SEGAL

THE SEGAL COMPANY
116 Huntington Avenue 8th Floor Boston, MA 02116-5744
T 617.424.7300 F 617.424.7390 www.segalco.com

July 28, 2011

William M. Gardner
Secretary of State
State of New Hampshire
107 North Main Street
State House, Room 204
Concord, NH 03301

Re: Target Capital/Surplus for HealthTrust

Dear Secretary Gardner:

HealthTrust is a non-profit pooled risk management arrangement established under Chapter 5-B of the New Hampshire Revised Statues Annotated (RSA). HealthTrust provides medical, prescription drug and other coverages to political subdivisions (school districts, towns, counties, and municipalities) within the State, allowing for the pooling of self-insurance reserves, risks, claims, administrative and other expenses among the political subdivisions. The Segal Company has been asked to review the reasonability of HealthTrust's current reserve policy using the Risk-Based Capital (RBC) approach of targeting reserve levels and to offer an alternative approach. Segal's alternative approach is based on a stochastic model that measures plan solvency based on risk factors such as claim fluctuation.

Why Reserves are Needed

As a self-insured health plan, maintaining an adequate reserve increases the likelihood that HealthTrust is able to withstand unanticipated financial losses caused by adverse fluctuation in claims, enrollment and other unforeseen changes in the demographic composition of the plan that could negatively impact underwriting performance. Maintaining an adequate reserve means that, to a very high degree of certainty, all obligations for the payment of claims and expenses are met. Over time, surpluses accumulate as underwriting gains, generated from the premiums paid by the participating employer groups. From this surplus, a reserve amount (or range) is targeted that, if retained, helps to ensure the long-term solvency of the plan.

HealthTrust is Not an Insurance Company

Milliman's March 3, 2011 letter *Re: Target Capital/Surplus for HealthTrust*, presents a case for HealthTrust to be viewed as an insurance company for the purpose of setting target reserve levels, although HealthTrust is not regulated as an insurance company in New Hampshire. In many respects, HealthTrust operates like a large ERISA-type multiemployer plan (without the collectively-bargained agreement component), in that it:

- Provides comprehensive health coverage to its member groups;
- Includes employer groups generally from a similar industry classification, such as political subdivisions;
- Holds assets in a segregated account; and
- Has a governing body that acts as manger over the affairs of the plan.

In the case of HealthTrust, its parent organization, Local Government Center (LGC), fulfills this managerial role. This role includes:

- Balancing the interests of the fund and its members
- Responsibility for the assets of the fund
- Benefit and plan design implementation and management
- Consulting with professional advisors
- Carrier selection
- Financial management of the plan's income, expenses, and reserves

LGC contracts with an outside actuary as a professional advisor to, among other things, (1) calculate the premium rates to be charged to the enrolled groups, (2) estimate the incurred but not reported (IBNR) claim liability to be booked in the financial statements and (3) to make recommendations regarding capital/surplus requirements in order to maintain the plan's long-term solvency. From an actuarial and underwriting point of view, HealthTrust operates like a large self-insured multiemployer (or association type) health & welfare plan wherein premiums paid by participating employer groups are guaranteed for a period of time, usually for twelve months. The participating groups typically have a common demographic background (similar industry, geographic location, etc) that should help keep the rates in a reasonable band. However, for various reasons, employer groups enter and leave the plan, mostly based on rates they are charged. Typically, those employer groups that perceive their claim utilization to be lower than the premium rates being charged, are likely to leave. Conversely, those employer groups that perceive their claim utilization to be higher than the premium rates being charged are likely to enroll. This is the underlying nature of pooled risk arrangements like HealthTrust. Therefore, the plan must maintain adequate surplus (reserves) to cover any shortfall and to ensure the continued long-term viability of the plan.

HealthTrust Reserve Calculations for the Period 2002 - 2009

Milliman's March 3, 2011 letter *Re: Target Capital/Surplus for HealthTrust* responded to The Segal Company's letter *Re: Actuarial Services/Pooled Risk Management Programs* dated December 29, 2010. Milliman's letter asserted that, had HealthTrust held the Segal Company calculated reserve target (95% confidence level) of $40.8 million during 2009 and experienced the $14 million reduction in net assets, it would have fallen below 200% of the Authorized Control Level (ACL), which is the trigger point for commercial insurance companies, who are subject to Risk-Based Capital reserve methodology. To address the implication of this statement in a more complete manner, Segal was asked to review HealthTrust's financial statements from 2002 – 2009 and to opine on actual reserve build-ups versus reserve target levels over that period of time. The year 2002 was selected as a starting point because it represented the year before HealthTrust began using the RBC methodology as a reserving benchmark.

