Commonwealth of Virginia Joint Legislative Audit and Review Commission

2021 Actuarial Review of the Virginia State Employee Health Insurance Program

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TRANSMITTAL LETTER

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September 7, 2021

Mr. Hal E. Greer, Director
Commonwealth of Virginia
Joint Legislative Audit and Review Commission
201 North Ninth Street, Suite 1100
General Assembly Building, Capitol Square
Richmond, Virginia 23219

Re: 2021 Actuarial Review of the Virginia State Employee Health Insurance Program

Dear Mr. Greer:

Presented in this report are the results of the 2021 Actuarial Review of the Virginia State Employee Health Insurance Program ("Program"). This review consisted of a non-replication actuarial review of the Fiscal Year 2020, 2021 and 2022 premium setting as performed by the retained actuary, Aon Hewitt ("Aon") for the active employee and pre-65 retiree segments. (Excluded from this review are the fully insured HMOs, Kaiser Permanente and Optima Health, and the various benefits utilized by the Medicare eligible population.) This review was conducted in accordance with generally accepted actuarial methods and the Actuarial Standards of Practice to provide the General Assembly with a comprehensive overview of the actuarial soundness of the calculations and assumptions used for the Program.

The results of the review are presented in the following format:

A. Executive Summary
B. General Review Approach
C. Reasonableness and Appropriateness of Actuarial Assumptions
D. Reasonableness and Adequacy of Data
E. Review of Rating Methodology, Reports and Exhibits
F. Results of Actuarial Rate Development
G. Target Cash Balance for the Health Insurance Fund ("HIF": in the remainder of this report refers to the balance pertaining to the Active and Early Retiree block)

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This study was performed at the request of the Commonwealth of Virginia Joint Legislative Audit and Review Commission ("JLARC"). It may be shared with other interested parties only with the permission of the JLARC. If shared with other parties, it should be shared in its entirety.

This study was performed by actuaries experienced with premium rate setting and review of actuarial assumptions for rate setting as well as with public sector retirement systems.

We would like to acknowledge the cooperation of the staffs of JLARC and Department of Human Resources Management ("DHRM") as well as Aon. Their full and willing cooperation was critical to the successful completion of this report.

It is important to remember that actuarial calculations are based on assumptions regarding future events. Future actuarial measurements may differ significantly from the current measurements due to such factors as the following: plan experience differing from that anticipated by the trend or demographic assumptions; changes in trend or demographic assumptions; increases or decreases expected as part of the natural operation of the methodology used for these measurements (such as additional costs or contribution requirements based on the health of the program); and changes in plan provisions or applicable law.

James E. Pranschke is a Member of the American Academy of Actuaries (MAAA) and meets the Qualification Standards of the American Academy of Actuaries to render the actuarial opinions contained herein.

GRS is independent of JLARC and Aon.

If you have any questions on this report or need additional information, please feel free to contact us.

Respectfully submitted,

James E. Pranschke

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Senior Health Care Consultant and Actuary

Michael Reed

Michael Reed
Senior Health Care Analyst

SECTION A

EXECUTIVE SUMMARY

Executive Summary

Gabriel, Roeder, Smith & Company ("GRS") was hired to conduct the 2021 Actuarial Review of the Virginia State Employee Health Insurance Program ("Program"), in accordance with the generally accepted actuarial methods and the Actuarial Standards of Practice.

The purpose of this review is to provide the General Assembly with a comprehensive overview of the actuarial calculations, methodology and assumptions used in the premium setting for the Program. This review consisted of a non-replication actuarial review of the actuarial calculations performed for the Program.

Based on the results of our review, we believe:

- **The methodology and rate increases proposed by the consulting actuary are reasonable and appropriate** (i.e., the experience of the Program indicated the level of increase was needed to provide the cash balance necessary to cover the claims, administrative expenses and contingency for the fiscal year). Generally, if a rate development recommends rate increases less than the medical / Rx trends being used in the projection, this indicates that the claim experience is running lower than what was projected in the prior rate setting developments.

