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

District of Columbia Department of Insurance, Securities, and Banking

# Rebuttal Statement Memorandum

Submitted by the
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# DC APPLESEED'S REBUTTAL STATEMENT

## Introduction

DC Appleseed is an interested third party in these proceedings and hereby submits its rebuttal statement in accordance with DISB's Action Plan for the review of GHMSI's surplus. In this statement, DC Appleseed addresses four issues: (1) the legal standard applicable to the Commissioner's review of GHMSI's surplus; (2) the reasons why GHMSI's surplus does not meet that standard; (3) the appropriate attribution of GHMSI's surplus to the District of Columbia; and (4) our recommendations concerning the action the Commissioner should take.

Before addressing those issues, however, we place them in context by responding to certain statements of Mr. Chet Burrell that reveal GHMSI's continuing and complete misperception as to what this proceeding is about and what the statute requires the Commissioner to do. Mr. Burrell contended that "the entire framework established by the MIEAA" rests on the "theory" that "a large portion of reserves" should be "taken from subscribers, as if their needs were secondary to the general public's." (Transcript, Sept 10, at 16). He goes on to attribute this theory to DC Appleseed, saying that, "If Appleseed gets its way, and the theory were to prevail," the result "will be harm to premium payers." (Id. at 42).

None of this is correct. DC Appleseed's "theory" is that, if GHMSI has excess surplus, the Company should spend it down. And it should do so in accordance with the MIEAA, which DC Appleseed supports. Under that statute, if the Commissioner finds excess surplus, she is to direct the Company to submit a plan to spend it down, and that plan "may consist entirely of expenditures for the benefit of current subscribers" if it is in fact an overall benefit to subscribers, is "fair and equitable," and satisfies government rate-regulation standards. (*See* Medical Insurance Empowerment Amendment Act of 2008, D.C. Law 17-369, Sec.2(g) now codified at; D.C. Code § 31-3506 (g)). There is nothing in the statute that requires GHMSI to "take" money from subscribers and "give" it to nonsubscribers. Nor would any different theory even be relevant; the Council enacted the MIEAA, which governs this proceeding.

In fact, as GHMSI knows, the statute – as well as the DC Attorney General's opinion and Commissioner Mirel's opinion which Mr. Burrell quotes at length -- explicitly authorize the Company to spend a portion of its community reinvestment other than directly for subscribers – something GHMSI has done for years. We believe that GHMSI's attempt to draw a stark, categoric distinction between the interests of its subscribers and those of others in the District is misleading.

For example, Mr. Burrell himself stated that "lowering the trend in healthcare costs may be, probably is the single-most important thing we could do." (Transcript, Sept. 10, at 118). Obviously, such a lowering would benefit persons in addition to GHMSI subscribers. Nonetheless, if GHMSI now believes any spending other than for direct and immediate benefit to its subscribers necessarily "harms" them, it may seek to craft a fair and equitable spend-down plan that avoids such supposed harm.

Second, Mr. Burrell claims that GHMSI's current community health reinvestment spending "is, by far, the highest in the nation." (Id. at 49). In fact, this is not so, but even if it were so, it would not be relevant to the proceeding before the Commissioner.

This proceeding is intended to determine whether GHMSI's surplus as of December 31, 2008 was excessive within the meaning of MIEAA. Even if GHMSI were currently spending at a rate that is the highest in the nation, this would not affect whether the Company had, by December 31, 2008, built excessive surpluses that should be spent down.

Moreover, the claim that GHMSI is spending at the highest rate in the nation is incorrect. Mr. Burrell bases this claim on his calculation that 3.3% of GHMSI's "total premium revenue is given over" to the District in community reinvestments. (Burrell written testimony, Sept 10, at 8; Transcript Sept.10 at 38). But he gets to the 3.3% only by excluding the largest part of GHMSI's premium revenue – the FEP. (Id.). If the FEP from 2008 were included in the calculation, GHMSI's community reinvestment would be at only the .7 % level. And if GHMSI's community reinvestment in the District were 1.6% of its total premium revenue as is required of the Pennsylvania Blues (minus premium and/or income taxes), or at the 1.5% level given by Kaiser Permanente, its giving would be $31.4 million or $29.5 million (including premium taxes), much more than the $14 million Mr. Burrell claimed in his testimony.

