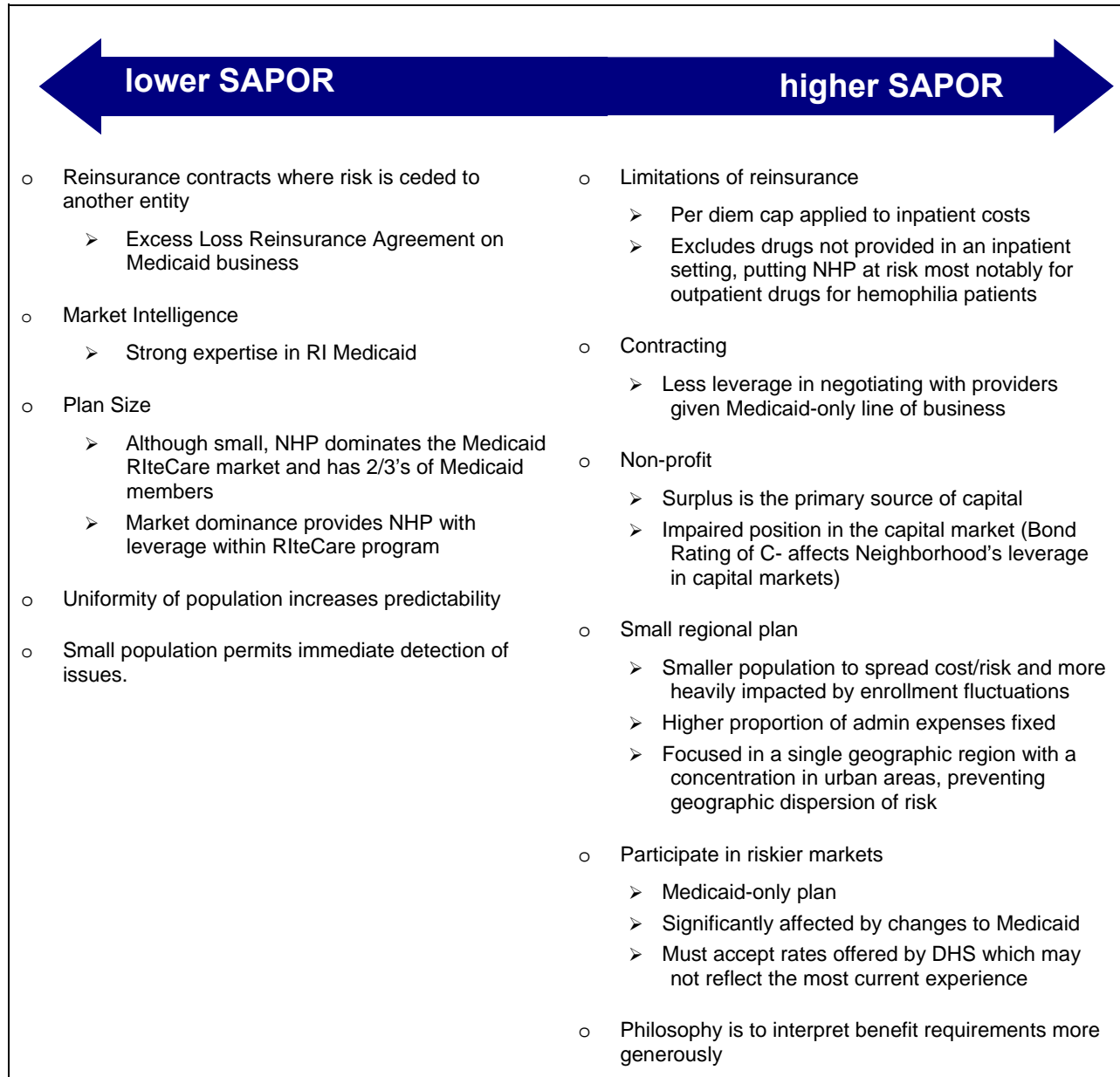
C. Neighborhood Health Plan Risk Assessment

RiteCare's risk sharing agreement provides a crucial offset to the risks NHP faces as a Medicaid-only plan in a small market. The following chart provides the various business

²⁶ Under this statute, the Commissioner may waive the RBC requirements for a domestic health organization that provides a plan of health insurance, health benefits, or health services to members, eighty-five percent (85%) or greater of which are participants in the Rite Care program administered by the State of Rhode Island, if the health organization has contracts with insurers, hospital or medical service corporations, governments, or other organizations that are sufficient to reasonably assure the performance of its obligations provided, that in no event shall the net worth or total adjusted capital requirement be less than one hundred thousand dollars (\$100,000). R.I. Gen. Laws. §§ 27-4.7-10.

factors associated with NHP that drive higher requirements for surplus and those business factors that drive lower requirements for surplus.

Factors Affecting NHP's SAPOR Needs



D. Actuarial Analysis of Surplus Levels

While NHP is insulated from claim fluctuation risk, underwriting cycle risk, and catastrophic risk from its reinsurance and state risk sharing agreement, the plan is not entirely immune. With regard to its reinsurance, there remains the risk that the per diem costs will exceed the maximums in the reinsurance contract (given the per diem reinsurance cap applied to inpatient costs) or that significant drug costs will be incurred for cases not confined to an inpatient facility

such as with a hemophiliac child (since outpatient drugs are excluded from reinsurance). Net of reinsurance recoveries, NHP receives 70% of medical costs incurred above an 89% medical loss ratio through its Risk Sharing Agreement with DHS. 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.