    - Based on the Fiscal Year 2018 experience, Aon proposed an increase of 0.01% to the FY 2019 premium rates.
    - Based on the Fiscal Year 2019 experience, Aon proposed a decrease of 0.09% to the FY 2020 premium rates.
    - Based on the Fiscal Year 2020 experience, Aon proposed an increase of 3.07% to the FY 2021 premium rates.

- **The primary actuarial assumptions** (including the medical and pharmacy trend assumptions between 5.0 - 6.0 percent and 7.5 – 9.0 percent respectively) **are reasonable**.

Although this review contains a number of observations which we believe should be considered to improve the measurement and communication of the actuarial results, we do not expect that any of these recommendations would have a significant impact on the actuarial rate setting results.

The health care cost trend rate is the rate of change in per capita health care claims over time as a result of factors such as medical inflation, utilization of health care services, plan design, and technological improvements. It is a critical economic assumption required for determining future rates to be used in a self-funded healthcare benefit program. While experience is often a good starting point for future costs, we do not rely solely on a group's experience in setting the near-term trend assumptions since trends vary significantly from year to year and are not credible for most groups. Therefore, we use professional judgment, trends from the actuary's book of business and industry benchmarks are used in conjunction with a group's historical experience to establish the trend assumptions.

Following is a high-level summary of the areas addressed in the review and our associated findings:

- The reasonableness and appropriateness of the actuarial assumptions and methods used by the Program's actuary, Aon, to establish rates for the Virginia State Employee Health Insurance Program.

The key assumptions used by Aon in their Fiscal Year Premium Rates development are:

- Assumed Trends – The rate of medical, pharmacy, and dental trends. Trends are the combination of the effect of increases in unit cost and utilization on the projected claims. The medical trend used by Aon was between 5.0% and 6.0%, pharmacy trend was between 7.5% and 9.0%, and dental trend was 3.0% over the three years of premium rate settings.
- Enrollment Assumptions – At the time of rate setting the current enrollment at the time was used to project the upcoming fiscal year.
- These key assumptions are reasonable and generally standard in the actuarial consulting industry.

- The reasonableness and adequacy of the data, including enrollment and claims data, and methods used by Aon to establish rates for the program, including a review of the most recent three years of rates and increases.
  - Overall, we found the data used in the development of premium rates to be reasonable and appropriate.

- The reasonableness and accuracy of the actuarial rate development process and assumptions used by Aon to estimate the impact of plan changes, develop rates and budget projections, and monitor claims experience.
  - Since Aon did not grant access to their proprietary actuarial models, GRS reviewed Aon's description of rating methodology, reports, assumptions and exhibits to form an opinion of the reasonableness and accuracy of the rate development.
  - Upon review of the methodology, reports and exhibits used by Aon in development of the Program rates, we find that the methodology is reasonable and accurate for the purposes of rate development based on the description provided by Aon.

- The results of the actuarial rate development process to determine if the calculations have been made in conformity with generally accepted actuarial principles and practices, and with the Actuarial Standards of Practice issued by the Actuarial Standards Board.
  - Although specific statements regarding compliance with ASOPs were not included, the professional nature of the reports and the extensive detailed analysis provides support that the ASOPs were complied with. We recommend that Aon add specific statements in compliance with the ASOPs to their future reports.

- The reasonableness of all program revenue and expenses for the Health Insurance Fund ("HIF"), and recommendations concerning the appropriate target level of cash balances for the fund.
  - Aon uses the NAIC's Risk Based Capital ("RBC") formula to determine their recommendation for the level of the contingency reserve. Although the RBC formula is intended to be used by state insurance regulators to monitor solvency levels of insurance companies, the formula provides a convenient method for establishing a recommendation for the level of the contingency reserve, which provides a solid recommendation.