Though we disagree with Mr. Burrell on those two points, there are two others where we agree with him. The first is his recognition that "a full fledged crisis is emerging. Indeed, the unaffordability of health coverage has reached alarming levels." (Transcript, Sept 10 at 30). He said further that "keeping premiums as low as possible is the most essential good we can do for the general community." (Id. at 34). He went on to say that "GHMSI subscribers are struggling greatly to pay premiums that are escalating faster than their incomes, and their ability to pay for them." (Id. at 48; Transcript, Sept. 11, at 29-30).

For DC Appleseed, however, this description of the urgent needs in the DC area demonstrates why GHMSI's refusal to spend down any of its $687 million surplus to benefit struggling subscribers should be closely scrutinized by the Commissioner under the standard set by the MIEAA. Further, unless there is a compelling case that GHMSI's financial soundness and efficiency depend on surplus at that very high level (and there is not remotely such a case), GHMSI should be required to spend the surplus down for the benefit of this community as expressly provided in the MIEAA. In doing so, GHMSI may choose to provide direct rate relief to the subscribers for whom it professes sympathy, so long as the plan satisfies the requirements stated earlier.

That brings us to the second point where we agree with Mr. Burrell -- or rather where he expressly agreed with us. We have said both in our written and oral presentations that, in the end, the Company's entire defense of its surplus comes down to whether the particular surplus range offered by the Company through Milliman should be accepted as being in compliance with the statute. In his closing remarks, Mr. Burrell agreed, saying that DC Appleseed "made a right point" in arguing that, in the end, "this is about the range." As Mr. Burrell said, the question is: "What is the range of reserves the Company ought to have?" (Transcript, Sept.11, at 44-45).

That is the question we primarily want to address in this rebuttal. We begin by addressing the standard for that range set by the statute. We then address why we think GHMSI's range doesn't meet that standard. After that we address the surplus attribution issue, and then close with our recommendations concerning actions the Commissioner might take.

1. The Governing Legal Standard

During the September 10 hearing, there was considerable discussion concerning the standard by which the Commissioner is required to assess GHMSI's surplus under the MIEAA. The discussion was triggered in part by Mr. Dobson's statement on behalf of Milliman that GHMSI's surplus is based on his studies regarding what he called an "optimal surplus," and his admission that those studies "were not done in view of this specific statute at all." (Transcript, Sept. 10, at 197).

When GHMSI was then asked how and whether its "optimal surplus" meets the statute's requirement that the Company "shall engage in community health reinvestment to the maximum feasible extent consistent with financial soundness and efficiency," GHMSI contended that the Council did not necessarily intend that the Commissioner apply that standard at all – in the very proceeding designed to implement it. Instead, counsel for GHMSI (Mr. Hogan) argued that the statute contemplates a "two-step process." First, he said, the Commissioner should determine whether GHMSI's surplus is "unreasonably large," and if it is not found "unreasonably large," "you don't get to the second part of the analysis of whether we are meeting our community health reinvestment obligation and the associated issue of financial soundness ...." (Transcript, Sept. 10, at 204.) Mr. Burrell then acknowledged that GHMSI had offered no testimony on the "financial soundness" standard. (Transcript, Sept. 10, at 211; *see also* Id., at 197 (Dobson)).

Mr. Hogan and Mr. Burrell thus contend that the Commissioner (1) should not be guided at all by the "maximum feasible/financial soundness" requirement in assessing whether the surplus is "unreasonably large" and (2) should not find that the surplus necessarily meets the "unreasonably large" test so long as it is within Milliman's "optimal surplus" range. In the face of this uncertainty about the statutory standard, Associate Commissioner Barlow invited further legal analysis on this issue. (Transcript, Sept. 10, at 357).

GHMSI's request to have its surplus upheld solely on the ground that it is within Milliman's "optimal surplus" range – a range that admittedly took no account of the statute's requirements at all, and that indeed took no account of the Company's charitable and benevolent nonprofit obligations at all -- should be rejected by the Commissioner. As explained in the attached legal analysis from Covington & Burling, for several reasons such a result is plainly not what the DC Council intended when it adopted MIEAA.

First of all, the whole purpose of MIEAA was to put in place an enforcement scheme ensuring that the Company would meet its charitable and benevolent obligation as set out in the federal charter; the whole impetus for the scheme was the concern expressed by the former Insurance Commissioner, the former and current Attorney General, and Members of the Council that the Company had built-up excessive surpluses contrary to its charitable and benevolent obligation; and the Council's vehicle and measure for ensuring that that obligation would be met was the "maximum feasible/ financial soundness and efficiency" standard. To suggest that the Council

contemplated that that standard would not apply in this proceeding at all is to ignore why this statute was passed.

