**GOVERNMENT OF THE DISTRICT OF COLUMBIA**
**DEPARTMENT OF INSURANCE, SECURITIES, AND BANKING**

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| IN THE MATTER OF: | ) | |
| Surplus Review and Determination Regarding Group Hospitalization and Medical Services, Inc. | ) | Order No: 09-MIE-006 |

# DECISION AND ORDER

## *Jurisdiction*

This Decision and Order sets forth the findings and conclusions of the District of Columbia (the "District") Commissioner for the Department of Insurance, Securities and Banking (the "Commissioner") pursuant to the Hospital and Medical Services Corporation Regulatory Act of 1996, effective April 9, 1997 (D.C. Law 11-245; D.C. Official Code § 31-3501 *et seq.*) (the "HMSCR Act"), as amended by the Medical Insurance Empowerment Amendment Act of 2008, March 25, 2009 (D.C. Law 11-369; 56 DCR 1346) ("MIEAA"), the regulations under Chapter 46, Title 26 of the District of Columbia Municipal Regulations ("MIEAA Regulations"), and the District of Columbia Administrative Procedure Act, approved October 21, 1968 (82 Stat. 1209; D.C. Official Code § 2-510 (2006 Repl.)). As required by the HMSCR Act, this Decision and Order addresses whether Group Hospitalization and Medical Services, Inc.'s ("GHMSI") surplus attributable to the District is excessive. The Commissioner has the authority to make this determination and to issue this Decision and Order pursuant to Section 7 of the HMSCR Act.

## *Background & Procedural History*

### A. GHMSI's Congressional Charter

In 1939, the United States Congress incorporated GHMSI[1] and prescribed its charter pursuant to An Act Providing for the incorporation of certain persons as Group Hospitalization, Inc. (Pub. L. No. 76-395; 53 Stat. 1412 (1939) (*amended by* An Act making appropriations for the government of the District of Columbia and other activities chargeable in whole or in part against the revenues of said District for the fiscal year ending September 30, 1994, and for other purposes (Pub. L. 103-127; 106 Stat. 1336 (1993))) ("GHMSI Charter"). The GHMSI charter authorized and empowered GHMSI to enter into individual and group contracts to provide health care services, as specified in their certificates. GHMSI Charter § 2. The GHMSI charter prescribes the corporation's charitable mission:

> This corporation is hereby declared to be a charitable and benevolent institution and all of its funds and property shall be exempt from taxation other than taxes on real estate.

*Id.* at § 8. The GHMSI Charter further provides:

> Said corporation shall not be conducted for profit, but shall be conducted for the benefit of the aforesaid certificate holders. The business and affairs of this corporation shall be conducted by its board of trustees, who shall have full power and authority in the premises, including authority to provide for all expenses incident to the conduct and management of its business and affairs.

*Id.* at § 3.

GHMSI is domiciled in the District, and its charter obligates GHMSI to submit to the regulatory authority of the Commissioner in accordance with the laws and regulations of the District. *Id.* at §§ 1, 5-7.

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[1] GHMSI was originally incorporated as Group Hospitalization, Inc., and later merged with Medical Services, Inc., to form GHMSI.

In 1998, GHMSI joined with CareFirst Maryland, Inc. (then known as Blue Cross and Blue Shield of Maryland, Inc.), to form a holding company, CareFirst, Inc., a non-profit corporation domiciled in Maryland. GHMSI currently provides Blue Cross and Blue Shield health care coverage in the District, Maryland, and portions of Northern Virginia.

### B. The District's Regulation of GHMSI

Consistent with the terms of the GHMSI charter, the Council of the District of Columbia enacted the HMSCR Act, establishing a comprehensive statutory framework for regulating GHMSI's provision of health care services. Among other things, the HMSCR Act empowers the Mayor (via the Commissioner) to monitor the financial aspects of GHMSI's non-profit business. *See* D.C. Official Code §§ 31-3504, 31-3508, and 31-3509. Effective March 25, 2009, the Council enacted the MIEAA, amending the HMSCR Act with respect to GHMSI's surplus and open enrollment requirements, establishing a new community health reinvestment mandate, and prohibiting GHMSI's conversion to a for-profit entity. *See* D.C. Official Code §§ 31-3505.01, 31-3506, and 31-3514. The MIEAA also mandated the Commissioner's current review of GHMSI's surplus and charitable activities.

In accordance with the Commissioner's authority granted under Section 4(a)(1) of the Department of Insurance and Securities Regulation Establishment Act of 1996, effective May 27, 1997 (D.C. Law 11-268; D.C. Official Code § 31-103(a)(1)), and Section 25 of the HMSCR Act (D.C. Official Code § 31-3524), the Commissioner issued an emergency and proposed rulemaking, effective July 10, 2009, and an emergency rulemaking effective November 8, 2009, that prescribed the procedures for the determination of excess surplus. 56 D.C. Reg. 005665 (July, 10, 2009); 56 D.C. Reg. 46 (Nov. 13, 2009). The Commissioner issued a Notice of Final

Rulemaking on November 13, 2009, adopting the emergency rules as final. 56 D.C. Reg. 008841 (Nov. 13, 2009); *see* D.C. Mun. Regs. Title 26, ch. 46.

