Excess Surplus Review Hearing of
Group Hospitalization and Medical Services, Inc.

District of Columbia
Department of Insurance, Securities, and Banking

Pre-hearing Report by
DC Appleseed Center for Law and Justice, Inc.
August 31, 2009

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Introduction

DC Appleseed endorses the current proceeding examining the surplus of GHMSI and is strongly supportive of the Insurance Commissioner's efforts to protect the public's interest in that surplus. In this pre-hearing report, we show that GHMSI has an "unreasonably large" surplus and has not committed the "maximum feasible" amount of that surplus toward community health reinvestment, as required by the governing statute.

Indeed, we will show that the company has not even acknowledged, much less attempted to apply, the governing "maximum feasible" standard. Instead, having strongly resisted the legislation holding the company accountable through this proceeding, in its July 31 filing the company has essentially repeated the same justifications for its surplus that were rejected by the Pennsylvania Insurance Commissioner in February 2005 and effectively rejected again by DC Insurance Commissioner Larry Mirel in May 2005. For the reasons explained in this Report, as supported by the attached statements from Covington & Burling, Actuarial Risk Management (ARM), and Deborah Chollet of Mathematica Policy Research, Inc., we urge the Commissioner to reject the justifications offered by GHMSI for its huge surplus and order that a significant portion of that surplus be committed to community health reinvestment.

In urging the Commissioner to determine that GHMSI's current surplus is unreasonably large and does not meet the "maximum feasible" standard, this Report shows four things:

- first, in light of the repeated need for public officials in both DC and Maryland to override actions of the company that were found inconsistent with the public interest, the Insurance Commissioner in this proceeding should closely scrutinize the company's surplus to ensure that it meets the statutory standard;
- second, as shown in the attached analysis from Covington & Burling, GHMSI has failed utterly to show that its current surplus meets the "maximum feasible" standard, and the justification the company now offers for that surplus has for good reason already effectively been rejected by the Pennsylvania Insurance Commissioner and former DC Insurance Commissioner Larry Mirel;
- third, as shown by the supporting analysis from Actuarial Risk Management, GHMSI's current surplus should be in a range between $325 and $427 million, which means that GHMSI's surplus is at least $300 million too high once a figure toward the lower end of that range is selected to comply with the "maximum feasible" standard; and
- fourth, as shown by the attached analysis from Deborah Chollet, Mathematica Policy Research, reducing GHMSI's surplus to the levels indicated by ARM will bring the company into line with its competitors and other comparably situated nonprofits and will require it to respond to the pressing healthcare needs in the District of Columbia. The Commissioner should reject GHMSI's overall attempt—notwithstanding its consistently high surpluses, unique brand, and dominant market share—to position itself as a vulnerable company, faced with for-profit competitors with potentially decisive competitive advantages, and faced with risks that somehow are both larger and more unpredictable than those of other health insurers in the District.

Below we address each of these four points in turn.

I. The DC Insurance Commissioner should closely scrutinize GHMSI's asserted justification for its current surplus

When the bill establishing this proceeding was introduced before the DC Council, CareFirst announced through a press release that it would "vigorously oppose this legislation."[1] In that press release, the company called the legislation "a direct and regrettable attack on a company with a long history of service to the District and to this Region."[2] In fact, however, the impetus for the legislation -- which simply establishes a procedure for holding the company accountable to its "charitable and benevolent" mission -- was in large part that the company's "long history" demonstrated that it could not be relied on to meet that mission in the absence of vigorous governmental oversight.

Because that history demonstrates that public officials in both DC and Maryland have repeatedly needed to police actions of the company to ensure compliance with its mission, heightened scrutiny of GHMSI's justification of its current surplus is called for here. This history begins in 1992 when the DC Insurance Commissioner had to seek congressional authority over GHMSI in the wake of the company's mismanagement, and it culminates in the recent legislation requiring that the company be held accountable through the current proceeding. We recount that history to support our contention that heightened scrutiny is called for here.

A. The DC Insurance Superintendent sought regulatory authority over GHMSI following its "gross mismanagement"

In 1992, the Superintendent of Insurance for the District of Columbia, Robert M. Willis, urged Senate investigators to grant his office regulatory authority over GHMSI to forestall its insolvency.[3] The Superintendent's request was due to the facts that (1) GHMSI had incurred losses of $182 million between 1985-1992 as a result of "gross financial mismanagement"[4] and (2) under GHMSI's federal charter granted in 1939, the company had been exempted from review by District of Columbia insurance regulators.[5]

Congress responded by amending GHMSI's federal charter to grant the District of Columbia primary regulatory authority over the company.[6] Senate investigators concluded that "GHMSI