Second, the statements of the statute's author and the Committee Report accompanying its passage make clear that the "maximum feasible/financial soundness" standard must apply in this proceeding. For example, the Committee Report on the MIEAA states, the Commissioner is to determine the "appropriate surplus range" for GHMSI "after a thorough review" and in a manner "set to be consistent with financial soundness and efficiency." (Committee Report, B17-934 The Medical Insurance Empowerment Amendment Act of 2008 at 11).

Third, in light of the statute's history and purpose, under the relevant case law the "unreasonably large" and "maximum feasible" requirements should be read together and in light of each other, not as two distinct, unrelated requirements. An "unreasonably large" surplus should be defined at least in part by whether it is greater than necessary to allow the Company to remain sound and efficient. The test of what is required for soundness and efficiency should guide the determination of the range and the ceiling within the range.

And fourth, the Company has an overarching "obligation" to meet the maximum feasible/financial soundness and efficiency requirement. It is clear that the Council intended that that obligation be enforced through this surplus proceeding because this proceeding is the only mechanism the Council established for enforcing that obligation. For all these reasons, further set out in the attached Covington & Burling memo, the Council's "maximum feasible/soundness and efficiency" standard applies to GHMSI's surplus.

Finally, however, as Covington & Burling also explains, even if the Commissioner determined that the "unreasonably large" requirement should be applied to GHMSI's surplus without regard to whether it meets the "maximum feasible/soundness and efficiency" standard, we submit that the surplus fails both standards, whether applied separately or together. Indeed, as shown in the attached statements of ARM and Dr. Deborah Chollet and discussed further below, by any measure GHMSI's surplus is "unreasonably large" and should not be approved.

2. GHMSI's Failure to Meet the MIEAA Standard

At the Sept 10 hearing, the Commissioner asked whether the Company had or should consider operating at a surplus level less than Milliman's "optimal range" but that "is still a sound position to be in financially." Mr. Burrell said "the place to be is within the range." (Transcript, Sept. 10, at 205-06). When the Commissioner then inquired "But where in that decision do you weigh your community obligation," Mr. Burrell said "it's part of it." (Transcript Sept. 10, at 207). In fact, though, the community obligation plays no part in the calculation of GHMSI's "optimal" surplus range, as Mr. Dobson candidly admitted at the hearing. (Transcript Sept. 10, at 197). Instead, GHMSI spends on community benefits only what is left over once its optimal surplus and target margins are achieved. In our view, this is the opposite of what MIEAA requires.

What MIEAA requires is that the Company do what the Commissioner suggested – determine a surplus range that may be less than a theoretical "optimal" range, but that would still allow GHMSI to be "financially sound and efficient." And in order to appropriately weigh its

corresponding obligation to maximize its spending on community benefits, we believe its surplus level should be toward the lower end of a range allowing it to be "financially sound and efficient."

Furthermore, as set out in the cover memo to our August 31 Pre-Hearing Report (at 6-9) and its accompanying analysis from Covington & Burling (at 3-6), we believe that the Pennsylvania Commissioner's decision presents an appropriate overall guide for determining a "sound and efficient" GHMSI's level of surplus. The Commissioner in Pennsylvania determined (at 34) that an "economically efficient level of surplus is the level at which a Blue Plan does not face solvency issues from routine fluctuations in factors such as underwriting results and returns on its investments."

Although we have not been given access to the details of Milliman's model and its assumptions, it is clear, we think, that its model is certainly not based on projecting "routine fluctuations" for GHMSI; rather, as was made clear at the hearing, the Milliman model is based on projecting a prolonged, severe downturn for the Company that has no precedent in its recent history, as well as "catastrophic events." (Transcript, Sept. 10, at 58 (Dobson). And although at the hearing Milliman took umbrage at our saying so (Transcript, Sept. 10, at 73-74), we stand by our contention that the Pennsylvania Commissioner rejected Milliman's approach and the much higher surplus range Milliman advocated for Highmark in that proceeding.

We also stand by our position (DC Appleseed Pre-hearing Report, Aug. 31, at 4) that Commissioner Mirel's 2005 decision confirms both that the Milliman approach is not a reliable guide to determining a sound and efficient surplus, but also that the "optimal" range Milliman now espouses for GHMSI is much too high. At a time when GHMSI's surplus level stood at $501 million, Commissioner Mirel determined the Company "should be engaging in charitable activity significantly beyond its current activities" and could afford to "reduce its surplus level without negatively impacting its financial strength and viability." (See Mirel, May 15, 2005 at 19). Yet, as acknowledged in GHMSI's testimony and at the hearing, its surplus now is at least $687 million –almost $200 million higher than when Commissioner Mirel found it could significantly increase its community benefits and still be financially sound, a substantial increase even after inflation.