In column (1) of the exhibit attached to this letter, net assets of HealthTrust grew from $23.4 million as of 12/31/2002 to $79.5 million as of 12/31/2009, an increase of $56.1 million over that eight year span as shown in column (2). Net assets would have grown by an even larger amount of $83.4 million over that same period without the $27.3 million in deductions paid from the assets of the plan to the parent organization (LGC). It should be pointed out that the $83.4 million increase in reserves (net assets) was primarily the result of premium rates to member groups that generated more revenue than the expenses that were incurred. While reserves grew by $83.4 million over that span, there was only one year (2009) out of the eight years where an actual underwriting loss was experienced. This was an $8.8 million loss in 2009 shown in column (4). This underwriting loss in 2009 did not jeopardize the solvency of the plan. Under normal circumstances, one would expect a less skewed distribution of underwriting gains and losses over that eight year period. However, due to the conservative trend factor assumptions used by the actuary to compute premium rates, coupled with the 1% explicit margin used in the development of premium rates, the underwriting results were skewed in favor of gains over losses. Therefore, one can see that even using the Segal alternative target reserve benchmarks, HealthTrust's reserves were never in jeopardy. It is critical not to downplay the dependent relationship between the assumptions built into the premium rate setting process and the likelihood that actual reserves will fall below a targeted level.

Using Segal's stochastic model as an alternative approach to estimating target reserves, column (8) shows a target reserve of $16.6 million in 2002 growing to $40.8 million in 2009 at a 95% confidence level. Likewise, at a 99% confidence level, column (11) shows a target reserve of $23.9 million in 2002 growing to $59.1 million in 2009. Stated in another way, Segal's stochastic model shows in Columns (10) and (13) that a target reserve level of between 1.3 and 1.9 months of underwriting expenses should be sufficient. This conclusion is conditional on HealthTrust continuing its policy of building in a 1% explicit margin and using conservative trend factors in the rate development process. Reserves accumulated over the targeted level can then be returned to member municipalities.

Other Observations

In addition to the above, Segal offers the following comments for your consideration:

1. The Risk-Based Capital approach is the de facto standard for determining solvency of insurance companies. It is not necessarily useful for determining *target* reserves.

2. Using a multiple of the Risk-Based Capital ratio (4.2 in this case) as a basis for setting target reserves is highly subjective.

Segal Summary Recommendations for Consideration

Upon review of all the information provided, we conclude the following:

1. In our opinion, using a 4.2 RBC ratio as the reserve target overstates the level required to maintain plan solvency at the 95% confidence level. Segal estimates that a reserve of 1.3 months of underwriting expense (incurred claims and expenses) is sufficient.

2. At the 99% confidence level, Segal estimates that a HealthTrust reserve greater than 1.9 months of underwriting expense could be considered excessive.

3. As of December 31, 2009, actual net assets (less IBNR) of $79.5 million were well above Segal's calculated target reserve level of $40.8 million and maximum reserve level of $59.1 million. In fact, net assets at that time exceeded the HealthTrust's own current policy target by $10 million. Prudent underwriting would call for trying to achieve the reduction over multiple (2 – 3) years during the rate revisit process.

References

As noted earlier, our review and analyses were based on the information supplied. In particular, we examined:

1. Financial Statements and Required Supplementary Information as of December 31, 2002-2009 with Independent Auditor's Report, Berry Dunn McNeil & Parker, submitted to the secretary of state per RSA 5-B:2.

2. Milliman's March 3, 2011 letter Re: Target Capital/Surplus for HealthTrust.

3. HT Enrollment by Product Bates Stamp LGC 007018

4. LGC HealthTrust, Authorized Control Level 2002 – 2005.

We appreciate the opportunity to provide this response and we are available to answer any questions you may have on its content.

The signing actuaries are members of the Society of Actuaries, the American Academy of Actuaries and other professional actuarial organizations, and collectively meet their "General Qualification Standards for Standards of Actuarial Opinion" to render the actuarial opinion contained herein.