- Our review indicates the Program has consistent and appropriate monitoring. To further augment this process, we recommend the Program:
    - Actively manage the HIF to reserves values provided in the actuary's annual FY end report titled "Actuarial Liabilities and Reserves" (or this level with a 10 to 25% margin).
    - Continue monitoring the HIF and further reducing by using premium holidays for one, two or three months.
    - Evaluate incorporating an additional adjustment to the premium rates by using a smoothing process to compare actual claims to projected claims. More detail and an example are provided in the final section of this report.

SECTION B

GENERAL REVIEW APPROACH

General Review Approach

The purpose of this review is to provide the General Assembly with a comprehensive overview of the actuarial calculations, methodology and assumptions used in the premium setting for the Program. This review consisted of a non-replication actuarial review of the actuarial calculations performed for the Program.

This review addresses the following areas:

1. The reasonableness and appropriateness of the actuarial assumptions and methods used by the program's actuary, Aon, to establish rates for the Virginia State Employee Health Insurance Program (the program).
2. The reasonableness and adequacy of the data, including enrollment and claims data, and methods used by Aon to establish rates for the program, including a review of the most recent three years of rates and increases.
3. Since Aon did not grant access to their proprietary actuarial models, GRS reviewed Aon's description of rating methodology, reports, assumptions and exhibits to form an opinion of the reasonableness and accuracy of the rate development.
4. The reasonableness and accuracy of the actuarial rate development process and assumptions used by Aon to estimate the impact of plan changes, develop rates and budget projections, and monitor claims experience.
5. The results of the actuarial rate development process to determine if the calculations have been made in conformity with generally accepted actuarial principles and practices, and with the Actuarial Standards of Practice issued by the Actuarial Standards Board.
6. The reasonableness of all program revenue and expenses for the Health Insurance Fund, and recommendations concerning the appropriate target level of cash balances for the fund.

The table on the following page presents a summary of the approach and steps GRS completed for the review of the Virginia State Employee Health Insurance Program.

General Review Approach

WORK PLAN FOR THE 2021 REVIEW OF THE VIRGINIA STATE HEALTH INSURANCE PROGRAM

	TASK DESCRIPTION	DUE DATE
PROJECT PLANNING	**1 Project Planning with Client and Team**	
	a.) Conference call to discuss scope	4/15/2021
	b.) Confirm Statement of Needs with JLARC and Virginia Legislative Liasons	04/19/2021
	c.) Send Final Statement of Needs	04/19/2021
	d.) Prepare and send Work Plan and Fee Agreement to JLARC	04/28/2021
DATA	**2 Census Data**	
	a.) Prepare and send data request	05/05/2021
	b.) Conference call, if needed, to answer any questions on the data request	05/07/2021
	c.) Submit complete description of the methodology used to develop rates, including three years of underlying reports, assumptions, data and exhibits	05/12/2021
	d.) Submit complete description of the methodology used to estimate the impact of plan changes, budget projections and any analysis to monitor emerging claim experience including large claims.	05/12/2021
	e.) Submit three years of reports documenting recommended and adopted rates	05/12/2021
ACTUARIAL RATE DEVELOPMENT REVIEW	**3 Actuarial Rate Development Review**	
	a.) Review assumptions and methods	May and June 2021
	b.) Review reasonableness and adequacy of the data	May and June 2021
	c.) Review three years of rate increases	May and June 2021
	d.) Review reasonableness of program revenue and expenses	May and June 2021
	e.) Review appropriate level of cash balances	May and June 2021
REPORT AND BRIEFINGS	**4 Deliverable Schedule**	
	a.) Draft report to JLARC	07/08/2021
	b.) First Exit Conference between JLARC, Virginia Legislative Liasons and GRS	07/20/2021
	c.) Report comments from JLARC and Virginia Legislative Liasons	07/23/2021
	d.) Second Draft Report to JLARC	08/11/2021
	e.) Second Exit Conference between JLARC, GRS, Legislative Liasons, DHRM and Aon Hewitt	08/20/2021
	f.) Report comments from DHRM and Aon Hewitt	08/25/2021
	g.) Final report copies to JLARC	09/07/2021
	h.) Send copies of briefing packets	09/09/2021
	i.) Briefing to JLARC	09/20/2021
	j.) If requested, respond to any additional questions or requests from JLARC or Virginia Legislative Liasons	10/04/2021