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[1] CareFirst Press Release, *Proposed Legislation Burdens CareFirst Members*, Sept. 16, 2008, available at http://www.carefirst.com/media/NewsReleasesDetails/NewsReleasesDetails_20080916.html).
[2] *Id.*
[3] *Fourth Interim Report on United States Government Efforts to Combat Fraud and Abuse in the Insurance Industry: Problems in Blue Cross/Blue Shield Plans in West Virginia, Maryland, Washington, DC, New York, and Federal Contracts*, United States Senate Committee on Governmental Affairs, Permanent Subcommittee on Investigations, Report 104-92. Washington, DC: U.S. Government Printing Office, June 1995, at 53.
[4] *Id.* at 49.
[5] Act of Aug. 11, 1939, ch. 698, 53 Stat. 1412.
[6] *See* Pub. L. 103-127, 107 Stat. 1336 (October 29, 1993) (amending the GHMSI charter to provide that "The corporation shall be licensed and regulated by the District of Columbia in accordance with the laws and regulations of the District." GHMSI Charter, § 5). This permanent charter amendment followed a temporary amendment to the

has adeptly played Maryland, Virginia, and D.C. insurance regulators against one another," and exploited the "patchwork system" of "inherently inadequate" regulation to cover up malfeasance and exorbitant executive compensation.[7]

Superintendent Willis took immediate action to stabilize the company, and entered into a consent order with GHMSI which limited the company's ability to enter into contracts, conduct transactions, or dispense funds without explicit authorization.[8] The Consent Order remained in effect for four years.[9] Superintendent Willis also ordered GHMSI to cease further payments of "excess and supplemental" benefits of more than $220,000 annually to its former President and CEO, Joseph P. Gamble, who was admonished by Senate investigators for his lavish spending at company expense.[10] The Commissioner's decision was challenged by Mr. Gamble and upheld by the U.S. Court of Appeals.[11]

B. The DC Insurance Commissioner took action to protect public interest when approving GHMSI affiliation with CareFirst

In 1997, the newly strengthened company sought to combine with Blue Cross Blue Shield of Maryland to form what is now known as CareFirst. Interim DC Insurance Commissioner Patrick E. Kelly played a leadership role in that proceeding in order to protect the public interest and policy holders. First, Commissioner Kelly required GHMSI "to be bound by, and to conduct its affairs pursuant to the requirements contained in its federal charter as a 'charitable and benevolent institution.'"[12] Second, as a condition of his approval of the affiliation, the Commissioner required GHMSI to design an open enrollment plan for District residents.[13] And finally, the Commissioner expressly reserved the authority to disapprove severance packages for GHMSI executives if they were "unreasonable and exceed industry standards."[14]

C. The Insurance Commissioners both in DC and Maryland rejected CareFirst's valuation of the company in conversion proceedings

In 2002, CareFirst petitioned the Insurance Commissioners in the District of Columbia, Maryland, and Delaware to convert to a for-profit corporation and be acquired by WellPoint Health Networks, Inc. CareFirst asserted the company's value at the time to be $1.3 billion.[15] If this value had been approved by regulators and the conversion allowed, the $1.3 billion would have been placed into a public trust to address community healthcare needs. However, an

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same effect enacted as part of District of Columbia appropriations legislation. See Pub. L. 102-382, 106 Stat. 1435 (1992).

[7] Senate Report at 49.

[8] *In re Group Hospitalization and Medical Services, Inc.*, Consent Order No. 93-09, (Feb. 12, 1993).

[9] *In Re Group Hospitalization and Medical Services, Inc.*, A-HC-97-01 Decision and Order, D.C. Dept. of Insurance and Securities Regulation, Dec. 23, 1997 at 1.

[10] *Gamble v. GHMSI*, 38 F.3d 126 (4th Cir. 1994).

[11] *Id.* at 132.

[12] *In Re Group Hospitalization and Medical Services, Inc.*, A-HC-97-01 Decision and Order, D.C. Dept. of Insurance and Securities Regulation, Dec. 23, 1997 at 17.

[13] *Id.* at 21.

[14] *Id.* at 20.

[15] Form A - Statement Regarding the Acquisition of Control or Merger with a Domestic Insurer, GHMSI by WellPoint Health Networks, Inc., Filed with DC DISR and OCC, Jan. 11, 2002 at 8.

independent study commissioned by DC Insurance Commissioner Larry Mirel placed CareFirst's value at $1.65-$1.75 billion[16] and an independent study conducted for Maryland Insurance Commissioner Steve Larsen concluded the company's true value to be $1.45 billion to $1.65 billion.[17] Together, these studies showed that the company had undervalued itself by at least $200-$300 million.

Although CareFirst filed its applications in all three jurisdictions simultaneously, the conversion proceedings began first in Maryland. Commissioner Steve Larsen denied the conversion, in part because "this deal does not ensure that the fair value of the public assets will be distributed to [a public] Foundation as the conversion law requires."[18] Commissioner Larsen's ruling effectively mooted the proceedings in the District.