Howard Atkinson, Jr., FCA, ASA, MAAA
Vice President and Health Actuary

Daniel J. Rhodes, FCA, ASA, MAAA
Consulting Actuary

cc: Kevin Moquin
Earle Wingate
Andrew D. Sherman (Segal)
Stuart Wohl (Segal)

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LGC HEALTHTRUST, LLC
COMPARISON OF NET ASSETS AND TARGET RESERVE LEVELS
(AMOUNTS IN MILLIONS)

	Net Assets (1)	Incr/(Decr) in Net Assets After Distr. (2)	Distributions to Parent (3)	Incr/(Decr) in Net Assets Before Distr. (4)	Current Policy Target* (5)	Target as a Multiple of ACL (6)	Actual as a Multiple of ACL (7)	Segal Target 95% Conf. (8)	% of Expenses (9)	# of Mths Expenses (10)	Segal Maximum 99% Conf. (11)	% of Expenses (12)	# of Mths Expenses (13)
2009	$79.5	($13.2)	($4.4)	($8.8)	$69.3	4.2	4.8	$40.8	10.7%	1.3	$59.1	15.5%	1.9
2008	$92.7	$1.2	($6.5)	$7.7	$60.9	4.2	6.4	$34.1	10.2%	1.2	$49.3	14.7%	1.8
2007	$91.5	$14.3	($4.5)	$18.8	$57.1	4.2	6.7	$31.3	10.0%	1.2	$45.2	14.5%	1.7
2006	$77.2	$20.9	($4.2)	$25.1	$53.8	4.2	6.0	$28.6	9.8%	1.2	$41.3	14.1%	1.7
2005	$56.3	$16.4	($2.7)	$19.1	$52.1	4.2	4.5	$26.6	9.8%	1.2	$38.5	14.1%	1.7
2004	$39.9	$14.9	($1.1)	$16.0	$47.0	4.2	3.6	$21.4	8.8%	1.1	$30.8	12.6%	1.5
2003	$25.0	$1.6	($3.9)	$5.5	$40.7	4.2	2.6	$19.2	9.0%	1.1	$27.6	12.9%	1.5
2002	$23.4	N/A	$0.0	N/A	$35.7	4.2	2.8	$16.6	9.0%	1.1	$23.9	13.0%	1.6
Total		**$56.1**	**($27.3)**	**$83.4**									

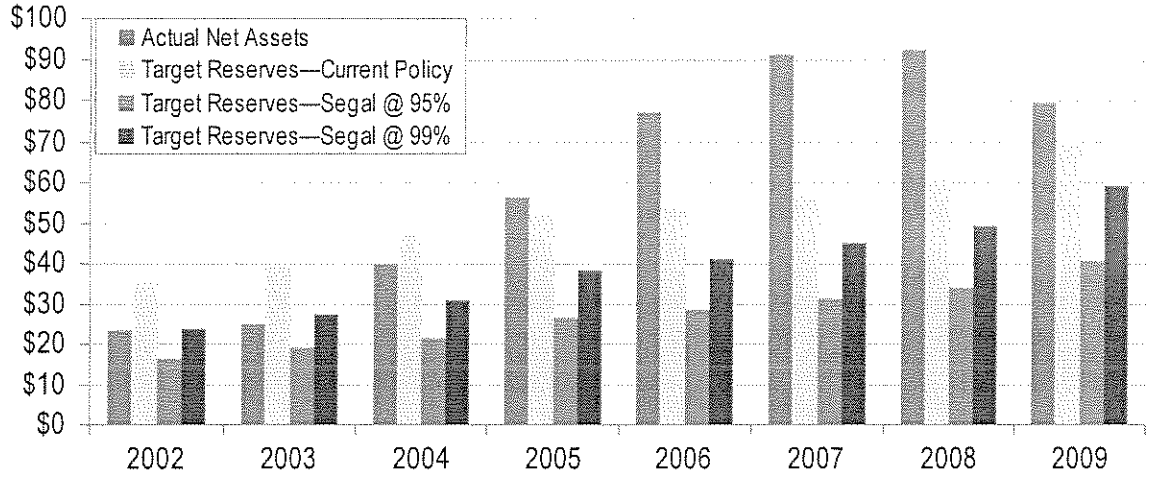
* Current Policy Target Reserves = 4.2 x ACL

ACL = Authorized Control Level = 50% of the Risk Based Capital amount

Expenses = Annual incurred claims, administrative and other operating expenses

# of Mth Expenses = Reserve target expressed as the number of average monthly expenses it will cover

NET ASSETS AND TARGETED RESERVES (IN $ MILLIONS)



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