Exhibit A

Legal analysis of the Medical Insurance Empowerment Act of 2008 by Covington and Burling, LLP

Prepared for DC Appleseed Center for Law and Justice, Inc

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

District of Columbia
Department of Insurance, Securities, and Banking

August 31, 2009

Analysis of the Legal Obligation of Group Hospitalization and Medical Services, Inc., Under the Medical Insurance Empowerment Amendment Act of 2008

I. Introduction

The DC Appleseed Center for Law and Justice, Inc. ("DC Appleseed") asked Covington & Burling LLP to analyze the legal standard set forth under The Medical Insurance Empowerment Amendment Act of 2008[1] (hereinafter, "the Act") regarding the charitable obligation of Group Hospitalization and Medical Services, Inc. ("GHMSI").

We conclude that the Act requires GHMSI to engage in community health reinvestment to the maximum feasible extent consistent with financial soundness and efficiency. Moreover, the Act requires GHMSI to demonstrate that its surplus is justifiable under this standard, which GHMSI has to date failed to do.

II. GHMSI Must Engage in Community Health Reinvestment to the Maximum Feasible Extent Consistent with Financial Soundness and Efficiency.

The Act requires GHMSI to "engage in community health reinvestment to the *maximum feasible extent* consistent with financial soundness and efficiency."[2] The purpose of the Act is to provide a framework to ensure that GHMSI meets this statutory requirement.[3]

Pursuant to the Act, the Insurance Commissioner must conduct a thorough review before issuing any order that requires GHMSI to reinvest a portion of its surplus for community health activities. GHMSI's surplus shall be considered excessive only if:

(1) it "is greater than the appropriate risk-based capital requirements as determined by the Commissioner for the immediately preceding calendar year;" and

(2) the Commissioner determines, after a hearing, "that the surplus is unreasonably large and inconsistent" with GHMSI's statutory obligation to engage in community health reinvestment to the maximum feasible extent.[4]

For the current calendar year, D.C. Insurance Commissioner Thomas E. Hampton (hereinafter, "the Commissioner") made an initial determination, after reviewing the relevant

---

1 Medical Insurance Empowerment Amendment Act of 2008 (MIEAA), D.C. Law 17-369 (Jan. 23, 2009) (emphasis added).

2 MIEAA, § 2(c); D.C. Code § 31-3505.01.

3 *See* Committee on Public Services and Consumer Affairs, Committee Report for Bill 17-934, the Medical Insurance Empowerment Amendment Act of 2008, Statement of Purpose and Effect, at 2 (Oct. 17, 2008) (hereinafter, "Committee Report").

4 MIEAA, § 2(d); D.C. Code § 31-3506(e).

data, that GHMSI's surplus is excessive with respect to the first factor.[5] The Commissioner subsequently scheduled a hearing, to be held on September 10, 2009, to determine whether GHMSI's surplus is "unreasonably large" and therefore "inconsistent" with GHMSI's statutory obligation. This hearing is vital to creating effective oversight as contemplated by the Act because, based on past practice, there is no reason to believe GHMSI will voluntarily meet its statutory obligation.[6]

A. GHMSI Must Demonstrate that Its Current Surplus Meets the "Maximum Feasible" Standard.

The purpose of the September 10 hearing is to determine whether GHMSI's surplus is inconsistent with the statutory obligation to engage in community health reinvestment to the maximum feasible extent consistent with financial soundness and efficiency. The District and the public must be able to measure whether GHMSI is complying with this statutory standard. The type of robust review envisioned by the Act cannot be completed, however, without access to internal documents within GHMSI's exclusive possession and control. This imbalance places the burden squarely on GHMSI to provide sufficient information and data to justify its current level of surplus. GHMSI should not be permitted to point to an indeterminable need to stockpile reserves to address future contingencies, whose possible impact can never be accurately quantified, to excuse not meeting its statutory obligations.