D. The DC Insurance Commissioner determined in 2005 that GHMSI can and should contribute more to charitable purposes given its high levels of surplus

In 2005, after the conversion was denied, Commissioner Mirel convened a hearing to inquire whether the company was meeting its charitable obligations as a nonprofit. In that proceeding, CareFirst relied on an analysis conducted by Milliman, Inc., that stated the company's surpluses were not unreasonable and that it could not afford to contribute any more to charitable activities.[19] As is discussed later (pp. 7-8, 11), Commissioner Mirel effectively disagreed with Milliman's analysis, stating that "GHMSI may reduce its surplus level without negatively impacting its financial strength and viability."[20] Commissioner Mirel further concluded that "GHMSI has total adjusted capital levels that are generally well above industry standards and above the levels of other providers in the District and Maryland. Based on its financial health, including its significant surplus and net income level, and the breadth of its operations in the District, we believe that GHMSI should be engaging in charitable activity significantly beyond its current activities."[21]

GHMSI spent $51 million on community benefits in 2005,[22] at a time when its stated December 31, 2004 surplus level was $501 million.[23] And yet, despite Commissioner Mirel's finding that the company held an unnecessarily high surplus and should be spending more on charitable activities, in the following years CareFirst/GHMSI decreased its community benefit contributions to only $14.9 million in both 2006 and 2007,[24] while it increased its surplus to $663

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[16] Cain Bros., *Valuation Report on CareFirst Inc.*, prepared for DISR and OCC, Jan. 23, 2003 at 61.
[17] The Blackstone Group, *Valuation Report on CareFirst, Inc.*, Feb. 11, 2003 at 13.
[18] In Re: The Consolidated Application Conversion of CareFirst, Inc. and CareFirst of Maryland, Inc. to For-Profit Status and the Acquisition of CareFirst, Inc. by WellPoint Health Networks, Inc., MIA No. 2003-02-032, Maryland Insurance Administration, March 5, 2003, at 198.
[19] *CareFirst, Inc. Group Hospitalization and Medical Services, Inc., Need for Statutory Surplus and Development of Optimal Surplus Target Range*, Milliman, March 22, 2005.
[20] *In the Matter of: Inquiry into the Charitable Obligations of GHMSI/CareFirst in the District of Columbia*, Report of the District of Columbia Dept. of Insurance, Securities, and Banking, Lawrence H. Mirel, Commissioner, May 15, 2005 at 21.
[21] *Id.* at 19.
[22] CareFirst Commitment Community Benefit Statement, Aug. 24, 2007 on file at DC Council Committee on Public Services and Consumer Affairs.
[23] GHMSI Key Annual Statements, 2004.
[24] CareFirst Commitment Community Benefit Statement.

million and $753 million respectively.[25] Today, its reported surplus stands at $687 million as of December 31. 2008.[26]

E. The MD Insurance Commissioner rejected CareFirst executive's $18 million severance package as "inconsistent with the company's nonprofit mission"

In 2008, Maryland Insurance Commissioner Ralph Tyler rejected CareFirst's proposal to pay outgoing CEO William L. Jews an $18 million severance package. Tyler determined that the proposal violated Maryland law enacted in 2003 which requires executive compensation be "fair and reasonable."[27] Commissioner Tyler emphasized that the proposed $18 million payment was inconsistent with the company's statutory nonprofit mission."[28] It is significant that CareFirst approved this $18 million after reducing GHMSI annual community benefits to below $15 million.

F. The DC Attorney General filed lawsuit to reduce GHMSI's surplus

In 2008, DC Attorney General Peter Nickles filed a lawsuit against GHMSI, charging that the company had been acting "contrary to GHMSI's legal obligations as a charitable and benevolent institution. These actions include using GHMSI's revenues to build up a level of surplus that exceeds the level required for any legitimate charitable or nonprofit purpose."[29] The Attorney General's Complaint asserted that, "absent regulatory or judicial intervention compelling GHMSI to rededicate itself to non-profit purposes and to its charitable mission of promoting public health, GHMSI is unlikely to cease building and maintaining its surplus at the expense of its obligations to serve the public."[30] Mr. Nickles and GHMSI ultimately agreed to dismiss the suit after the DC Council passed the Medical Insurance Empowerment Act that now governs this proceeding.