In further support of our view that GHMSI's surplus does not meet the MIEAA standard and that the Milliman "optimal" range is not a reliable guide in determining a surplus that does meet that standard, we provide additional analyses in response to matters addressed at the Sept 10 hearing. The first is a response to a request to Dr. Chollet at the hearing that she address GHMSI's contention that Capital Blue Cross in Pennsylvania is comparable to GHMSI and, therefore, that the surplus range permitted for CBC by the Pennsylvania Commissioner should be persuasive here. (Transcript, Sept. 10, at 352). The second is supplementary information from ARM addressing several factors that arose at the hearing and that bear on ARM's demonstration that a sound and efficient surplus for GHMSI should be in approximately the 450% to 525% RBC range, rather than the 750% to 1050% espoused by Milliman.

First, as Dr. Chollet shows in her attached supplementary statement, Capital Blue Cross is not at all similar to GHMSI either in size or the population it serves. Rather, GHMSI is much closer to Highmark and Independence, both of which the Insurance Commissioner assigned a surplus

range of 550% to 750% RBC -- much lower than the range Milliman now espouses for GHMSI. Furthermore, as Dr. Chollet notes in her statement, comparable companies outside of Pennsylvania range from 384% to 563% RBC, all much lower than GHMSI's current 845%. While we agree that each company presents particular circumstances, the comparisons to these companies, chosen for their comparability to GHMSI, are strongly suggestive of GHMSI's excess. And, as ARM points out in its supplemental attached statement, CareFirst of Maryland is at 503% RBC ---significantly less than GHMSI. As Dr. Chollet stated at the hearing, "if this company is so much more heavily reserved than other companies, then other companies must be under reserved because they face similar risk," (Transcript, Sept.10 at 296). Either all of them have too little surplus, or GHMSI has an excessive amount. (Chollet Prehearing Report, Aug. 31, at 5-7). We submit it is the latter.

Second, in its attached statement, ARM offers commentary on several key points that Milliman and the Commissioner and her panel discussed at the hearing. ARM (1) comments on key assumptions Milliman made, and explains why those assumptions are not in keeping with the MIEAA standard, and (2) identifies an appropriate surplus range for GHMSI based on a statistical approach and the available data. ARM shows for several reasons that Milliman's methodology and model produces an unreasonably large surplus range that is far above the amount needed for GHMSI to be financially sound and efficient. These include the facts that: (1) Milliman uses underwriting results as the basic metric for predicting surplus needs, but the proper metric is net income, which includes both investment income and underwriting results, and which has a much higher statistical correlation with surplus (ARM Rebuttal Report, at 9-12); (2) GHMSI's 14-year history of positive net income (which was at least $25 million in each year) provides a strong statistical basis for concluding with 99.99% probability that losses on after-tax net income in consecutive years will not occur; indeed, the probability of having *any* such loss in any given year is less than one percent (Id., at 11); (3) even as to underwriting losses, Milliman's analysis is misconceived. Its entire model is premised on a presumed multi-year period of underwriting losses that is completely inconsistent with GHMSI's most recent ten consecutive years with no underwriting losses. ARM demonstrates based on those ten years and applying standard statistical analysis that the possibility of underwriting losses in multiple consecutive years is "extremely remote" (Id. at 12). For example, the likelihood of an even number of gain and loss years is one tenth of one percent; the likelihood of having any losses in three consecutive years is about three tenths of one percent; and, even in any single years the possibility of having an underwriting loss greater than 2% is about one half of one percent (Id. at 12-13.); (4) Milliman's downturn assumes, erroneously, that once the downturn begins management will not or cannot take action to limit it (Id. at 14); (5) Milliman's model is designed to avoid with near certainty reaching the 375% BCBSA reporting level, at the expense of meeting the statute's "maximum feasible" requirement (Id. at 22-23); and (6) Milliman fails completely to consider the particular characteristics of GHMSI itself, including its size and its surplus as compared with its affiliates (Id. at 15-17) -- as is required by the letter the Commissioner received recently from the BlueCross BlueShield Association.

