GOVERNMENT
OF
THE DISTRICT OF COLUMBIA

+ + + + +

DEPARTMENT OF INSURANCE, SECURITIES,
AND BANKING

+ + + + +

PUBLIC HEARING ON SURPLUS AND

REVIEW OF GHMSI

Thursday,
September 10, 2009

Office of Zoning

Hearing Room 220 South
441 4th Street, N.W.
Washington, D.C.

The Public Hearing on Surplus and Review of GHMSI before the District of Columbia Department of Insurance, Securities, and Banking convened at 10:00 a.m., Gennet

Purcell, Acting Commissioner, presiding.

DISB COMMISSIONERS PRESENT:

GENNET PURCELL, Acting Commissioner
PHILIP BARLOW, Associate Commissioner

ALSO PRESENT:

LESLIE JOHNSON, Hearing Officer, DISB
STEPHEN C. TAYLOR, General Counsel, DISB
MICHELLE MATHIS, Paralegal Specialist, DISB
ROBERT H. MYERS JR., Morris, Manning & Martin
CINDY CHANG, Morris, Manning & Martin

JIM TOOLE, Rector and Associates
NEIL RECTOR, Rector and Associates
SARAH SCHROEDER, Rector and Associates

TABLE OF CONTENTS

P-R-O-C-E-E-D-I-N-G-S

(10:01 a.m.)

COMMISSIONER PURCELL: Good morning. Before we get started, if I could just ask everyone to please set their phones to vibrate, or turn them off, so we don't have any witness interruptions. I'd appreciate that. Thank you all for coming.

I am Gennet Purcell, Acting Commissioner for the District of Columbia Department of Insurance, Securities, and Banking. I would like to welcome everyone to this public hearing.

This hearing is being held pursuant to D.C. Official Code, Section 31.3506, Subsections (e) and (f) of the Hospital and Medical Services Corporation Regulatory Act of 1996, or the HMSCR Act, as amended by the Medical Insurance Empowerment Amendment Act of 2008, or the MIEAA Act.

The Department convenes this hearing to assist in making its determination

as to whether the portion of surplus attributable to the District of Columbia of Group Hospital and Medical Services, Inc., or GHMSI, a subsidiary of Care First, Inc., is excessive under the MIEAA.

With me today also representing the Department are Mr. Phil Barlow, Associate Commissioner for the Insurance Department, Ms. Leslie Johnson, Department Hearing Examiner, Mr. Stephen Taylor, General Counsel for the Department, Ms. Michelle Mathis, Department Paralegal. Serving as experts on behalf of the Department are Mr. Jim Toole, Mr. Neil Rector, and Ms. Sarah Shroeder of Rector & Associates, and Mr. Robert Myers, and Ms. Cindy Change of Morris, Manning & Martin LLP.

The purpose of today's hearing is to assist the Department in gathering information about the appropriate levels of surplus necessary for the corporation to meet its, one, statutory and corporate surplus requirements; two, actuarial determined risk

exposures; and, three, expected an unanticipated contingencies. Additionally, the Department hopes to gather information regarding the most appropriate way to determine the portion of the corporation's excess surplus, if any, which is attributable to the District of Columbia.

GHMSI is unique among all Blue Cross/Blue Shield plans in the United States, in that it was created by an act of Congress, which establishes its purpose in a Congressional charter. This charter empowers GHMSI to enter into contracts with individuals, or groups of individuals for the provision of health insurance coverage as a non-profit company for the benefit of its subscribers.

GHMSI is a Hospital and Medical Services Corporation chartered by the Department, and subject to the surplus review required by the HMSCR Act. The MIEAA's implementing regulations, DCR Chapter 46,

Title 26 provide the regulatory standards governing these proceedings, and define greater than the appropriate risk-based capital requirements to mean greater than the minimum risk-based capital requirements of the National Association of Insurance Commissioners, the NAIC, and the Blue Cross/Blue Shield Association.

On July 17th, 2009, the former Commissioner for DISB, Mr. Thomas Hampton, issue the 2009 Group Hospitalization and Medical Services Inc. adequate surplus determination. He determined that the surplus as of December 31, 2008 was greater than the appropriate risk-based capitol requirements, as that phrase is defined in MIEAA's implementing regulations.

Pursuant to the terms of the MIEAA Act, the Department is required to conduct a public hearing to determine whether GHMSI surplus attributable to the District of Columbia is excessive. The surplus

attributable to the District shall be deemed excessive only if the further finding is reached that the portion of the surplus is unreasonably large, and inconsistent with GHMSI's Community Health Reinvestment obligation set forth in Section 6A of the HMSCR Act.

The purpose of today's hearing is to shed light on this very important issue. In order to make a final determination as to whether GHMSI surplus which is attributable to the District is excessive, and unreasonably large, I will take into consideration the entire record, which will include all submissions and testimony. I will listen and consider the views of interested parties and members of the public. The information received here today will be made a part of the official record of this hearing.

Notice of the public hearing was published in the District of Columbia Register on July 24th, 2009 at 56 DCR 005967, and

revised notice was published in the District of Columbia Register on July 31st, 2009 at 56 DCR 006000. Notice was delivered to Care First on July 24th, 2009, and again on July 31st, 2009. The revised notice of public hearing was also posted on the Department's website.