The Act itself requires the Insurance Commissioner to evaluate GHMSI's surplus based on information provided by GHMSI, including "the corporation's financial obligations arising in connection with the conduct of the corporation's insurance business, including premium tax paid and the corporation's contribution to the open enrollment program."[7] To prepare for the hearing, the Insurance Commissioner has ordered CareFirst, the holding company of GHMSI,

> to provide a report on the amount and calculation used to determine the reasonable surplus it needs to maintain in order to conduct its business. The report will detail the appropriate level of surplus necessary for the GHMSI to meet its: (1) statutory and corporate surplus requirements; (2) actuarially determined risk

---

[5] Department of Insurance, Securities and Banking (DISB), 2009 Group Hospitalization and Medical Services Inc. Adequate Surplus Determination, Department of Insurance, Securities and Banking, *available at* http://disb.dc.gov/disr/frames.asp?doc=/disr/lib/disr/pdf/ghmsi_hearing_determination.pdf (hereinafter "Adequate Surplus Determination").

[6] *See* Committee Report, Background/Committee Reasoning, *supra* note 3, at 4-6.

[7] MIEAA, § 2(d); D.C. Code § 3506(f). The Act authorizes the Commissioner to review the portion of GHMSI's surplus that is "attributable to the District." MIEAA, § 2(d); D.C. Code § 3506(e). D.C. Appleseed previously submitted comments to DISB regarding how allocation of the surplus should occur. This submission does not address the allocation issue because CareFirst stated in its July 31 filing that it would address allocation in a future document.

> exposures; and (3) expected and unanticipated contingencies. The report shall also include the community health reinvestment expenditures, premium taxes paid and the company's contribution to the open enrollment program.[8]

CareFirst's July 31 report by its very nature purports to justify GHMSI's current surplus level.[9] That GHMSI should bear the burden to do so is appropriate as it is GHMSI which possesses virtually all of the information necessary to evaluate whether it is engaging in the statutorily mandated "maximum feasible" level of community health reinvestment. GHMSI clearly has not met this burden. CareFirst's report fails to even acknowledge the statutory standard, much less show that GHMSI's surplus level meets the standard. In addition, the report makes no mention of GHMSI's spending on community benefits, even though the Commissioner's order contemplates that such an analysis would be included in the report.

B. GHMSI Has Failed to Justify Its Current Level of Surplus In Light of the "Maximum Feasible" Standard.

There is, of course, every reason to safeguard the solvency of GHMSI, so that it has the financial strength to continue insuring the health needs of so many of the District's residents, but the legislation does exactly that, by requiring GHMSI to provide community health benefits only to the maximum feasible extent *consistent* with financial soundness. In light of applicable precedents, the Milliman analysis is inadequate to even demonstrate a reasonable range for GHMSI's surplus, and CareFirst's conclusions do not satisfy the "maximum feasible" standard.

1. Surplus Determinations by the Pennsylvania Insurance Commissioner Rejected Milliman's Approach and Do Not Support CareFirst's Conclusions.

Acting pursuant to its general regulatory authority over the rates, reserves, and contracts of non-profit hospital plans and professional health services plans, the Pennsylvania Insurance Commissioner conducted an inquiry over several years into the surplus levels of the four non-profit Blues plans operating in that state. The Commissioner issued a decision early in 2005, and has subsequently issued annual determinations concerning surplus levels for each of those

---

[8] Adequate Surplus Determination, *supra* note 5; *see also* DISB, Public Summary and DISB Action Plan for the Surplus Review of GHMSI under the Medical Insurance Empowerment Amendment Act of 2008, *available at* http://disb.dc.gov/disr/frames.asp?doc=/disr/lib/disr/pdf/carefirst_review_public_summary_timeline.pdf.

[9] CareFirst Public Report (July 31, 2009), *available* at http://disb.dc.gov/disr/frames.asp?doc=/disr/lib/disr/pdf/carefirst_7_09_report_2.pdf.

companies, using the methodology adopted in its 2005 decision.[10] The Pennsylvania decisions do not support CareFirst's position here.