SECTION C

REASONABLENESS AND APPROPRIATENESS OF ACTUARIAL ASSUMPTIONS

Reasonableness and Appropriateness Actuarial Assumptions

Actuarial Assumptions

The actuarial reports prepared by Aon contain actuarial assumptions which are commonly used in premium rate developments. Aon provided us with the assumptions used in the development of the premium rates for the program. We have reviewed these assumptions, and compared them to market sources, in order to assess the reasonableness of the assumptions used in the actuarial reports.

The set of actuarial assumptions is one of the foundations upon which an actuarial rate is based. An actuarial rate is, essentially, a statistical projection of the amount and timing of future expense payments to be paid under the plan. In any statistical projection, assumptions as to future events will drive the process.

It is important to understand the nature of the health plan when assessing the reasonableness of the actuarial assumptions. No projection of future events can be labeled as "correct" or "incorrect." However, there is a "range of reasonableness" for each assumption. We evaluate individual elements as follows:

- Whether or not they fall within the range of reasonableness; and
- If they fall within that range, whether they are reasonable for the plan.

The key assumptions used by Aon in their Fiscal Year Premium Rates are:

1. Assumed Trends – The rate of medical, pharmacy and dental trends. The trends are the measurement of unit cost and utilization increase of the projected claims. The medical trend used by Aon was between 5.0% and 6.0%, pharmacy trend was between 7.5% and 9.0% and dental trend was 3.0% over the three years of premium rate settings.
2. Enrollment Assumptions – At the time of rate setting the current enrollment at the time was used to project the upcoming fiscal year.

According to the Actuarial Standards of Practice ("ASOPs"), an actuarial assumption is reasonable if it has the following characteristics:

- It is appropriate for the purpose of the measurement;
- It reflects the actuary's professional judgment;
- It considers historical and current economic data that is relevant as of the measurement date;
- It reflects the actuary's estimate of future experience, the actuary's observation of the estimates inherent in market data, or a combination thereof; and
- It has no significant bias (i.e., it is not significantly optimistic or pessimistic).

Also, according to these ASOPs, the actuary should recognize the uncertain nature of the items for which assumptions are selected and, as a result, may consider several different assumptions reasonable for a given measurement. The actuary should also recognize that different actuaries will apply different professional judgment and may choose different reasonable assumptions. As a result, a narrow range of reasonable assumptions may develop both for an individual actuary and across actuarial practice.

In GRS's opinion these key assumptions are reasonable and generally standard in the consulting industry.

Reasonableness and Appropriateness Actuarial Assumptions

Actuarial Standards of Practice

The Actuarial Standards Board (ASB) promulgates Actuarial Standards of Practice for use by actuaries when rendering actuarial services in the United States. The ASB is vested by the U.S.-based actuarial organizations with the responsibility for promulgating ASOPs for actuaries rendering actuarial services in the United States. Each of these organizations requires its members, through its Code of Professional Conduct, to satisfy applicable ASOPs when rendering actuarial services in the United States.

Development of health care rates, incurred health liability for unpaid claims, and contingency reserves must be developed in accordance with appropriate ASOPs. Relevant ASOPs include but are not limited to:

- ASOP No. 5, Incurred Health and Disability Claims
- ASOP No. 8, Regulator Filing for Health Benefits, Accident and Health Insurance, and Entities Providing Health Benefits
- ASOP No. 12, Risk Classification
- ASOP No. 23, Data Quality
- ASOP No. 25, Credibility Procedures
- ASOP No. 28, Statements of Actuarial Opinion Regarding Health Insurance Liabilities and Assets
- ASOP No. 41, Actuarial Communications
- ASOP No. 42, Health and Disability Actuarial Assets and Other Liabilities for Incurred Claims

In the development of the various analysis involved in writing this report, we have complied with these ASOPs and the Code of Professional Conduct. As part of this process, we have reviewed numerous reports and analysis developed by the Aon actuaries. Although specific statements regarding compliance with ASOPs were not included, the professional nature of the reports and the extensive detailed analysis provides support that the ASOPs were complied with. We recommend that Aon add specific statements in compliance with the ASOPs to their future reports.