### C. Procedural History

In accordance with Section 7(e)(1) of the HMSCR Act (D.C. Official Code § 31-3506(e)(1)) and Section 4601.4 of the MIEAA Regulations, former Commissioner Thomas E. Hampton, on July 17, 2009, issued a determination that GHMSI's surplus exceeds, and is expected to exceed, the greater of the National Association of Insurance Commissioners ("NAIC") Risk-Based Capital Authorized Control Level ("RBC-ACL") requirement and the Blue Cross and Blue Shield Association minimum capital requirements. Commissioner Hampton determined that GHMSI's surplus as of December 31, 2008, was "greater than appropriate [RBC-ACL] requirements," as defined under Section 4601.4 of the MIEAA Regulations. *See* Department of Insurance, Securities and Banking, 2009 Group Hospitalization and Medical Services Inc. Adequate Surplus Determination (July 17, 2009).

On July 24, 2009, pursuant to Section 7(e) of the HMSCR Act (D.C. Official Code § 31-3506(e)) and the MIEAA Regulations, Commissioner Hampton gave notice of a public hearing to determine whether the portion of GHMSI's surplus attributable to the District is unreasonably large and inconsistent with GHMSI's community health reinvestment obligations set forth in Section 6a of the HMSCR Act. *See* 56 D.C. Reg. 005967 (July 24, 2009) [republished at 56 D.C. Reg. 006000 (July 31, 2009) to provide new location and correct typographical error].

On July 31, 2009, GHMSI submitted a report on its 2008 surplus ("GHMSI Surplus Report") and a 2008 report from Milliman entitled "Need for Statutory Surplus and Development of Optimal Surplus Target Range" ("Milliman Surplus Report"). Additionally, on August 31,

2009, GHMSI submitted a pre-hearing report ("GHMSI Pre-Hearing Report"), which included a second report from Milliman regarding the calculation of GHMSI's surplus attributable to the District (GHMSI Pre-Hearing Report, Exhibit A) and a report from the Lewin Group ("Lewin") analyzing both Milliman reports (GHMSI Pre-Hearing Report, Exhibit B).

On August 31, 2009, D.C. Appleseed submitted an extensive pre-hearing report, which included legal analysis of the MIEAA by Covington and Burling LLP, an actuarial study from Actuarial Risk Management, and a public policy report from Mathematica Policy Research, Inc.

On or before August 31, 2009, over a dozen community members and the Maryland Insurance Administration ("MIA") Commissioner, Ralph S. Tyler, submitted letters and reports for the record.

On September 10 and 11, 2009, the Commissioner held a public hearing (the "Commissioner's Hearing") where representatives from GHMSI and various community organizations, including D.C. Appleseed, testified, responded to questions, and submitted statements for the record. The Commissioner's expert consultants, including Rector & Associates, Inc. ("Rector"), who was retained pursuant to Section 7(h) of the HMSCR Act, also participated in the hearing and had the opportunity to question witnesses.

Because GHMSI operates in Virginia and Maryland in addition to the District, the Commissioner received several letters from community organizations and representatives from those jurisdictions. All correspondence received urged the Commissioner to consider carefully the impact of her decision on GHMSI members who reside outside of the District. At the Commissioner's Hearing, MIA Commissioner Tyler also testified and submitted a statement for the record. Commissioner Tyler informed the Commissioner that the MIA was in the midst of examining GHMSI's surplus and expected to receive a report from an outside consulting firm,

Invotex Group ("Invotex"), within approximately 45 days of the Commissioner's Hearing. Accordingly, Commissioner Tyler asked the Commissioner to delay her final determination in order for the two jurisdictions to continue working together.

Recognizing that MIEAA directs the Commissioner to consider the "interests and needs of the jurisdictions in the corporation's service area," following the Commissioner's Hearing, the Commissioner issued an order extending the time for her determination to a date no later than December 31, 2009, and keeping the record of the Commissioner's Hearing open until 6:00 P.M. on November 2, 2009. Department of Insurance, Securities and Banking, In re: Surplus Review of Group Hospitalization and Med. Srvs., Inc., Order No. 09-MIE-001 (Sept. 24, 2009); *see* D.C. Official Code § 31-3506.01(b).

On or before November 2, 2009, the Commissioner received over two dozen additional submissions from community members, including an additional filing from D.C. Appleseed. GHMSI also filed several post-hearing documents, including a rebuttal brief ("GHMSI Post-Hearing Brief"), responses to questions posed during the hearing ("GHMSI Post-Hearing Responses"), an independent report from Lewin regarding an "appropriate" level of RBC-ACL for GHMSI ("Lewin Post-Hearing Report"), and data relating to GHMSI's community health reinvestment contributions ("2009 D.C. Community Health Giving Data" and "2008 D.C. Community Health Giving Data"). The complexity and importance of the surplus determination was reflected in the diverse community opinions received regarding GHMSI's surplus and, if the surplus is found to be excessive, how the excessive surplus should be attributed to the District and used.

On November 19, 2009, the MIA held a public hearing (the "MIA Hearing") on the surpluses of GHMSI and CareFirst Maryland, Inc. At the hearing, Invotex presented its report, and CareFirst and a few community members testified and made submissions to MIA's record.

Prior to the MIA Hearing, the Commissioner issued an order to reopen the Commissioner's Hearing record for the limited and sole purpose of the Commissioner obtaining and considering information and testimony provided at or in connection with the MIA Hearing. Department of Insurance, Securities and Banking, In re: Surplus Review of Group Hospitalization and Med. Srvs., Inc., Order No. 09-MIE-002 (Nov. 18, 2009). Subsequently, on December 31, 2009, the Commissioner issued an order extending the time for her determination to a later time after the completion of the Commissioner's review of GHMSI's surplus. Department of Insurance, Securities and Banking, In re: Surplus Review of Group Hospitalization and Med. Srvs., Inc., Order No. 09-MIE-004 (Dec. 31, 2009); *see* D.C. Official Code § 31-3506.01(b).