In response to the Pennsylvania Insurance Commissioner's inquiry, Highmark, one of the two largest Blues in Pennsylvania, commissioned and submitted a report by Milliman, as CareFirst has done here.[11] Milliman found that a "reasonable" range for Highmark's surplus was 650-950% of risk-based capital (RBC).[12] The Pennsylvania Insurance Commissioner flatly rejected this finding and instead found the "efficient" range to be 550-750%.[13] Thus, the Commissioner found that the efficient upper end was 17% lower than Milliman's upper end.

There, as here, Milliman and the Blues argued that the surplus had to be large enough to cover catastrophic events. "Prudence *dictates*," Milliman insisted, that surplus had to be sufficient to cover terrorism, epidemics, pandemics, natural or other disasters, and extraordinarily high damage awards from litigation.[14] Milliman repeats this contention in its report for CareFirst.[15] CareFirst echoes it as well.[16]

The Pennsylvania Insurance Commissioner rejected this contention unequivocally. While agreeing that such risks are real, the Commissioner stated that

> 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*

---

[10] *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, *available at* http://www.ins.state.pa.us/ins/lib/ins/whats_new/2004bc/BCBS_DETERMINATION.PDF (hereinafter, "Pennsylvania Surplus Decision"). The decision was judicially reviewed and affirmed on a purely procedural challenge. *See City of Philadelphia et al. v. Pa. Insur. Dept*, 889 A.2d 664 (Pa. Commw. Ct. 2005). The annual determination for 2008 is available at http://www.ins.state.pa.us/ins/lib/ins/whats_new/2004bc/Surplus_Statement.pdf.

[11] The Milliman report submitted in Pennsylvania is available as an attachment beginning at page 00628 of the Highmark submission to the Commissioner, which is available at http://www.ins.state.pa.us/ins/lib/ins/whats_new/2004bc/Highmark.pdf ("2004 Milliman Report").

[12] 2004 Milliman Report, *supra* note 11, 48.

[13] Pennsylvania Surplus Decision, *supra* note 10, at 37.

[14] 2004 Milliman Report, *supra* note 11, at 9 (emphasis added); *see also id.*, at 33, 37.

[15] 2008 Milliman Report, at 12, *available at* http://disb.dc.gov/disr/frames.asp?doc=/disr/lib/disr/pdf/miliman_report.pdf.

[16] CareFirst Public Report, *supra* note 9, at 2.

> *accumulate enough premiums to cover any and all catastrophic events no matter how remote of unforeseeable.*[17]

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."[18]

Here too, the D.C. Insurance Commissioner should reject the Milliman-CareFirst contention that GHMSI should be allowed to accumulate surplus sufficient to cover catastrophic events. Notwithstanding Pennsylvania's earlier rejection of its position, however, Milliman, in its submission on behalf of GHMSI, does not identify the portion of its calculated surplus requirements for GHMSI that are attributable to such risks. CareFirst should be required to provide such information, which the Commissioner can then appropriately take into account in reaching his ultimate judgments.[19]

The rejection by the Pennsylvania Insurance Commissioner of the Blues' desire to accumulate surplus to cover catastrophic risks reflected a broader failure of the Blues to acknowledge what the Pennsylvania Insurance Commissioner properly viewed as a fundamental element in the proper analysis of surplus, namely, the "diminishing nature of the marginal reduction in probability of ruin or default from successive dollars of surplus."[20] Likewise, CareFirst has completely failed to acknowledge a fundamental element in the analysis of GHMSI's surplus, namely GHMSI's statutory obligation to "engage in community health reinvestment *to the maximum feasible extent consistent with* financial soundness and efficiency."[21]

We have already discussed the meaning of this language, its implication for this proceeding, CareFirst's astonishing failure not only to apply this standard to Milliman's analysis but to mention it at all, and CareFirst's surely incorrect view that this language has no bearing at all on the choice of the upper end of the surplus range for GHMSI and is instead simply surplusage.[22] It bears mention here, however, that the Pennsylvania Insurance Commissioner

---

17 Pennsylvania Surplus Decision, *supra* note 10, at 12 (emphasis added).

18 *Id.*, at 17 (emphasis added).