Moreover, ARM also shows that when it makes its own calculation of an appropriate surplus for GHMSI, following the criteria identified in the BCBSA letter, it computes an appropriate range of 450% to 525% RBC, nearly identical to the range it calculated in its earlier submission correcting for Milliman's flawed assumptions. In addition, as further confirmation that such a

range is appropriate, ARM recalculates what GHMSI's financial condition would have been had it had a 500% RBC for the past 14 years and shows that during those years there would have been only a one hundredth of one percent (0.01%) chance of GHMSI experiencing consecutive-year losses on after-tax net income. (ARM Rebuttal Report, at 11). Furthermore, ARM notes that the 500% RBC suggested by its work is actually endorsed by the BCBSA itself, i.e., as ARM notes, that is the level the Association identifies as a guideline for a "strong plan." (ARM Rebuttal Report, at 20, (citing New Jersey Department of Banking and Insurance, *Horizon Blue Cross Blue Shield New Jersey Foundation Plan Revised Response to Question 12*, filed March 30, 2009, available at http://www.state.nj.us/dobi/horizon/fp_question12.pdf)).

For all these reasons, we believe the Milliman "optimal" surplus range should be found to be both "unreasonably large" and higher than is necessary to meet the "soundness and efficiency" requirement. And we urge the Commissioner to determine that an appropriate range in compliance with the "soundness and efficiency" requirement is something close to 450% to 525% RBC and that compliance with the "maximum feasible" requirement suggests a surplus toward the lower end of that range.

3. The Appropriate Attribution of Surplus to the District

In our previous submissions, we have shown that the language of MIEAA, industry practice, GHMSI's own practice, and actions taken by the Maryland Insurance Commissioner all support attributing GHMSI's surplus to the District based on the percentage of premium for GHMSI's total contracts written in the District. (See Smith Testimony Sept. 10, at 5-6; Covington and Burling Memo, Sept. 10). We have also shown that this percentage is approximately 60%. (Covington Memo, Sept.10, at 2-3; ARM Report, Attribution of Surplus, Sept. 10, at 6). We have furthermore shown that Milliman's contrary position – that attribution should be based on the percentage of total GHMSI subscribers who are DC residents -- appeared to be based exclusively on an erroneous interpretation of MIEAA, i.e., that MIEAA requires the Commissioner to ensure that any surplus spend-down go only to District residents. (Covington Memo Sept. 10, at 1).

Milliman acknowledged that its approach was non standard (see GHMSI Pre-hearing Report, Aug. 31, 2009, Appendix A at 38, 40) and that its justification was based on its erroneous understanding of the statute. We contended at the hearing that the contract method was the appropriate attribution mechanism.

Following the hearing, the Commissioner and the Associate Commissioner arranged a conference call for DC Appleseed to learn from Milliman how it developed its position on attribution. We learned in that call one additional basis for Milliman's approach – that it based attribution on residence because GHMSI asked it to do so, and GHMSI asked it to do so because the Company intends to spend down surplus based on residence. (See Teleconference Transcript, Sept. 22, at 29, 33). This of course is neither an exercise of Milliman's professional judgment nor a basis for the Commissioner's determination of appropriate attribution, and whether or not the Commissioner would approve such a residence-based spend down plan is an issue for another day.

Moreover, as shown in the attached rebuttal report from ARM, Milliman's estimate that only 11% of total subscribers are DC residents is an unreliable number and, furthermore, the net return to GHMSI from the DC-based contracts during 2002-2008 is more than twice as high as the non-DC contracts. This confirms that more than 50% of GHMSI's surplus (even excluding FEP) is derived from DC individual and small group contracts in the District and is being derived because GHMSI is earning significant net returns on those contracts. On that basis, at least 50% of this surplus should be allocated to the District. (See ARM Supplemental Report, at 5-6; ARM Rebuttal Report, at 25).

Finally, it worth noting that GHMSI's position on the attribution issue is undermined by its own conflicting position regarding its claimed 3.3% annual contribution to community benefits in the District -- a contribution that GHMSI stressed at the hearing was much higher than its percentage contribution in Maryland or Virginia.

As support for this latter claim, GHMSI contended through Mr. Burrell's Sept 10 testimony (at 7-8) that GHMSI contributes 3.3% of its District-allocated premium revenue to community benefits, whereas it contributes only 2.3 % of its Virginia revenue and 1.7% of its Maryland revenue. But for this calculation, because it served its purpose to do so, GHMSI allocated revenues using the standard approach based on Schedule T, i.e., allocating revenues to the jurisdiction where the contract was a written. And yet, without even acknowledging the contradiction when it reached the question of attribution when it wished to allocate a lesser number to the District, it reversed course and used the residency method instead. We submit GHMSI got it right the first time and that Milliman's argument for a residency-based attribution has neither a legal nor a policy basis to support it.