On July 21, 2010, the Commissioner reopened the Commissioner's Hearing record for the limited and sole purpose of including information from the Commissioner's experts, including Rector's "Report to the Commissioner of the District of Columbia Department of Insurance, Securities and Banking: Group Hospitalization and Medical Services, Inc." ("Rector Report"). Department of Insurance, Securities and Banking, In re: Surplus Review of Group Hospitalization and Med. Srvs., Inc., Order No. 09-MIE-005 (July 20, 2010. The Commissioner's Hearing record closed on July 21 2010. Department of Insurance, Securities and Banking, In re: Surplus Review of Group Hospitalization and Med. Srvs., Inc., Order No. 09-MIE-005 (July 20, 2010).

### D. Post-Hearing Legislation, Orders, and Partnership Agreement

During the Commissioner's review and analysis of GHMSI's surplus, the Council of the District of Columbia and Congress enacted several pieces of legislation that could have a significant impact on the operations of GHMSI.

On March 2, 2010, the Council enacted the Reasonable Health Insurance Premium Increase Emergency Amendment Act of 2010 ("D.C. Health Insurance Premium Act"). The D.C. Health Insurance Premium Act amended the HMSCR Act to limit GHMSI's annual rate increases to be no more than 10% above the prior year's rates, unless the Commissioner approves an increase up to 15% "upon receipt of adequate documentation supporting the requested increase." *Id.* at § 3.

Contemporaneous with enactment of D.C. Health Insurance Premium Act, the Department entered four orders that reduced GHMSI's recently approved rate increases for various products. *See In Re GHMSI, Rate Filing # 1284 DC*, Case No. IB-RF-01-10 (Mar. 3, 2010); *In Re GHMSI, Individual Non-Medigap PPO/Blue Preferred Underwritten Saver Plan*, Case No. IB-RF-02-10 (Mar. 12, 2010); *In re GHMSI, Rate Filing # 1277 DC*, Case No. IB-RF-03-10 (Mar. 12, 2010); and *In Re GHMSI,* Small Group Medical and Drug Products PPO HRA and PPO HAS, Case No. IB-RF-04-10 (Apr. 13, 2010). The proposed rate increases ranged from 17.3% to 35% above 2009 premium rates, and the orders limited the rate increases to 12% above the 2009 premium rates.

At the end of March 2010, the President signed into law the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, and the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152 (collectively, "Federal Health Care Reform Acts"). The Federal Health Care Reform Acts, among other changes, will expand oversight of health care

plan premium rate increases, restrict the use of pre-existing condition limitations, and limit the structure of health care plans.

In addition to the legislation impacting GHMSI, the District and GHMSI have entered into a Public-Private Partnership Agreement ("Agreement") pursuant to section 15 of the HMSCRA Act (D.C. Official Code § 31-3514(p)), which authorizes GHMSI to enter into a public-private partnership with the District in lieu of meeting the new Open Enrollment Program ("OEP") requirements.

The Agreement includes the following major provisions:

- GHMSI shall pay to the Healthy DC Fund: (a) $5 million within five business days of the Effective Date of the Agreement, and (b) $5 million on or before January 15th of each succeeding year (representing an aggregate of $25 million in payments) during the term of the Agreement.

- The payments to the Healthy DC Fund shall be used for subsidies that expand health insurance coverage for low-income residents of the District.

- GHMSI shall continue to offer and shall provide maintenance and support for the existing OEP, with a maximum premium and other specified terms.

- GHMSI shall offer, through its affiliate, CareFirst BlueChoice, Inc., a new health maintenance organization product for new members of the OEP, and as an alternative option for current subscribers to the OEP.

- GHMSI shall design and submit for approval to the Mayor a targeted city-wide health care initiative aimed at improving nutrition and increasing physical fitness among the District's senior citizens (individuals age 60 and older). Once approved by the Mayor, GHMSI shall promptly implement such senior citizen initiative and maintain and support it throughout the term of this Agreement.

### *Findings of Fact*

After full consideration of all testimony, reports, and other submissions in the record for this matter, the Commissioner makes the following findings of fact:

### A. GHMSI's Policies, Members, and Providers

1. At the end of 2008, GHMSI had 36,752 individual policies with 12,905 (35%) of those policies issued in the District, 9,816 (27%) issued in Maryland, and 14,031 (38%) issued in Virginia. (GHMSI Post-Hearing Responses at 1).

2. At the end of 2008, GHMSI had 16,510 group policies with 3,712 (22%) of those policies issued in the District, 9,263 (56%) issued in Maryland, and 3,535 (21%) issued in Virginia. (GHMSI Post-Hearing Responses at 1).

3. At the end of 2008, GHMSI had 77 self-insured contracts, of which 25 (32%) were based in the District, 43 (56%) were based in Maryland, and 9 (12%) were based in Virginia. (GHMSI Post-Hearing Responses at 1).

4. At the end of 2008, based on the situs of the policy or contract, approximately 31% of GHMSI's polices and contracts were located in the District, approximately 36% of the policies and contracts were located in Maryland, and the remaining policies and contracts (approximately 33%) were located in Virginia. (Rector Report at 18).