SECTION D

REASONABLENESS AND ADEQUACY OF DATA

Reasonableness and Adequacy of Data

We have reviewed the data provided by the retained actuary, Aon, for reasonableness and appropriateness. In addition, we reviewed the data that was directly used by Aon in the development of premium rates. This data received was not original line item claim data but was in a format sufficient to complete a premium rate setting. Overall, we found the data used in development of premium rates to be reasonable and appropriate.

The data provided included:

- Monthly Participant Data
- Aggregated Medical Claims and Lag Reports
    - Vision experience is included in the medical documents
- Aggregated Pharmacy Claims and Lag Reports
- Aggregated Dental Claims and Lag Reports
- Administrative Expenses
- Contracted Rates for Claims Administrators
- High Cost Claimant Reports
- Pharmaceutical Rebates
- Health Insurance Fund (HIF) Cash Balances Report

As this data was not original claim information, GRS assumed it to be complete and did not review it against line item claims from the respective vendors.

GRS deemed the data provided to be adequate for the purposes of premium setting, IBNP (Incurred but not Paid) reserving and contingency setting. IBNP Reserve setting is the process of estimating claims for services that have been provided during the experience period under consideration but are not yet processed and paid as of the end of the period.

SECTION E

REVIEW OF RATING METHODOLOGY, REPORTS AND EXHIBITS

Review of Rating Methodology, Reports and Exhibits

As Aon did not grant access to the propriety actuarial models, GRS relied upon the methodology and the data provided to determine the accuracy of the premium rates.

The following is a summary of data and information provided and most pertinent to the project objectives:

a. Detailed description of methodology.
b. Detailed description of the Incurred But Not Reported methodology and assumptions.
c. Participant data summarized month by month by number of employees, number of spouses and number of children. Additionally, participant data needs to be segmented by line of business and benefit plan.
d. Paid claims by line of business, benefit plan, paid month and month of Incurral.
e. Summary of benefit plans and any benefit plan changes incorporated into the rate development. Description of the rating impact of the benefit change and how the impact was determined.
f. Reports on pharmaceutical rebates and subsidies.
g. Schedule of rate recommendations and final rates used.

GRS reviewed the methodology, reports and exhibits supplied by Aon as to the level of funding needed by the Program.

We also reviewed the actuarial liabilities and contingency calculations as provided in Aon's annual opinion letters at the end of each fiscal year.

Upon review of the methodology, reports and exhibits used by Aon in their development of the program rates, we have deemed that the methodology is reasonable and accurate for the purposes of rate development.

SECTION F

RESULTS OF ACTUARIAL RATE DEVELOPMENT

Results of Actuarial Rate Development

One of the primary purposes of an actuarial rate setting for the program is to help ensure the fund is healthy enough to cover the expenses of the Program for the upcoming fiscal year. Accordingly, it is very important to make sure that the funding necessary to achieve this is adequate but not excessive.

Aon indicates that the main purposes of the Rate Detail Reports are to provide the premium rates and budget for the upcoming year of the Program. This report includes:

1. Base actuarial rates by health benefit and family structure;
2. Budget by health benefit; and
3. Overall premium needed to fund health liabilities of the program.

We find that these are the appropriate main purposes of the rate development, budget projection and estimation of FY end liabilities.

- Aon indicates that enrollment for the active, COBRA and early retirees for the upcoming fiscal year is based on enrollment at the time of the premium rate setting.