G. The DC Council required GHMSI to be held accountable to spend the "maximum feasible" amount on community health benefits

As mentioned earlier, the DC Council recently passed legislation designed to hold GHMSI accountable to its non-profit, charitable mission - the Medical Insurance Empowerment Act. The Act, which became effective on March 25, 2009, has two primary components. First, it codifies GHMSI's obligation under its federal charter to "engage in community health reinvestment to the maximum extent feasible consistent with financial soundness and efficiency."[31] Second, it requires the DC Insurance Commissioner to conduct an annual review of GHMSI's surplus and

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[25] GHMSI Key Annual Statements, 2006-2007.
[26] GHMSI Key Annual Statement, 2008.
[27] MIA Press Release, Insurance *Commissioner Reduces Termination Payment to Former CareFirst CEO by 50%*, July 14, 2008, available at http://www.mdinsurance.state.md.us/sa/documents/CareFirstCompensationdecision07-08.pdf.
[28] *Insurance Commissioner for the State of Maryland v. CareFirst, Inc. and William L. Jews*, Statement of Reasons in Support of Final Order, MIA-2007-10-027, July 14, 2008 at 13-14.
[29] OAG Complaint ¶ 1, CV 4562-08; June 24, 2008.
[30] *Id.* at ¶ 25.
[31] DC Code § 31-3505.01.

to order the company to spend on community health benefits any excess that is attributable to the District.[32]

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This history, we believe, is important background and context for the Council's recent legislation and for this proceeding. The history demonstrates that the Insurance Commissioner should do what her predecessors have done -- closely scrutinize GHMSI's actions to determine whether they are in compliance with the company's statutory and charter responsibilities.

II. GHMSI has completely failed to demonstrate that its current surplus meets the District's statutory requirements

The Medical Insurance Empowerment Amendment Act of 2008 requires GHMSI to set its surplus at a level that will allow it to "engage in community health reinvestment to the maximum feasible extent consistent with financial soundness and efficiency." As Covington & Burling explains in its statement (attached as Exhibit A), the Act contemplates that GHMSI submit to the Commissioner information and data demonstrating that its surplus meets that standard. Unfortunately, as the Covington statement explains, GHMSI's July 31, 2009 submission to the Commissioner *does not even acknowledge* the "maximum feasible" standard, much less show that the company is meeting it.

Instead, GHMSI premises the defense of its current surplus entirely on an analysis performed by Milliman on December 4, 2008. The 2008 Milliman analysis, in turn, is almost identical to an analysis Milliman submitted to the Pennsylvania Insurance Commissioner and to the DC Insurance Commissioner (Larry Mirel) for purposes of surplus proceedings that those two Commissioners held in 2005. It is surprising to us that GHMSI continues to rely on Milliman's analysis in light of the fact that both Commissioner Koken in the Pennsylvania proceeding and Commissioner Mirel in the District's proceeding effectively rejected Milliman's analysis - - both its methodology and its conclusions.

Milliman's analysis is premised solely on the proposition that GHMSI's current surplus needs to be large enough to (1) weather a near-catastrophic four-year downturn where it would have cumulative losses of 9 to 16% (2) ensure that it will have the amounts it would have earned in that downturn if its premium growth were 12 to 14% annually and (3) still have remaining surpluses above levels recommended by the BlueCross BlueShield Association. A similar analysis caused Milliman to argue in Pennsylvania that Highmark (a BlueCross similar to GHMSI) needed surplus levels ranging from 650 to 950 percent times its basic capital requirements (called "authorized control level").[33] Likewise, Milliman's approach caused it to argue before Commissioner Mirel that GHMSI needed 800 to 1100 percent times its authorized control level.[34]

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[32] DC Code § 31-3506 et seq.

[33] *Highmark, Inc. – Need for Statutory Surplus and Development of Optimal Surplus Target Range,* Milliman USA, Inc. March 21, 2004 at 54.

[34] *CareFirst Inc. – Group Hospitalization and Medical Services, Inc., Need for Statutory Surplus and Development of Optimal Surplus Target Range*, Milliman USA Inc., March 22, 2005 at 57.

As Covington explains in its statement, Pennsylvania Insurance Commissioner M. Diane Koken rejected Milliman's approach for several reasons. First, she concluded that an economically efficient level of surplus is one at which "a Blue Plan does not face solvency issues from *routine* fluctuations in factors such as underwriting results and returns on its investments."[35] Accordingly, she reasoned, while any number of extreme or adverse contingencies might be imagined, they should not be the predicate for establishing surplus levels. Rather, she concluded:

> their low probability of occurrence or unforeseeable or catastrophic nature recommend that they are most efficiently prepared for through a combination of government, industry-wide, societal and individual company specific initiatives. The reality is, *no individual insurer can or should be permitted to collect or accumulate enough premiums to cover any and all catastrophic events no matter how remote or unforeseeable.*[36]