5. At the end of 2008, GHMSI had approximately one million members. Approximately 32% of members were fully-insured by GHMSI, 33% of members were self-insured, and 35% were Federal Employee Health Benefit Plan ("FEP") members. (GHMSI Surplus Report at 1; GHMSI Pre-Hearing Report at 16).

6. At the end of 2008, approximately 10% of GHMSI's members lived in the District, 44% lived in Maryland, and the balance lived in Virginia and other jurisdictions. (Rector Report at 20; *see also* Commissioner's Hearing 09/10/09 Tr. at 14; GHMSI Surplus Report at 2; GHMSI Pre-Hearing Report at 16).

7. Approximately 13% of the providers in GHMSI's provider network are located in the District. An additional 12% of the providers in CareFirst BlueChoice's provider network, of which GHMSI owns 40%, are located in the District.[2] (Rector Report at 20; GHMSI Post-Hearing Responses at 1).

8. Based on the average of premiums reflected in Schedule T of GHMSI's Annual Statements for 1999-2008, approximately 69% of GHMSI's premiums for this ten-year time frame were attributable to policies or contracts issued in the District. Similarly, approximately 69% of claims expenses by situs of the policy are attributable to policies or contracts issued in the District. (Rector Report at 21-22).

**B. GHMSI's Surplus and RBC-ACL**

9. GHMSI's surplus level as of December 31, 2008, was approximately $687 million. As of the same date, GHMSI had an RBC-ACL ratio of approximately 845%. (GHMSI 2008 Annual Statements).

10. For each year from 2004 until 2007, GHMSI had RBC-ACL levels of 951%, 893%, 955%, and 916%, respectively. (GHMSI 2008 Annual Statements; GHMSI Surplus Report at 6).

11. If Blue Cross Blue Shield insurers, including GHMSI, do not maintain an RBC-ACL level above 375%, they trigger the Blue Cross and Blue Shield Association's "Early Warning Monitoring" threshold for "potential lack of financial soundness." (GHMSI Pre-Hearing Report at 20).

[2] This data reflects individual providers (practitioners) rather than provider groups. In addition, if a practitioner is affiliated with multiple provider groups or office locations in multiple jurisdictions, the practitioner is counted one time in each jurisdiction where the practitioner has an office location. If the practitioner has multiple office locations in the same jurisdiction, only one location is included in the number of providers for that particular jurisdiction.

12. The Milliman Surplus Report, which GHMSI commissioned prior to these proceedings, concluded that an "optimal surplus target range" for GHMSI as of December 31, 2008, is 750-1050% RBC-ACL. (Milliman Surplus Report at 57).

13. According to the Milliman Surplus Report and additional data Milliman provided Rector, the Milliman range represents the following: the bottom number of the range (750%) is the amount of surplus Milliman calculates that GHMSI needs as of December 31, 2008, (1) to not fall below 200% RBC-ACL at a 98% confidence level assuming a 2-year trend miss[3] and (2) to not fall below 375% RBC-ACL at a 90% confidence level assuming a 2-year trend miss; the top number of the range (1050%) is the amount of surplus Milliman calculates that GHMSI needs as of December 31, 2008, to not fall below 375% RBC-ACL at a 95% confidence level assuming a 2.5-year trend miss. (Rector Report at 3-4).

14. GHMSI also commissioned Lewin to determine an "appropriate range of surplus," and Lewin concluded that 750-1000% RBC-ACL is "an appropriate range of working surplus" for GHMSI as of December 31, 2008. (Lewin Post-Hearing Report at 24). Although Lewin indicates what RBC-ACL ratios and confidence levels it used to establish its range, it is not clear what methodology or assumptions Lewin used in its analysis.

15. Appleseed commissioned Actuarial Risk Management ("ARM") to prepare an actuarial analysis of GHMSI's surplus to determine whether the surplus was excessive. ARM determined that GHMSI's surplus RBC-ACL range as of December 31, 2008, should be 400-525%. (Appleseed Pre-Hearing Report, Exhibit B at 27).

16. Rector reviewed ARM's analysis and conclusions it reached in its report, and determined that is was not appropriate to compare ARM's analysis to Milliman's analysis in the

[3] Trend miss is the number of years assumed that is needed to identify and address rating fluctuations.

same manner as it did with the other experts' reports because ARM did not have access to the same information as Lewin and Invotex.

17. MIA's expert consultant Invotex concluded that an "appropriate" RBC-ACL range requirement for GHMSI under Maryland law is 700-900% as of December 31, 2008. (Invotex Report at 80-81). Although Invotex indicated that it relied on the Milliman methodology for its analysis, it is not clear how the assumptions made by Invotex resulted in its range.

18. Rector, the Commissioner's expert consultant, did not determine a "range" of acceptable or optimal surplus. Rather, based on its calculations, Rector determined that as of December 31, 2008, GHMSI needs RBC-ACL of 600% to not fall below 200% RBC-ACL at a 99% confidence level assuming a 2.5-year trend miss, and that GHMSI needs RBC-ACL of 850% to not fall below 375% RBC-ACL at a 95% confidence level assuming a 2.5-year trend miss. (Rector Report at 3-4).

### C. GHMSI's Financial Obligations and Community Giving

19. In 2008, GHMSI paid approximately $7.1 million in premium taxes to the District. In its submitted materials, GHMSI estimated that it expected to pay approximately $9 million in premium taxes to the District by the end the 2009 calendar year. (CareFirst's 2009 D.C. Community Health Giving Data; Rector Report at 25 (Ex. 2)).