  We agree with this assumption.

- Aon indicated the tier factors for family type are provided by the Program. The information provided does not make it clear if Aon has completed an experience study with respect to the tier structure or if they have recommended that an experience study be conducted. Aon has recommended adjusting these relationships to be more representative of claim experience, if warranted.

  Given the purpose of the tier structure (employee only/employee plus one/employee plus two or more) is to spread claim costs between these subgroups there is wide latitude in what tier structure to use. A tier structure is adequate as long as it does not create undue subsidization between subgroups or is discriminatory. The relative premiums and employee contribution scheme can be used to achieve plan goals; for example, 1) to encourage families to participate in the plan or 2) to encourage partners to take advantage of benefits provided by their own employers. Based on our review, the existing structure is within acceptable practices with no undue subsidization between subgroups.

- Aon concluded that the amount of premium necessary to have a fund that meets all program obligations, including administrative expenses, associated with contracts issued at the time for FY20 was $1.475 billion, $1.462 billion in FY21 and $1.508 billion in FY22.

  Based on our analysis, we believe this premium needed is reasonable at the time of rate setting.

Based on our review, we find that the conclusions included in the Aon Rate Detail reports are generally reasonable, and that Aon used reasonable assumptions, and complied with actuarial standards and guidelines.

SECTION G

TARGET CASH BALANCE FOR THE HEALTH INSURANCE FUND

Target Cash Balance for the Health Insurance Fund

A part of rate setting includes projecting an Incurred But Not Paid ("IBNP") and contingency reserve at the end of each plan year to be incorporated into premium rates to maintain enough cash balance to pay the liabilities of the plan after the end of a plan year. These liabilities include the IBNP and a contingency needed for unforeseen circumstances. During the three fiscal years included in the review, large claims (defined as over $300,000 for Anthem and over $100,000 for the smaller Aetna block) routinely exceeded $100 million. An adequate contingency reserve in addition to the IBNP is critical to ensuring plan solvency.

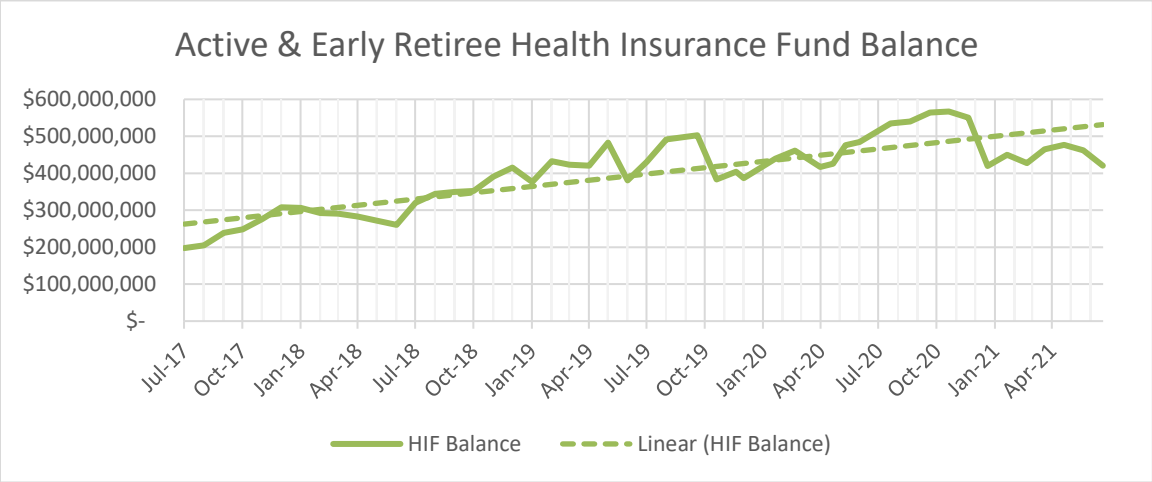
The Aon actuaries use the NAIC's Risk Based Capital ("RBC") formula at 200% of the Authorized Control Level (ACL) to determine their contingency reserve recommendation. This level is used since at this level the state insurance regulator would not be placing an insurance company under regulatory control. Using this methodology provides a structured process for determining a recommended contingency reserve which factors in the claims paid level (i.e., group's size) and the level of managed care utilized by the benefit program. Since the RBC calculation is intended for state regulators to monitor insurance companies, it provides a suitable method to support development of a contingency reserve for a self-insured benefit program. The chart below summarizes these calculations.