4. Recommended Action by the Commissioner

We urge the Commissioner to find the efficient surplus range for GHMSI under MIEAA to be something close to 450% to 525% RBC, and that a figure toward the lower end of that range should be selected to meet the "maximum feasible" requirement. We also urge the Commissioner to attribute 50 to 60% of the resulting excess surplus to the District. Finally, we urge the Commissioner not to be deterred by three warnings Mr. Burrell appeared to issue at the Sept 10-11 hearing.

His first warning was that the great uncertainty facing the Company from the health reform effort on the Hill should deter enforcement action by the Commissioner. This is an unfounded concern. As the New York Times recently reported, nearly all of the congressional health reform changes being proposed will take effect no earlier than 2013, and some much later (See NY TIMES, *Changes Aren't So Imminent*, Oct. 22, 2009 at A 21[1]). The issue before the Commissioner concerns the excessiveness of the Company's surplus at the end of 2008 and the spend-down of that excess beginning in 2010. The federal health reform effort, whatever it is, will take effect much later than that, and GHMSI will have plenty of notice and time to make appropriate adjustments, including any necessary increases in premiums.

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[1] For example, S 1796, America's Healthy Future Act of 2009 (The Baucus Bill), includes a 5-year phase-in for provisions, including the elimination of pre-existing condition exclusions for the small group market, §§ 2211, 2213.

Mr. Burrell's second warning was that because the Company operates with such "thin" margins –which he repeatedly said were approximately only 1% -- it would be risky to require any spend down of surplus. (GHMSI Pre-hearing Report, Aug. 31, at 18; Burrell Testimony Sept. 10, at 6). First of all, Mr. Burrell subsequently acknowledged that his claimed "thin margins" do not include net investment income (Transcript, Sept. 10, at 213-214); and that, in addition to underwriting results, the "second way the reserve gets built is from earnings on the invested funds that are in the reserve." (Transcript, Sept. 11, at 52). Second, the fact is that GHMSI's huge surpluses were built in part from its margins, however, they are characterized. Mr. Burrell acknowledged that fact, as he had to. (Id.). Whatever the Company's margins are, as ARM points out, those margins have been sufficient to produce 14 years' consistent profits and to grow the surplus to $687 million. (ARM Rebuttal Report, at 9). Third, and perhaps more important, ARM also points out that in fact the individual and small group portion of GHMSI's business, which Mr. Burrell repeatedly characterized as the most critical segment of its DC-based operation, is earning a margin of more than 5%. (Id., at 25-27). And, as ARM points out, it is these margins that are producing the lion's share of the DC surplus. (Id.).

Mr. Burrell's third warning was that since his plan would be to spend down excess by reducing premiums over approximately a two-year period, after that period the Company would have to institute "spring-back" increases to make up the difference. (Transcript, Sept. 11, at 42). With due respect to Mr. Burrell, for three reasons this also is not a legitimate concern.

First, it may be true that, as the Pennsylvania Commissioner recognized in her opinion, "a rate rollback, or a rate freeze, could prove detrimental to the market place." (PA Decision, at 17). But there is also no question that the Commissioner has the authority under MIEAA to withhold approval of a spend-down plan that would have that effect -- by determining that it does not meet the statute's "fair and equitable" requirement. Second, as ARM explains in its attached report, the three-year premium reduction plan proposed by Mr. Burrell would not be of significant magnitude to disrupt the market. (ARM Rebuttal Report, at 29). Third, as Dr. Chollet and ARM show in their attached statements, that GHMSI would have many choices other than the one Mr. Burrell suggest that would not lead to marketplace disruption but still would benefit subscribers. For example, GHMSI can scale premium relief to subscribers to avoid disruptive fluctuations in the market. GHMSI might also (or alternatively) invest in strategies to reduce medical costs, support disease management initiatives, raise the prescription benefit caps on guaranteed issue plans, and increase prevention efforts. Such activities would not only benefit current policy holders, but also benefit the community.

In the end, if GHMSI's has accumulated excess surplus that should be spent down, the Commissioner has full authority and flexibility under MIEAA to ensure that (1) a spend down plan will benefit subscribers and potential subscribers in the way the Council intended, while (2) appropriately protecting the Company. We look forward to assisting the Commissioner in helping to meet both those goals.