20. GHMSI stated that it makes community health reinvestment contributions though corporate sponsorships related to community health efforts, targeted giving, programmatic giving, catalytic giving, and subsidies. (CareFirst Commitment: 2008 Year in Review at 2-18; Rector Report at 25 (Ex. 2)).

21. In 2008, GHMSI's contributions to the District's open enrollment program through December 31, 2008, equaled approximately $3 million.[4] Program administration costs equaled approximately $439,000. In its submitted materials, GHMSI estimated that it expected to contribute approximately $4.1 million in subsidies for the District's open enrollment program in 2009. (CareFirst Commitment: 2008 Year in Review at 17; CareFirst's 2008 D.C. Community Health Giving Data; Rector Report at 25 (Ex.2)).

22. In 2008, GHMSI's contributions to the District for corporate health-related sponsorships, target giving, programmatic initiatives, and catalytic giving through December 31, 2008, equaled approximately $2.9 million. Its contributions to the District's open enrollment subsidies equaled approximately $3.5 million, including administrative costs. (CareFirst's 2008 D.C. Community Health Giving Data; Rector Report at 25 (Ex. 2)).

23. GHMSI's new open enrollment program/public-private partnership is estimated to cost $5 million per year, for a projected term not to exceed 5 years, subject to extension.

24. The majority of GHMSI members who submitted comments cited dramatic rate increases in recent years and requested that any excessive surplus of GHMSI be returned to or used for the benefit of its subscribers. *See, e.g.,* Email from Dennis Bass, Deputy Executive Director of Center for Science in the Public Interest (Oct. 28, 2009); Email from Beth C. Clark (Oct. 27, 2009); Letter from Mark Gruenberg, President of Press Associates News Service (Oct. 26, 2009); Letter from Patricia Raz (Oct. 26, 2009); Letter from Stephen Bennett, President/CEO of United Cerebral Palsy (Sept. 9, 2009); Letter from Bob Witeck, CEO of Witeck Combs

[4] GHMSI provided slightly conflicting data regarding its contributions to the District's open enrollment program through December 31, 2008. In its "CareFirst Commitment: 2008 Year in Review" submission, GHMSI stated that it provided approximately $3.3 million in subsidies for the District's open enrollment, but in a subsequent response to a request for additional data from DISB's experts, GHMSI indicated that it had contributed approximately $3.1 in subsidies to the open enrollment program. The approximately $200,000 difference does not have a substantive effect on the Commissioner's decision in this matter.

Communications (Sept. 8, 2009); Letter from Bill Pullen (Sept. 8, 2009); Letter from Aubrey Sarvis (Sept. 8, 2009).

25. GHMSI's financial position accounted for unknown financial pressures that it anticipated would result from federal health care reform. Commissioner's Hearing 09/11/09 Tr. at 41-42.

26. GHMSI's surplus level as of December 31, 2009, was approximately $761 million. As of the same date, GHMSI had an RBC-ACL ratio of approximately 902%. (GHMSI 2009 Annual Statement).

27. The Federal Health Care Reform Acts will expand federal oversight of health care plan premium rate increases and plan access, restrict insurers' use of pre-existing condition limitations, and limit the overall structure of health care plans.

28. Several federal agencies and organizations, including the Department of Health and Human Services, the Department of Labor, the Treasury Department, and the National Association of Insurance Commissioners are currently drafting comprehensive regulations in several phases to implement sections and related provisions of the Federal Health Reform Acts.

29. The first phase in the series of implementing federal regulations was a pair of publications consisting of a Request for Information relating to the medical loss ratio provisions of the Federal Health Reform Acts and a Request for Information relating to the rate review process of the Federal Health Reform Acts, both published in the Federal Register on April 14, 2010 (75 FR 19297 and 19335). The second phase was interim final regulations implementing coverage of adult children until age 26 published in the Federal Register on May 13, 2010 (75 FR 27122). The third phase was interim final regulations relating to status as a grandfathered health plan, published in the Federal Register on June 17, 2010 (75 FR 34538) followed by

interim final regulations published to implement the prohibition of preexisting condition exclusions and regarding lifetime and annual dollar limits on benefits, restrictions on rescissions and patient protections.

30. The impact of the Federal Health Reform Acts and their implementing regulations on the health insurance market and on health insurers and all participants in the health insurance markets are expected to be unprecedented, extremely significant, and are not fully known.

## *Commissioner's Analysis and Conclusions of Law*

### A. Applicable Laws

#### 1. Congressional Charter

As discussed above, GHMSI's Congressional charter mandates the corporation's powers and charitable mission. Its primary mandate is to provide health insurance to individuals or groups and to "cooperate, consolidate, or contract with groups or organizations interested in promoting and safeguarding the public health." GHMSI Charter § 2. The charter dictates that GHMSI is to be not-for-profit and is to be conducted for the benefit of its certificate holders. *Id.* at § 3. It vests GHMSI's board of trustees with the power and authority to conduct the business and affairs of the corporation. *Id.* Additionally, the charter declares that GHMSI is to be "a charitable and benevolent institution and all of its funds and property shall be exempt from taxation other than taxes on real estate." *Id.* at § 8.

#### 2. MIEAA

MIEAA added a new Section 6a to the HMSCR Act which provides, "[a] corporation shall engage in community health reinvestment to the maximum feasible extent consistent with financial soundness and efficiency." D.C. Official Code § 31-3505.01. "Community health

reinvestment" under MIEAA is defined as "expenditures that promote and safeguard the public health or that benefit current or future subscribers, including premium rate reductions." *Id.* at § 31-3501(1A).