Furthermore, the Pennsylvania Insurance Commissioner rejected Milliman's contention that an appropriate surplus level should be calculated solely by estimating the impact of an imagined downturn for the company. Rather, she said, such an approach improperly ignores "differences in underwriting volatility associated with size and diversity" and other factors related to the company; it also ignores important benchmarks such as the surplus levels of other comparable companies and surplus standards set by the BlueCross BlueShield Association.[37] In the latter category, Commissioner Koken (and later Commissioner Mirel) pointed to the fact that the BCBSA treated an upper range of 800% RBC as one where it may be presumed "that the Plan is sufficiently strong to meet its obligation to its insureds well into the future."[38]

In the Pennsylvania case, as here, Milliman considered none of these other factors. Instead, as here, it premised its entire case on a projected enormous, adverse cycle for the company and, based on that cycle concluded that the company needed a surplus range from 650 to 900% of risk-based capital ("RBC"). The Pennsylvania Commissioner determined instead that the range should be 550 to 750% of RBC.[39] Thus, the Commissioner found that Milliman's proposed upper end was too high by 15% (at the low end of the range) to 17% (at the high end).

Significantly, as Covington explains, it is not just the Pennsylvania Insurance Commissioner that has rejected Milliman's methodology and its proposed surplus ranges. In 2005, DC Insurance Commissioner Larry Mirel held a hearing to determine among other things whether GHMSI was committing enough of its surplus toward meeting its "charitable and benevolent" nonprofit mission. There, as here, GHMSI argued that its surplus should be found acceptable because it was within a range argued by Milliman to be reasonable.[40] And again, as here, Milliman's range

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[35] *In re: Applications of Capital BlueCross, Highmark Inc., Hospital Service Association of Northeastern Pennsylvania d/b/a Blue Cross of Northeastern Pennsylvania and Independence Blue Cross for Approval of Reserves and Surplus*, Misc. Dkt. No. MS05-02-006, Insurance Dept. of the Commonwealth of Pennsylvania, (Feb. 9, 2005) at 34 available at http://www.ins.state.pa.us/ins/lib/ins/whats_new/2004bc/BCBS_DETERMINATION.pdf (emphasis added)

[36] PA Surplus Decision at 12 (emphasis added).

[37] *Id.* at 13, 22, 25-28, 33, 36.

[38] PA Surplus Decision at 22 (quoting letter from BCBSA). Accord, Mirel Decision at 17.

[39] *Id.* at 37

[40] *CareFirst Inc. – Group Hospitalization and Medical Services, Inc., Need for Statutory Surplus and Development of Optimal Surplus Target Range*, Milliman USA Inc., (March 22, 2005).

was calculated on the basis of a presumed extreme, prolonged downturn for the company. Based on that presumed downturn, Milliman testified that a reasonable surplus range for the company was 800 to 1100% RBC, which translated to $502.3 million to $690.1 million of surplus dollars in 2005.[41]

As had Commissioner Koken, Commissioner Mirel rejected Milliman's proposed range. Although he concluded that there was not sufficient evidence before him "to establish a maximum level of surplus," he did conclude that:

> Based on the evidence before the Department, it appears that GHMSI may reduce its surplus level without negatively impacting its financial strength and viability, and the Department believes that could be achieved by increasing financial contributions to organizations, activities, or joint efforts that will advance the public health in the District of Columbia.[42]

He underscored this point in the concluding section of his opinion by stating "the Department believes that it is possible for GHMSI to make these additional charitable contributions while maintaining a financially strong health insurance program for its subscribers..."[43] Remarkably, GHMSI reported surplus at the time Commissioner Mirel release his decision was $501 million; as of December 31, 2008 it had increased by almost $200 million to $687 million.[44]

In the face of these two rejections of Milliman's analysis and proposed surplus ranges, it is surprising to us that GHMSI stakes its whole case before the Commissioner in this proceeding on repeating the Milliman analysis yet again.[45] We believe, for the reasons stated by Commissioner Koken as well as those presented in the attached statements of Actuarial Risk Management and Deborah Chollet, Milliman's analysis should be rejected again here.

While the repetition of the Milliman's analysis is surprising, even more surprising is GHMSI's complete failure to even acknowledge -- much less apply – the surplus standard that governs these proceedings. As noted, that standard requires GHMSI to show that it has committed the maximum feasible amount of its revenues to community health reinvestment, consistent with financial soundness and efficiency. As the Covington analysis explains, there is simply no indication anywhere in CareFirst's July 31st letter to the Commissioner or in Milliman's analysis that the company has established its surplus against that standard.