19 CareFirst does not state whether it attempts to take catastrophic risks into account when setting premiums and when determining its RBC. If it does not, it leaves the entire coverage of such risks to surplus. However, the function of surplus is to cover risks that are underestimated in the setting of premiums and the calculation of RBC—not to cover risks that can to some degree be anticipated. Surplus is the final, not the first, line of defense.

20 Pennsylvania Surplus Decision, *supra* note 10, at 15.

21 MIEAA, § 2(c); D.C. Code § 31-3505.01 (emphasis added).

22 Although the Pennsylvania Blues were by statute deemed to be charitable and benevolent organizations (40 Pa. Cons. Stat. §§ 6103(b), 6307(b)), Pennsylvania had not imposed a specific "maximum feasible" obligation. Thus, there was no occasion for the Pennsylvania Insurance (continued...)

emphasized that a range of efficient surplus represents a "continuum of efficient levels of surplus ranging from the lowest point to the highest."[23] The implication for this proceeding under the "maximum feasible" standard is that, because no point in an efficient range would constrain GHMSI to an insufficient surplus, any upper end within an efficient range is "consistent with" financial soundness and efficiency. GHMSI need not as a matter of efficiency and should not as a matter of statutory interpretation be allowed to accumulate surplus at the upper end of its efficient range. Upper limits set within and not at the upper end of that efficient range would be "consistent with" GHMSI's financial soundness and efficiency.

The Pennsylvania Insurance Commissioner further faulted the Blues for failing to balance the marginal reduction in risk from any given increment to surplus against "the benefits of using these same surplus funds in alternative fashion."[24] The D.C. Council, of course, has already specified the relevant alternative benefits to be taken into account in assessing GHMSI's surplus, namely the various activities coming within the definition of "community health reinvestment." In the instant proceeding, marginal increments to GHMSI's surplus must be weighed against those statutorily specified alternative uses, which must be given priority to the maximum extent "consistent with financial soundness and efficiency." As outlined in the statement of Deborah Chollet, the benefits of such alternative uses in the District would be immense.

In this proceeding, as in Pennsylvania, Milliman contends that the absence of equity is a financial disadvantage relative to its for-profit competitors.[25] The Pennsylvania Insurance Commissioner pointed out, however, that the non-profit status of the Blues meant that they are "not subject to all of the efficiency constraints imposed by competitive capital markets." It was precisely the absence of those efficiency constraints that was "critical to the need of the Department to set standards for efficient surplus levels."[26] Here, as with the Blues in Pennsylvania, GHMSI is not subject to the efficiency constraints imposed by capital markets. And here, there is all the more reason for rigorous, independent examination by the Commissioner, where the D.C. Council has specified the alternative beneficial uses of surplus that are to be weighed against incremental increases in GHMSI's surplus, and has required that those alternative uses be given priority to the maximum feasible extent consistent with financial soundness and efficiency.[27]

Commissioner to determine the implications of such an obligation for the proper limits of surplus.

[23] Pennsylvania Surplus Decision, *supra* note 10, at 15.

[24] *Id.* at 15.

[25] *See* 2008 Milliman Report, *supra* note 15, at 11-12; 2004 Milliman Report, *supra* note 11, at 8, 9; CareFirst Public Report, *supra* note at 3.

[26] Pennsylvania Surplus Decision, *supra* note 10, at 14.

[27] The Pennsylvania Insurance Commissioner also pointed out that equity is generally a more expensive source of capital than debt. "Since equity funding is not contractually guaranteed a specific return, a higher return than interest yields is demanded over time to compensate for additional risk." Pennsylvania Surplus Decision, *supra* note 10, at 14. Further, (continued...)

2. Previous Independent Evaluations Have Established that GHMSI Is Not Meeting Its Obligation to Engage in Community Health Reinvestment.