Section 2(d) of MIEAA amends the surplus requirements under the HMSCR Act and requires the Commissioner to issue a determination as to whether the surplus that is "attributable to the District" is excessive. The surplus may be excessive only if:

> (1) The surplus is greater than the appropriate risk-based capital requirements as determined by the Commissioner for the immediately preceding calendar year; and
>
> (2) After a hearing, the Commissioner determines that the surplus is unreasonably large and inconsistent with the corporation's obligation under [§ 31-3505.01] [the community health reinvestment mandate].

D.C. Official Code § 31-3506(e).[5]

In July 2009, the former Commissioner determined that GHMSI, with a $686,779,719 surplus as of December 31, 2008, had an RBC-ACL level of 845%, which he determined to be greater than the "appropriate risk-based capital requirements," as defined under section 4601.4 of the MIEAA Regulations. *See* Department of Insurance, Securities and Banking, 2009 Group Hospitalization and Medical Services Inc. Adequate Surplus Determination (July 17, 2009). Accordingly, a public hearing was held in September 2009 to examine whether the surplus attributable to the District is excessive by examining whether the surplus is "unreasonably large" and inconsistent with the corporation's obligation to engage in community health reinvestment to the maximum feasible extent consistent with soundness and efficiency.

[5] The D.C. Official Code § 31-3506(e) appears to have an error by citing the corporation's obligation under "§ 31-3505(a)," which actually references the corporation's requirements for issuance of certificate of authority. The corporation's obligation is contained in § 31-3505.01. *See also* MIEAA § 2(c).

The MIEAA Regulations define the factors that must be considered when allocating portions of the surplus as "attributable to the District." D.C. Mun. Reg, Title 26, § 4699.2. Those factors are (1) the number of policies by geographic area, (2) the number of health care providers under contract with the company by geographic area, and (3) any other factor that the Commissioner deems to be relevant based on the record of the public hearing. *Id.*

According to the MIEAA Regulations, "unreasonably large surplus" means:

> [A] surplus of a corporation that is greater than the sum of the following:
>
> (a) The appropriate NAIC risk-based capital level requirements determined by the Commissioner and the Blue Cross/Blue Shield Association capital requirements based on the company's surplus from the immediately preceding year; and
>
> (b) The amount of surplus needed by the corporation to meet its expected and unanticipated contingencies.

*Id.* at § 4699.4. The Commissioner interprets the definition of "unreasonably large surplus" as set forth in 26 DCMR § 4699.4 as referring to a surplus that is greater than the sum of these two surplus levels. The intent of the Regulation is to define "an unreasonably large surplus" as a surplus that exceeds the sum of the NAIC and Blue Cross and Blue Shield Association RBC-ACL requirements and the amount of additional surplus above the required RBC-ACL levels that is necessary for the corporation to meet its expected and unanticipated contingencies. Simply put, "unreasonably large surplus" is any amount in excess of the RBC-ACL level that is necessary for the corporation to meet its expected and unanticipated contingencies, assuming the RBC-ACL level is at or above the NAIC and Blue Cross and Blue Shield Association RBC-ACL requirements.

Additionally, in determining whether the surplus attributable to the District is "unreasonably large," the MIEAA Regulations specify that the Commissioner may consider

"actuarially determined risk exposures" and the "expected and unanticipated contingencies of the company." *Id.* at § 4601.8. The anticipated cost for implementing MIEAA's open enrollment requirement should also be considered in the determination. *Id.*

Additionally, in determining whether or not the surplus attributable to the District is excessive, MIEAA requires the Commissioner to weigh the corporation's financial obligations associated with its insurance business, including premium tax paid and the corporation's contribution to the open enrollment program required under Section 15 of the HMSCR Act (D.C. Official Code § 31-3514). D.C. Official Code § 31-3506(f).

If the Commissioner makes a finding that the surplus is excessive, then GHMSI must submit a plan for dedication of the excess to community health reinvestment in a fair and equitable manner. *Id.* § 31-3506(g)(1); D.C. Mun. Reg. Title 26, §§ 4603.1-.2. The plan may consist entirely of expenditures for the benefit of current subscribers of the corporation. D.C. Official Code § 31-3506(g)(2).

**B. Analysis and Legal Conclusions**

In accordance with the MIEAA and all other applicable laws within the context of GHMSI's obligations under its Congressional charter, and based on a comprehensive record, including expert actuarial opinions, submissions and testimony from GHMSI, D.C. Appleseed, and various other community members, the Commissioner hereby concludes as follows regarding GHMSI's surplus level:

**1. The Expert Reports Overlap Substantially.**

The record includes five expert consultant analyses regarding GHMSI's surplus: the ARM report, the Milliman Surplus Report, the Lewin Post-Hearing Report, the Invotex Report,

and the Rector Report. However, the Commissioner does not accord any weight to the ARM report because the methodology employed is unclear, and ARM lacked all the necessary data from GHMSI to perform a comprehensive and accurate analysis of GHMSI's surplus. Accordingly, the Commissioner used the other four expert analyses in reaching her determination.