In our view, as the Covington statement describes, the appropriate method of applying that standard would be for the Commissioner to develop a reasonable range for the surplus of the company and then require the company to adopt a figure toward lower end of that range in order to comply with the "maximum feasible" standard. In other words, because any surplus level

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[41] *Id.* at 57.
[42] Mirel Decision at 21.
[43] Mirel Decision at 22.
[44] GHMSI Key Annual Statements, 2004, 2008. We are aware that at the time of his 2005 opinion, Commissioner Mirel doubted that GHMSI had a *legal obligation* to spend down its surplus, although he plainly determined that the company had the *financial capability* to do so. Any doubt that the company has such a legal obligation has been removed by the DC Council legislation that led to this proceeding.
[45] *CareFirst Inc. – Group Hospitalization and Medical Services, Inc., Need for Statutory Surplus and Development of Optimal Surplus Target Range*, Milliman USA Inc., (Dec. 4, 2008).

within the optimal designated range is adequate to protect the financial soundness and efficiency of the company, the lower end of the range should be selected to ensure that the company is committing the maximum feasible amount to community health reinvestment.

Significantly, although Pennsylvania does not have a 'maximum feasible' standard as has been adopted here, nevertheless Commissioner Koken in her decision recognized that part of a company's obligation in setting its surplus is to consider alternative allocations of its funds the company might have made, rather than simply further increasing its surplus. As she said in her opinion, before adding further to surplus in order to gain some "marginal reduction in risk," the company must balance that risk "against the benefits of using these same surplus funds in an alternative fashion."[46] Here, as Covington explains, GHMSI appears never to have considered that in the District of Columbia one "alternative" use of its significant surplus is the subject of a statutory mandate: the company *must* commit the maximum feasible amount of that surplus to community health reinvestment, consistent with financial soundness and efficiency. In our view, the company plainly has not done this. And nothing in the Milliman analysis takes any account of this requirement.

For these reasons, DC Appleseed enlisted its own independent actuarial expert to determine an appropriate level of surplus for GHMSI that is consistent with the statute. We next explain why we believe, based on ARM's analysis, that GHMSI's surplus is excessive by several hundreds of millions of dollars.[47]

III. A fair analysis of GHMSI's surplus shows that it should be in a range between $325 and $427 million

GHMSI's reported surplus as of December 31, 2008 was $687 million. To help us determine whether that level of surplus meets the "maximum feasible" standard we engaged Actuarial Risk Management (ARM) to consider what a reasonable range for the surplus for the company would be. ARM is an emerging global provider of actuarial, employee benefit, and risk management services. ARM is an independent U.S. alliance member of the global organization, BDO. The firm of ARM and their consulting representatives, specifically Mr. Corwin Zass, Principal, and Mr. Mark Shaw, are both qualified actuaries and are collectively known as the ARM Consulting Team. Although we of course urge the Commissioner to consider the report in full, we briefly summarize its conclusions here.

First, we asked ARM to develop a list of the data it would need in order to do a complete "bottom-up" analysis of GHMSI's surplus. That list was submitted to DISB on August 6, 2009 as is attached to ARM's statement as Appendix C. Because the data sought on August 6 were not received, ARM proceeded with its surplus analysis by considering the information presented

[46] PA Surplus Decision at 15.

[47] We have not attempted in this Report to address the portion of GHMSI's excess surplus that is allocable to the District. This is because CareFirst stated in its July 31 letter to the Commissioner that it intended to address this issue in "another report being prepared by GHMSI in preparation for the hearing scheduled for September 10, 2009." (CareFirst July 31 letter at 8). We hope to address CareFirst's report once it is made available. However, we offered preliminary views on this issue in written comments submitted to the Commissioner on the procedures for the hearing (*see* DC Appleseed Comments on Emergency and Proposed Rulemaking, submitted to DISB on Aug. 10, 2009).

in Milliman and in other publically available sources. ARM concluded that while it would have been preferable to do its own bottom-up analysis, it could produce a sufficiently reliable range of appropriate surplus for GHMSI by correcting what it perceives to be biases or mistakes in the Milliman presentation.

With respect to GHMSI's surplus level, ARM concluded as follows:

> a prudent amount of surplus is necessary for an insurer to remain financially healthy. However, an egregious amount, such as GHMSI's at 12-31-2008 is simply unnecessary. We assessed GHMSI's history and experience along with the corporate structure and business operations, including the products sold and the risks therein, and we must conclude that the amount of surplus held by GHMSI is not optimal but rather grossly in excess of a reasonable amount to ensure financial soundness.[48]

As explained in its Report, to reach this conclusion ARM essentially did the following. First, while ARM completely agrees with the Pennsylvania Insurance Commissioner that a fair surplus analysis cannot be premised alone on the kind of calculation Milliman did, ARM does believe that a calculation like Milliman's is useful so long as it is based on reasonable assumptions. However, as ARM explains, if the calculation is based on unreasonable assumptions it will produce unreasonable -- indeed, grossly excessive -- surplus ranges. And that is the case here.