Previous independent evaluations of GHMSI's surplus by former Maryland Insurance Commissioner Steve Larson, former D.C. Insurance Commissioner Larry Mirel, and former D.C. Attorney General Robert Spagnoletti established that GHMSI has not, in fact, met its (now codified) community health obligations. Although these evaluations precede passage of the Act, they make clear that GHMSI has a history of failing to engage in community health reinvestment to the maximum feasible extent consistent with financial soundness and efficiency.

In 2003, then-Maryland Insurance Commissioner Steve Larsen issued an opinion denying CareFirst's conversion application.[28] In his opinion, Commissioner Larsen determined that CareFirst had disregarded its mission as a nonprofit company once it determined to seek conversion and sale of the company. Larsen pointed out that CareFirst had been focused on growth and market dominance and on exiting unprofitable market segments, rather than providing insurance at minimum cost to those that needed it. Specifically, he noted that "[f]rom 1997 to the present, CareFirst management retreated from, and ultimately abandoned, its mission as articulated in the Articles of Incorporation and assumed all the operating characteristic of a for-profit company. The Board did not question the action by management to abandon the corporate mission and took no action to prevent it."[29] Larsen further pointed out that other nonprofit Blues plans had been able to "not only survive but also thrive as a social mission oriented nonprofit" and that CareFirst had failed to consider whether it could do the same.[30]

In 2005, then-Insurance Commissioner Mirel held a hearing to inquire whether GHMSI was in fact meeting its federally chartered charitable obligations. At that hearing GHMSI took the position that it has no legal obligation to the community at all; rather, its obligations are—according to the company—no different than those of for-profit health insurance companies.

Following the hearing, Commissioner Mirel issued a report in which he found that GHMSI has a legal obligation under its charter to operate as a non-profit charitable institution but that it was meeting this obligation by operating a non-profit health plan that serves residents in the District of Columbia.[31] But he also concluded that "not only does GHMSI have the

---

the Blues' not-for-profit structure means that they "are in fact not subject to the operational constraints to which publicly traded for-profit corporations are subject. The Plans do not have to earn a market-determined rate of return on owner-supplied equity." *Id.*

[28] Steve Larson, Report of the Maryland Insurance Administration, Steven B. Larson, Commissioner, Regarding the Proposed Conversion of CareFirst, Inc., to For-Profit Status and Acquisition by WellPoint Health Networks Inc. (Mar. 5, 2003).

[29] *Id.* at 111.

[30] *Id.* at 99.

[31] Lawrence H. Mirel, Report of the District of Columbia Department of Insurance, Securities, and Banking In the Matter of: Inquiry into the Charitable Obligations of (continued...)

authority to engage in charitable activity outside the provision of health insurance, it has the responsibility to engage in such activity."[32] He also determined that GHMSI could "reduce its surplus level without negatively impacting 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."[33]

Following Commissioner Mirel's report, then-Attorney General Spagnoletti issued a memorandum to the City Administrator, in which he concluded that GHMSI has a "legal obligation to *devote its entire operation* to serving, directly or indirectly, the charitable, public health purposes" created by its federal charter.[34] In describing GHMSI's "corporate mission" as "promotion of public health," Attorney General Spagnoletti clarified that any other goals, including "generation of operating profits" and, more importantly, "accumulation of 'surplus'" are only "the *means* of advancing" GHMSI's public health mission.[35] Attorney General Spagnoletti then stated that GHMSI would be "acting contrary to its charitable obligation" if it accumulated surplus for reasons unrelated to community health reinvestment.[36] He added that "[u]ntil GHMSI acknowledges its obligation as a 'charitable and benevolent institution' to operate for the benefit of the public, one cannot presume that its corporate decisions are based on a board determination as to how best to fulfill the corporation's charitable purposes."[37]

This obligation has now been codified by the Act, and the Commissioner recently determined that GHMSI's surplus is unreasonably excessive. GHMSI now has an opportunity to attempt to justify its surplus, both through written submissions and via testimony at a hearing on the matter. Assuming that GHMSI fails to meet its statutory obligation (and the above-described history suggests skepticism that it can), the Commissioner can direct GHMSI to spend down unreasonably excessive surplus to bring GHMSI to the lower end of the range of appropriate operating surplus range as required by the "maximum feasible" statutory standard.