With the exception of the Rector Report, each report recommends an RBC-ACL range that is either "optimal" or "appropriate." However, each "range" is based on levels of current surplus that GHMSI would need so as not to drop below various RBC-ACL threshold targets. The Rector Report also determines levels of current surplus that GHMSI would need so as not to drop below various RBC-ACL threshold targets, but it does not apply any qualitative adjective to its lowest and highest levels of RBC-ACL. All four reports use an actuarial modeling approach. Invotex and Rector used the Milliman methodology and made adjustments to Milliman's assumptions and calculations, and also examined other factors. Although it is not clear what methodology Lewin used in its approach, Lewin did use an actuarial modeling approach. Despite the various methods for developing the RBC-ACL range, the results of the four reports overlap substantially. For example, based on calculations of GHMSI's surplus as of December 31, 2008, all four ranges determined by the experts include in the RBC-ACL range of 750% to 850% as a subset.

The Milliman Surplus Report primarily examines two issues—maintaining statutory surplus and quantifying an "optimal surplus range." The major risk and contingency categories the Milliman Surplus Report examines are: rating adequacy and fluctuation, unpaid claim liabilities and "other estimates," interest rate and portfolio asset value fluctuations, overhead expense recovery risk, other business risks, catastrophic events, and provision of unidentified

development and growth. The two levels of RBC-ACL that the Milliman Surplus Report concludes are important to measure are: 200% RBC-ACL, the level GHMSI needs to avoid a statutory action level event and to avoid loss of the Blue Cross Blue Shield trademarks; and 375% RBC-ACL, the level at which the Blue Cross and Blue Shield Association's "Early Warning Monitoring" is triggered. Based on various assumptions, its simulation of loss cycles, pro forma projections, and consideration of the statutory and association thresholds, the Milliman Surplus Report recommends an "appropriate target" for GHMSI's surplus as of December 31, 2008, to be within the range of 750-1050% RBC-ACL.

The low-end of the Milliman range, 750% RBC-ACL, represents as of December 31, 2008, (1) a 98% confidence that GHMSI would stay above 200% RBC-ACL assuming a 2-year trend miss and (2) a 90% confidence that GHMSI would stay above 375% RBC-ACL assuming a 2-year trend miss. *See* Rector Report at 3, n.1. The high-end of that range, 1050% RBC-ACL, represents as of December 31, 2008, a 95% confidence level that GHMSI would maintain a surplus level above 375% RBC-ACL assuming a 2.5-year trend miss. The report states that such a range should be "wide enough to allow for a reasonable degree of fluctuation in operating results year-to-year, under normal operating circumstances, over a multi-year horizon." (Milliman Surplus Report at 7).

Similarly, the Lewin Post-Hearing Report focuses on developing an "appropriate" "working surplus range" that the insurer needs to maintain operations. The Lewin Post-Hearing Report identifies its general risk categories, which are similar to those used to calculate RBC-ACL ratios, as: underwriting risk, asset risk, cost of capital and credit risk, and operational and business risk. Lewin also incorporated additional "vitality-related" considerations: planned capital expenditures, anticipated business plan changes, direct subsidization of health care

marketplace, and social mission philosophy and obligation. Like Milliman, Lewin centered its calculations on GHMSI's statutory and Blue Cross and Blue Shield Association threshold RBC-ACL levels. The Lewin Post-Hearing Report's recommended range of 750-1000% RBC-ACL as of December 31, 2008, reflects a 90% likelihood of GHMSI not dropping below 375% RBC-ACL on the high-end and a 95% likelihood of GHMSI not dropping below 200% RBC-ACL on the low-end. (Lewin Post-Hearing Report at 23). The Lewin Post-Hearing Report does not specify its duration of trend miss but did indicate it used up to seven-year modeling periods to assess confidence levels. Additionally, Lewin conducted a comparative analysis of unidentified "comparable plans" to cross-check the "reasonableness" of its range in a historical context. Lewin used other Blue Cross Blue Shield plans as peer-group companies with which they uniquely share several characteristics: large market shares in their geography, coverage of a disproportionate percentage of the individual and small group markets, inability to spread risk across a wider geography, subject to additional scrutiny, and a lack of access to equity markets.

The Invotex Report develops an "appropriate" surplus range that is "adequate and reasonable" for GHMSI to maintain given its business and risk profile, size and operations, anticipated plans and forecasts, and "an appropriate degree of conservatism, consistent with sound financial regulatory oversight of any insurer." (Invotex Report at 62). Invotex's analysis relies upon Milliman's model, Milliman's work, and adjusted assumptions that were "developed and agreed upon by Milliman and CareFirst." (Invotex Report at 68). Invotex also compared GHMSI's surplus range to other mid-sized non-profit Blue Cross Blue Shield insurers that share similar types of business with GHMSI. Their peer review found an average RBC-ACL ratio range of 336-917% and concluded that GHMSI has "comparable" surplus compared to its peer-

group members. Based on these factors, the Invotex Report recommends an "appropriate" surplus range as of December 31, 2008, of 700-950% RBC-ACL.

On the other hand, the Rector Report recognizes that the characterizations of GHMSI's surplus as "necessary," "optimal," and "appropriate," are subjective and that all of the "ranges" discussed are actually based on calculations regarding the amount of surplus needed for GHMSI to remain above 200% and 375% RBC-ACL levels. *See* Rector Report at 3-4. Although the Rector Report notes shortcomings of the Milliman methodology, it also generally recognizes the methodology's usefulness in analyzing the amount of surplus GHMSI requires for future operation. After making adjustments to Milliman's assumptions, the Rector Report calculates that as of December 31, 2008, 600% RBC-ACL would provide a 99% likelihood that GHMSI would remain above 200% RBC-ACL assuming a 2.5-year trend miss, and that 850% RBC-ACL would provide a 95% likelihood that GHMSI would remain above 375% RBC-ACL assuming a 2.5-year trend miss.