ARM explains that three of the critical assumptions Milliman makes for purposes of its calculations are unreasonable. The first unreasonable assumption is to suppose as Milliman does that current surplus requirements can fairly be measured by the supposed need to guard against a prolonged four-year downturn that bears no relationship to likely future operating results. As ARM states, Milliman relies in part on severe operating losses from the 1980s that Milliman itself acknowledges are not likely to occur today.[49] According to ARM, "given both the significant change in industry approach as a result of the adoption of RBC requirements AND the significant changes in the way GHMSI has been regulated after 1993, Milliman should revise their analysis using only data for 1992 and later with respect to all insurers, and for 1994 and later, with respect to GHMSI specifically."[50]

The second major adjustment that ARM finds necessary addresses the assumption of "unrealistic premium growth rates assumed in Milliman's pro-forma projections."[51] As ARM explains, by assuming premium growth rates of 12-14%, -- which is approximately double the company's actual compound growth rate of 7-8% per year since 2003 -- Milliman has significantly inflated its need for surplus.[52]

The third major bias that ARM found in Milliman's analysis is that Milliman excluded from that analysis consideration of the most important part of GHMSI's business -- the consistent profitability from the Federal Employee Program ("FEP") and other insured non-comprehensive product lines. Milliman expressly acknowledges in its analysis that GHMSI's FEP business has

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[48] ARM Report at 29.
[49] *Id.* at 14.
[50] *Id.* at 14-15.
[51] *Id.* at 10.
[52] *Id.* at 13-14.

a significantly reduced underwriting risk because the BlueCross BlueShield Association underwrites at least part of the risk associated with that program.[53] Nevertheless, in calculating the risk associated with GHMSI's business -- and therefore the amount of surplus needed to address that risk -- Milliman limits its analysis only to potential losses associated with the non-FEP insured portion of GHMSI's activity and does not consider potentially offsetting profitability from FEP and other product lines.[54] As ARM explains, excluding this consistently profitable subset of GHMSI's business from its analysis causes Milliman to overstate the company's overall underwriting risks and therefore to overstate its need for additional surplus.

Although ARM notes a number of other differences with Milliman's analysis, correcting only for these three significant assumptions allows ARM to restate the surplus ranges Milliman should have produced. As ARM explains, (1) taking into account only the more recent data (since 1992) reflecting GHMSI actual experience, and noting that the profitability of the FEP and other non-comprehensive insured portion of its business should be taken into account, should cause one to guard against a less severe operating downturn than Milliman postulated, i.e., one that assumes only a 9-13% cumulative loss cycle (including interest rate and asset valuation risks that Milliman identified and then ignored in establishing their range) and (2) assuming premium growth of only 7-8% over that loss cycle, together have enormous dollar impact on the need for surplus.[55] In fact, as ARM shows, making only those adjustments produces an optimal target surplus range for GHMSI of 400-525% RBC rather than the 750-1050% that Milliman endorses.[56] This 400-525% range equates to a surplus of $325-$427 million, which at the lower range is more than $300 million less than GHMSI's current surplus.[57]

In our view, the range computed by ARM is a fair, reliable estimate of the surplus GHMSI should be holding. And, for the reasons earlier stated, we believe a figure toward the lower end of this range should be selected by GHMSI in order that it faithfully comply with the "maximum feasible" standard.

IV. Other pertinent factors confirm that a surplus of approximately $325 million is appropriate to comply with the statute

We believe that several other factors confirm our contention that a GHMSI surplus of approximately $325 million is appropriate and in compliance with the statute. First, as earlier mentioned, when Commissioner Mirel examined GHMSI's surplus in 2005 he concluded that the company should then have been spending down its surplus. Its surplus then (as of end of year 2004) was $501 million. When GHMSI's surplus was at that level, Commissioner Mirel said that the company's ability "to do more for the community than it is doing currently is beyond doubt." He also said that "GHMSI should be engaging in charitable activity significantly beyond

[53] Milliman's 2008 Report at 1, 32.
[54] Milliman's 2008 Report at 32; ARM Report at 12.
[55] Milliman's 2008 at 56.
[56] ARM Report at 5, 27.
[57] This computation of GHMSI's excess surplus may significantly understate that excess. This is because, as both ARM and Deborah Chollet explain in their statements, in 2008 GHMSI caused a decline in its surplus by moving a significant amount of funds into tax-deferred and other unexplained, non-admitted assets. If those assets had been included in surplus, it would increase GHMSI's end-of-year 2008 total by $186 million, giving it surplus of nearly $873 million rather than its reported $687 million. (See Chollet Statement at 1-2; ARM Report at 16).

it current activities."[58] Had GHMSI heeded Commissioner Mirel's determination, it could and should have spent down its surplus toward the levels we are now recommending. Instead, as already noted, GHMSI has steadily *increased* its surplus and steadily *decreased* its spending on community benefits.