	Actuarial Liabilities						Contingency Reserves	Total Liabilities & Reserves
	Unpaid Claims			Other Liabilities		Total		
	IBNP Claims	Margin	Unpaid Claims Liability	Claims Settlement Expenses	Estimated Pharmacy Rebates			
COVA Care as of 6/30/2018 (@11/15/2018)								
COVA Care Total	$111,692,006	$5,584,600	$117,276,606	$4,268,608	($22,083,000)	$99,462,214	$102,828,205	$202,290,419
COVA Care as of 6/30/2019 (@11/26/2019)								
COVA Care Total	$126,894,417	$6,344,720	$133,239,137	$4,915,628	($24,829,000)	$113,325,765	$107,548,642	$220,874,407
COVA Care as of 6/30/2020 (@11/25/2020)								
COVA Care Total	$141,404,956	$7,070,248	$148,475,204	$6,708,293	($31,337,000)	$123,846,497	$102,031,146	$225,877,643

There is no industry standard or Actuarial Standard of Practice to establishing the contingency reserve. Generally, self-insured programs use a "rule of thumb" such as 1.5 to 2 months of expected claims to establish a contingency reserve. The Florida Office of Insurance Regulation uses two months of claims as a "safe harbor" for their review of self-funded public employer filings. South Carolina statutes requires 1.5 months be set aside. One of GRS' major clients uses a fixed dollar amount which generally translates to 1.2 to 1.3 months of claims. These "rules" would provide a recommended contingency reserve between $131 million to $218 million. The $102 million contingency reserve recommendation at the 2020 fiscal year-end is approximately 94% of one month of the claims level for fiscal year 2021. Paid claims during the FY 2021 were $1.31 billion. The $102.0 million contingency reserve provides a 7.8% margin for adverse deviation from the expected claim level. Based on review of the program's claim volatility, modeling using the rating software leased by GRS and review of pertinent actuarial literature, in GRS' opinion the RBC methodology provides an adequate level for the contingency reserve for this Program due to the large size, its long history and routine monitoring.

Target Cash Balance for the Health Insurance Fund

GRS reviewed the history of the cash balance along with the reserves projected and needed to maintain an adequate cash flow to cover the expenses of the Program. This review of the projected premium review, coupled with pharmacy rebates and subsidies, showed the projected cash balance was sufficient to maintain a balance in excess of the liabilities and contingency. The graph below displays the monthly Health Insurance Fund ("HIF") balances for the last four fiscal years and a linear trendline increasing by slightly over 12 percent per year.



In the chart on the previous page, the trend of Actuarial Liabilities & Reserve shows an annual trend of approximately 6% ($225 million / $202 million over two years). Note the composite annual healthcare trend used in the rate setting for FY 2022 is 6.3%. Therefore the actual increase in the HIF greatly exceeds the trend in other assumptions used by the program actuaries.

The driver of the increase in the HIF during the FY 2020 is due almost entirely to low paid claims (including Rx rebates) and offset by a major movement to the use of the Optima HMO network. Low paid claims in FY 2020 was due to Covid 19 which led to a very significant decrease in elective surgeries, physical therapy, doctor office visits, and other medical services. During FY 2020 the program implemented a one month "premium holiday" for both premium contributed by the system and by the participants. In FY 2021, another "premium holiday" was used to reduce the level of assets in the HIF. Largely due to this premium holiday, the HIF balance dropped by over $40 million.