The Rector Report agrees with the rationale behind the peer review analysis performed by Invotex. However, to provide the Commissioner with additional relevant data, the Rector Report analyzes the surplus of for-profit stock insurance holding company systems. Rector explains that it added for-profit stock companies to the not-for-profit companies reviewed by Invotex because MIEAA requires GHMSI to engage in community health reinvestment to the maximum feasible extent consistent with financial soundness and "efficiency," and for-profit insurers, in many ways, face greater pressures to maximize efficiency while remaining financially sound. *See* Rector Report at 12-13; *see also* D.C. Official Code § 31-3505.01. The Rector Report observes that "for-profit insurers often are recognized as having more efficient operations due to the pressures exerted by the capital markets on for-profit insurers' profitability

goals." (Rector Report at 12). However, the Rector Report also acknowledges that for-profit stock insurers often have access to capital that is not available to non-profit Blue Cross Blue Shield plans. (Rector Report at 12).

The Rector Report's peer analysis includes RBC-ACL levels for over 20 individual insurers within two publicly traded systems and one privately held system. The RBC-ACL weighted average for the publicly traded companies is 470% RBC-ACL, and the RBC-ACL weighted average for the privately held companies is 700% RBC-ACL.

Importantly, the Rector Report had the benefit of including in its analysis the most recent health care reform legislation and Department orders regarding GHMSI's premium rate increases. The Rector Report noted that the limitations on GHMSI's rate increases were not factored into the actuarial work of any of the expert consultant analyses, and the conclusions in those reports would need to be adjusted accordingly. (Rector Report at 10). Moreover, the Rector Report observes that the Federal Health Reform Acts establish "a wide range of health care and insurance changes and reforms." (Rector Report at 10). Although it is not yet clear what those changes will be or how they will impact GHMSI's surplus,[6] the actuarial work included in all of the expert consultant analyses would need to be adjusted to accommodate the reform.

**2. Additional Information of the Impact the Federal Health Reform Acts is Necessary for the Commissioner to Determine Whether GHMSI's Surplus is Excessive.**

The Commissioner concludes that it would be problematic to make a final determination regarding the various expert opinions given the current uncertainly of the impact of the Health Reform Acts on the operations of GHMSI. Rather, the Commissioner determines that it is

[6] For many aspects of the Federal Health Care Reform Acts, administrative rules, guidance, and procedures still need to be adopted, and such agency actions will have a substantive effect on the reform's impact on health insurers.

necessary for her to obtain and consider additional information regarding GHMSI's unanticipated costs, if any, to comply with the various tranches of regulations implementing the Federal Health Reform Acts. This information is critical in order to attribute the relevant weight to the several expert analyses under consideration, and to ultimately determine whether GHMSI's surplus is excessive under the HMSCR Act. Therefore, the Commissioner will be in a better informed position to conclude which assumptions regarding future GHMSI costs and the appropriate level of surplus are correct, and the interests of the District would be better served, if the Commissioner's Hearing record is reopened to allow for the submission of relevant information regarding the impact of the Federal Health Reform Acts on GHMSI from GHMSI, interested parties, the Commissioner's Experts, and members of the public.

***Order***

Based upon the foregoing Decision, it is therefore **ORDERED**:

1. The record of the Commissioner's Hearing shall be reopened on August 6, 2010, for purpose of the Commissioner obtaining information regarding the financial impact of the Federal Health Reform Acts on GHMSI from GHMSI, interested persons, the Commissioner's Experts, and members of the public as part of the Commissioner's determination of whether the portion of GHMSI's surplus attributable to the District is unreasonably large and inconsistent with GHMSI's obligation under Section 6a of the HMSCR Act, and the Commissioner's Hearing record shall close at 5:00 p.m. on September 30, 2010.

2. GHMSI, no later than September 3, 2010, shall submit to the Commissioner comprehensive information regarding the financial impact of the Federal Health Reform Acts on GHMSI, including the appropriate level of GHMSI's surplus and GHMSI's financial obligations

arising in connection with the conduct of the its insurance business as required pursuant to section 7(f), and such submission(s) shall be posted on the Department's website within two days of receipt. GHMSI shall include written justification of GHMSI's costs, if any, to comply with and implement the provisions of the Federal Health Reform Acts.

3. No later than September 20, 2010, interested persons, the Commissioner's Experts, and members of the public may submit information regarding the financial impact of the Federal Health Reform Acts on GHMSI or rebut any information provided by GHMSI pursuant to this Order, and all such submissions shall be posted on the Department's website within two days of receipt.

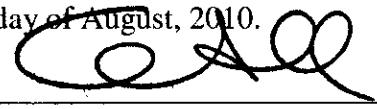
4. GHMSI may submit information that rebuts any information submitted pursuant to paragraph 3 of this Order prior to the close of the Commissioner's Hearing record at 5:00 p.m. on September 30, 2010.

5. Subsequent to the closing of the Commissioner's Hearing record, the Commissioner shall issue, in writing, the Commissioner's final determination of whether the portion of GHMSI's surplus attributable to the District is unreasonably large and inconsistent with GHMSI's obligation under section 6a of the HMSCR Act upon the completion of the Commissioner's review of the information submitted pursuant to this Order.

**SO ORDERED**:

This 6 day of August, 2010.

Approved and so Ordered:
In Witness Whereof, I have hereunto set my hand and affixed the official seal of this Department in the District of Columbia, this 6 day of August, 2010.



Gennet Purcell
Commissioner