Furthermore, as Commissioner Mirel also noted in his decision, "GHMSI has total adjusted capital levels that are generally well above industry standards and above the levels of other providers in the District and Maryland."[59] The information provided in the attached statement from Deborah Chollet confirms that this is still true today. As Ms. Chollet explains, GHMSI's surplus, by any measure remains "much higher than its competitors."[60] And this is so even though, as Ms. Chollet explains, when matters of size, diversity, corporate affiliation, and stability of earnings are considered, its relative need of surplus is *lower* than many of its competitors, not higher.[61] Furthermore, as noted in the Pennsylvania Insurance Commissioner's decision, these are all factors that should be carefully considered in assessing surplus (factors that were *not* considered by Milliman).

Given its consistently large surpluses, which exceed those of its peers, GHMSI understandably must resort to depicting its situation as uniquely precarious. In doing so, it ignores the fact that surplus is not the first or the only protective tier in the overall management of risk. It wrongly insists that GHMSI's management must be given a green light to accumulate levels of surplus sufficient to cover any and all contingencies no matter how remote, a position the Pennsylvania Insurance Commissioner has rightly rejected.

To muster supposed evidence of volatility in underwriting results, GHMSI relies on fluctuations that occurred decades ago, which arose in large measure because of its own widely recognized mismanagement, which occurred prior to the imposition of RBC requirements and of the present regulatory regime (after which GHMSI's surpluses have regularly increased), and which GHMSI's own consultants say are unlikely to occur again (but then inexplicably include in their analysis). And it simply excludes consideration of FEP premiums, which account for nearly half of its premium revenues and which carry less risk than other premium-paying business.

In addition, it asserts a lack of diversification, which simply ignores the several major sources of GHMSI's effective diversification; relies on a specious notion of the supposed advantages of equity capital; and simply ignores GHMSI's dominant and growing market share in the District.

Moreover, as also explained in Deborah Chollet's statement, by any measure GHMSI's contribution to community benefit is lower than other nonprofit insurers - - when in fact it should be higher than those other insurers given the application of the "maximum feasible" standard.[62]

Finally, as was first addressed by Ms. Chollet in DC Appleseed's December 2004 Report (*CareFirst: Meeting its Charitable Obligation to Citizens of the National Capital Area),* and is addressed by her again in the attached statement, the community healthcare needs in Washington

[58] Mirel Decision at 19.
[59] *Id.* at 19.
[60] Chollet at 5,7.
[61] *Id.* at 10.
[62] Chollet at 8-9.

DC are enormous. Commissioner Mirel expressly recognized this to be so in his 2005 opinion.[63] In some ways, the economic downturn and the national focus on healthcare reform has made it more important than ever that GHMSI be required to meet it statutory obligation to address these needs. We believe that it is quite clear that the company is falling well short of doing so. The Commissioner should rectify that shortcoming in this proceeding.

Conclusion

In 2003, Maryland Insurance Commissioner Steve Larson issued his opinion denying CareFirst's request to convert and become a for-profit company. In that decision, he declared that "from 1997 to the present," the company had "abandoned its mission" to operate in the public interest as a not-for-profit company.[64] We believe that the history of the company from 2003 to the present shows that it is still not meeting its mission. We also believe that the statute the Commissioner is now enforcing was passed to make sure that GHMSI would be held strictly accountable to that mission. The heart of that statute is the requirement that the company spend the maximum feasible amount on community benefits. The record before the Commissioner shows that the company is falling well short of meeting that standard.

As the DC Attorney General has determined, "GHMSI's assets belong to the public."[65] In determining whether those assets are being administered in the public interest, the Commissioner must of course be mindful that the company needs sufficient surplus to remain financially sound and efficient – as the statute requires. But the Commissioner must also ensure that in selecting such a surplus level, the company is required to commit the maximum feasible amount to community benefits. The record now before the Commissioner shows that the company has not fairly struck that balance; indeed, the record shows that the company has not struck that balance at all. At a minimum, our submission shows that the company can easily afford to reduce its surplus by a substantial amount.

In proceeding to select the specific amount of the reduction that is appropriate, we urge the Commissioner to promptly do two things: (1) engage her own independent actuarial expert, as the statute contemplates;[66] and, (2) require CareFirst to make available to our independent expert and to any expert selected by the Commissioner the data that the company and Milliman used to calculate GHMSI's surplus. Both CareFirst and Milliman appear to offer these data in their submissions,[67] and our experts wish to accept that offer.

DC Appleseed looks forward to further participating in this proceeding.

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[63] Mirel Report at 12-13.
[64] Larson Decision at 111.
[65] *Memorandum to the City Administrator*, DC Office of the Attorney General, Robert Spagnoletti, March 9, 2005 at 4.
[66] Medical Insurance Empower Amendment Act of 2008, D.C. Law 17-369, Sec.2(h) now codified at; D.C. Code § 31-3506 (h).
[67] CareFirst July 31 letter at 8.