GHMSI/CareFirst in the District of Columbia (May 15, 2005). One purpose of the Act was to make clear that GHMSI's obligation to engage in community benefit spending extends beyond its basic operations.

32 *Id.* at 11.

33 *Id.* at 21.

34 Letter from Robert J. Spagnoletti, Attorney General, to Robert Bobb, City Administrator, at 1 (Aug. 4, 2005) (emphasis added).

35 *Id.* at 2 (emphasis in original).

36 *Id.* at 2-3.

37 *Id.* at 2.

III. The Commissioner Should Establish a Reasonable Initial Range for GHMSI's Surplus, and then Require GHMSI to Adopt the Lower End of that Range to Meet the "Maximum Feasible" Standard.

The Act does not require GHMSI to maintain a reasonable surplus or to engage in reasonable levels of community health reinvestment; instead it requires GHMSI to engage in these activities *to the maximum feasible extent consistent with financial soundness and efficiency*. Thus, to the extent that GHMSI's surplus is greater than the appropriate risk-based capital requirements, even by a small amount, the Commissioner must consider whether GHMSI could and should increase its community health reinvestment activities while still remaining financially sound. There is, undoubtedly, a range of operating surplus that would be appropriate for GHMSI to meet this standard, and absent some justification from GHMSI that its surplus is within this range, the Act requires the Commissioner to direct GHMSI to provide a plan to bring it within such a range. Importantly, given that the Act specifies that GHMSI's over-arching obligation is to engage in community health reinvestment "to the maximum feasible extent," it necessarily follows that GHMSI's surplus should be set at the lowest end of that range.

Several cases support this view. The D.C. Circuit has explained that, even if a rate falls within the zone of reasonableness, it may be challenged on other grounds. Indeed, "[the Federal Energy Regulatory Commission's] responsibility under the Federal Power Act does not end with a determination that a proposed rate is reasonable, for it may be unlawful on other grounds."[38] Similarly, in *Interstate Commerce Commission. v. Inland Waterways Corp.*, the Supreme Court stated: "[T]rue, the Commission found that the proposed schedules are shown to be just and reasonable. But this does not constitute a finding that the rates were lawful; they may lie within the zone of reasonableness and yet result in undue prejudice or otherwise violate the Act."[39]

Here, a finding that GHMSI's surplus is appropriate simply because it is close to the appropriate risk-based capital requirements or otherwise falls within a broad range set by the Insurance Commissioner may nevertheless fail to meet the Act's requirements if GHMSI is not engaging in community health reinvestment to the maximum feasible extent consistent with financial soundness and efficiency. Although the determination regarding GHMSI's surplus is within the discretion of the Commissioner, such a determination must comport with the requirements of the Act. To the extent that the Commissioner's determination is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law;" or that is "in excess of statutory jurisdiction, authority, or limitations or short of statutory rights," the determination violates not only the Act and could be subject to a court challenge.[40]

---

38 *Alabama Elec. Coop., Inc. v. FERC*, 684 F.2d 20, 27 (D.C. Cir. 1982) (further noting that, "as the Supreme Court established long ago, 'rates may lie within the zone of reasonableness and yet result in undue prejudice'").

39 319 U.S. 671, 687 (1943).

40 D.C. Code § 2-510.

IV. Conclusion

Prior to passage of the Act, previous independent evaluations of GHMSI's surplus established that GHMSI had not met its community health obligation. The Act provides a framework for ensuring that GHMSI engages in community health reinvestment to the maximum feasible extent consistent with financial soundness and efficiency. Moreover, the Act requires GHMSI to demonstrate that its surplus is justifiable under this standard. As such, the Commissioner should establish a reasonable initial range for GHMSI's surplus and then require GHMSI to adopt the lower end of that range to meet the "maximum feasible" standard.