Overall, the Program has been very well managed as evidenced by the healthy HIF balance. The HIF balance at June 2021 is over $420.2 million (approximately 85% more than the $225.9 million for the recommended Total Liabilities and Reserves provided in the Aon report "Actuarial Liabilities and Reserves" report published December 2020). Clearly there is room to reduce the level of the HIF.

Recommendations

We recommend the Program actively manage the HIF to reserves values provided in the actuary's annual FY end report titled "Actuarial Liabilities and Reserves" or this level with a 10 to 25% margin. These reserve values are provided in the chart at the beginning of this section. Using the Reserves & Liability amounts from FY 2020, this range is 100%: $225 million to 125%: $282 million.

Target Cash Balance for the Health Insurance Fund

We recommend continued monitoring of the HIF and further reducing the HIF by using premium holidays for one, two or three months.

In future premium rate developments, increases could be modified (either up or down) based on recent claim experience versus the projected claims for the same period. The experience period could be a rolling one to three years depending on the variability of the claims experience. To incorporate a three-year smoothing scheme would entail incorporating one-third of the difference in actual vs projected claims experience of each year for the next three rate setting cycles. The example that follows more fully illustrates this concept.

Illustration of a Three Year Smoothing Adjustment Based on Claims Experience (Loosely based on recent experience from the HIF details)

Step One: Determine the Gain or Loss of the Projected Claims (i.e., used in the rate development) for the most recent three Fiscal Years.

	Projected Claims in FY 20XX (used in Rate Development)	Actual Claims in FY 20XX	Projected vs Actual [Gain / (Loss)]
FY 2021	$ 1,389,972,668	$ 1,306,417,232	$ 83,555,436
FY 2020	1,390,486,397	1,162,055,185	228,431,212
FY 2019	1,401,121,184	1,275,736,457	125,384,727

Step Two: Allocate one third of each gain / loss to rate developments in future years. Note in this example the rates for FY 2021 and FY 2022 have already been established and therefore the gains / losses for these years are ignored. This method determines that there would be a $145,790,458 adjustment made to the FY 2023 rate development.

		Apply to Rate Setting of FY 20XX				
	Projected vs Actual [Gain / (Loss)]	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
FY 2021	$ 83,555,436			$ 27,851,812.00	$ 27,851,812.00	$ 27,851,812.00
FY 2020	228,431,212		$ 76,143,737.33	76,143,737.33	76,143,737.33	
FY 2019	125,384,727	$ 41,794,909.00	41,794,909.00	41,794,909.00		
				$ 145,790,458.00		

Target Cash Balance for the Health Insurance Fund

Step Three: The normal rate development takes place using the FY 2021 actual claims trended for two years to FY 2023 and add in administrative expenses. The last step would be to then apply the Smoothing Adjustment. Gains from the three year formula are subtracted from the initial Projected Premium for 2023. In this example the smoothing adjustment would be quite large, reducing the FY 2022 premium by 7.8%.

Example of Setting 2023 Rates using a Three Year Smoothing Adjustment		
Assumptions		
Trend from FY 2021 to FY 2022	6.5%	
Trend from FY 2022 to FY 2023	6.0%	
Enrollment FY 2021	88,170	
		PEPM
Actual Claims Exper. FY 2021	$ 1,306,417,232	$1,234.75
Trend to FY 2022	$ 1,391,334,352	$1,315.01
Trend to FY 2023	$ 1,474,814,413	$1,393.91
Administration	$ 60,819,086	$57.48
Projected Total Premium 2023	$ 1,535,633,499	$1,451.39
Smoothing Adjustment (+ or -)	-$ 145,790,458	
	$ 1,389,843,041	$1,313.60
Adjustment	-9.5%	
Expected Premium in 2022	$ 1,508,083,980	$1,425.36
Percent increase in Projected Prm 2023	1.8%	
with Smoothing Adjustment	-7.8%	