In order to quantify the amount of surplus NHP would need to have in order to protect against future losses, maintain and upgrade technological capability, and withstand competitive pressures, we estimated the percent of current premium needed to cover specific risks, using standard actuarial techniques based on percent of premium as a measure.

Risk Analysis

NHP Risk	Percentage of premium (approximate)
Claims Risk <ul style="list-style-type: none"> ○ Increased accrual of surplus is needed to prepare for the <i>potentiality</i> 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 	6.5-10.5%
Risk of Fluctuation in Asset Values	5%
Risk of loss of business to the other two Medicaid insurers (UHCNE, BCBSRI) <ul style="list-style-type: none"> ○ 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 with 12% of premium as expense and the possibility of 50% erosion in plan membership 	4%
Business interruption caused by catastrophe	2%
Litigation risk	.5%
Capital outlay	1%
External Factors <ul style="list-style-type: none"> ○ Competitor withdrawal from the market and subsequent enrollment in NHP would strain NHP’s 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. 	1-2%

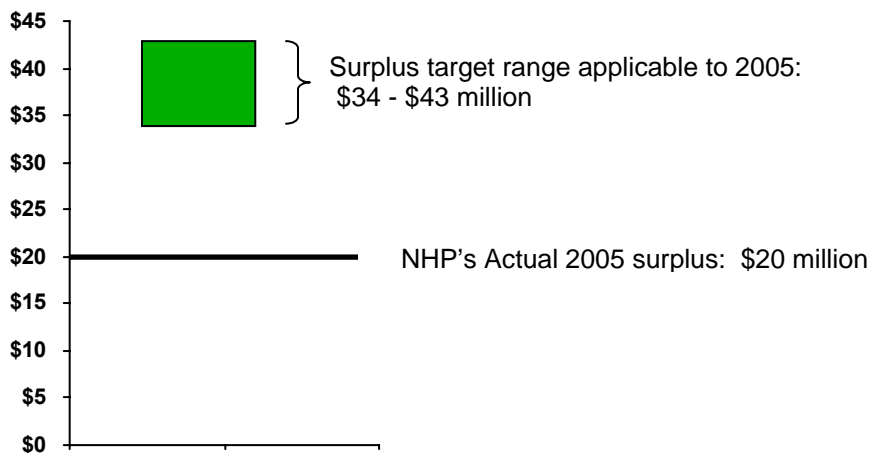
II. TARGET SURPLUS RANGE

While 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 they want to provide an adequate margin of safety enabling them to endure periods of adverse experience without triggering any

form of regulatory intervention. Thus, the “right” level is plan-specific; it is not a single number that can be applied to all plans. The target surplus level presented here reflects what we believe is a prudent and conservative range and can be justified to protect against underwriting swings based on NHP’s circumstances. We note that surplus levels below the lower end of the range do not reflect insufficient surplus.

Based on the above actuarial evaluation, we estimate NHP’s surplus needs to be between 20 and 25 percent of revenue. This range assumes no change to the risk sharing corridor in the near term. We note that significant changes to the RItCare program would require immediate re-evaluation of this range. As of 2005, Neighborhood had a SAPOR of 12 percent.

Recommended NHP Surplus Range Applied to 2005



While NHP’s net worth has certain protection due to the risk share with DHS, the plan is dependent on DHS to provide an adequate premium and to assume risk through its risk share arrangement. If this does not occur, a material strain on the plan’s capital and surplus will occur. Thus, NHP should consider a target surplus range of 20 to 25 percent of revenue to provide for the risks enumerated earlier and in recognition of the eventuality of the degradation of the risk sharing protection. NHP’s ability to maintain this target depends on the adequacy of capitation rates in future periods. In the event that RItCare eliminates or significantly weakens the reinsurance provided, NHP’s target surplus level must be re-evaluated promptly. This reinsurance, which covers virtually 100 percent of NHP’s insured business at effectively no cost to NHP, is of significant value to NHP and would be difficult, and possibly cost-prohibitive, to replace on the commercial reinsurance market.²⁷

²⁷ NHP does not pay a premium, per se, for the reinsurance, although the RItCare program establishes that capitation rates and is required by federal regulators to take the value of the reinsurance into account when developing these rates.

In consideration of NHP's current RItCare contract and the regulatory and market environment, we believe it advisable for NHP to focus its surplus between 20 and 25 percent of insured revenue.

Appendix B
Neighborhood Health Plan:
Company Response

**COPY**

August 9, 2006

Ms. Nalini K. Pande
Senior Manager
The Lewin Group
3130 Fairview Park Dr.
Suite 800
Falls Church, VA 22042

Dear Ms. Pande;

As requested, we have reviewed the surplus analysis reports. Our review did not disclose any material misstatement of fact related to Neighborhood Health Plan of Rhode Island (NHPRI).

We understand that the results of this study are based on surplus levels expressed in terms of percentages of total net revenue that the Lewin Group believes are prudent and conservative target ranges that reflect the necessary capital for a plan to withstand financial downturns of some significance. The Lewin report indicates that setting reserve levels is as much an art as a science, and that insurers' targets may fall outside of the range developed by the Lewin Group.

NHPRI believes that targeting reserve levels for the plan between 100% and 200% of Company Action Level provides an appropriate and responsible level of surplus.

Sincerely,


George Brier
Director of Financial Services