On July 31st, 2009, as required by the Department, GHMSI issued the GHMSI Report incorporating the December 4th, 2008 Milliman Report entitled, "Need for Statutory Surplus and Development of Optimal Surplus Target Range." Pursuant to the regulations governing these proceedings, on August 31st, 2009, GHMSI issued the GHMSI Pre-Hearing Report incorporating as Exhibit A the August 28th, 2009 Milliman Report titled, "Evaluation of GHMSI Surplus Attributable to D.C.", and several attachments.

Also on August 31st, 2009, a Pre-Hearing Report was issued by the District of Columbia Appleseed Center for Law and Justice

incorporating Exhibits A-C, a Covington & Burling LLP Legal Analysis Report, an actuarial risk management report titled, "Excess Surplus Assessment Report of GHMSI Position", and a Mathematica Policy, Incorporated Senior Fellow Research Statement.

Additional written materials have also been submitted to the Department. These parties have been listed on our witness list, and will testify as public witnesses here today.

So, next I will try to explain the general procedure for today's hearing. We'll commence each witness or witness panel with a swearing in of each witness. This will be conducted by a Hearing Officer, or by me. After each panel's presentation, the Department Staff and experts may pose questions to the witnesses. After all testimony has been heard, and all the Department's questions have been answered, we will proceed to the next panel, or witness as

listed on the witness list, or to other members of the public who have signed up here at the hearing today to testify.

There are witness cards located throughout the room, I believe to the rear to my left of the room. Please list your name, affiliation, if any, and deliver the card to our transcriber at the front of the room to my right. We will first hear from GHMSI and panel. The GHMSI Panel Members will have 90 minutes for the presentation of their testimony. We will then hear from the District of Columbia Appleseed Center for Law and Justice, which will have 20 minutes for the presentation of their testimony. Next, we'll hear from other interested parties, who also have 20 minutes, and other public witness will have a total of three minutes for the presentation of their testimonies.

I will call for a 20-minute break approximately halfway through today's proceedings. We will end at 5 p.m. today, and

we'll continue the hearing tomorrow morning beginning at 10 a.m. to hear any remaining witnesses, and the rebuttal testimony.

Once all the parties and public witnesses have been heard, and all the Department's questions have been answered, GHMSI will be permitted 30 minutes to deliver their final rebuttal statement, after which time these hearing proceedings will adjourn.

Please note that the Department will be producing a stenographic record of these proceedings, which will be a part of the official record of this hearing, so, as such, again, witnesses not listed on the witness list please fill out a card, and provide it to our court reporter. Witnesses, please speak into the microphone, and begin your testimony by giving your full name, affiliation, and title. All testimony should be addressed to this hearing body, should be relevant to the issues just outlined, and should not be of a personal nature.

In the interest of time, please be mindful of the time limits allotted for your testimony.

The official record in this matter will remain open until close of business on September 25th, 2009. Anyone wishing to submit written testimony or rebuttal statements may submit those in writing to the attention of Ms. Leslie Johnson, DISB Hearing Examiner, 810 1st Street, N.E., Washington, D.C. 20002, or by email to Leslie.Johnson@DC.gov.

Following the hearing, after a final review of all the relevant submissions, consideration of the entire record and application of the relevant laws and regulations, I will make a final determination as to whether GHMSI Surplus which is attributable to the District is excessive and unreasonably large. The final determination will be issued in writing no later than September 30th of 2009. If I determine that the surplus is excess and unreasonably large,

I will order GHMSI to submit a plan for my approval for dedication of the excess to Community Health Reinvestment pursuant to the statute.

So, again, welcome to this DISB Public Hearing this morning. Are there any preliminary matters that need addressing before we get started? Okay. And with that, we will commence.

I will call our first witnesses who are already seated, GHMSI. Good morning. If you could just, after being sworn in, identify those who are testifying on your behalf in what order, and then we will proceed. Thank you.

HEARING OFFICER: Would each of you raise your right hand to be sworn in, please.

WHEREUPON ,

CHET BURRELL, MARK CHANEY, ROBERT DOBSON, THOMAS CARLSON, DESMOND HOGAN

was called as a witness and, after having been

first duly sworn, was examined and testified as follows:

MR. BURRELL: I'll just introduce the speakers for GHMSI. I am Chet Burrell. I am the CEO of GHMSI. Speaking will be Robert Dobson. He is a principal with Milliman, and to his right, Tom Carlston, who is a Managing Director of Lewin. Others with me at the table to my immediate right are Mark Chaney, CFO of GHMSI and of Care First, Inc. And to my left, Des Hogan, a partner at the law firm of Hogan & Hartson.

Again, my name is Chet Burrell, and I am the CEO of both Care First and our affiliate in the District, Group Hospital and Medical Services, Inc., GHMSI. Together the companies serve 3.4 million members, approximately one million of whom are members of GHMSI. Of the GHMSI members, approximately 10 percent are residents of the District of Columbia. Nearly half live in Maryland, with the balance in Virginia, and out of area. In

total, Care First serves 45 percent of the insured population living in Maryland, Northern Virginia, and the District of Columbia region.

We are here today, as you know, to talk about GHMSI's surplus. The very word "surplus" means, or seems to imply extra, unneeded, or too much. Yet, in the insurance world, it is an essential requirement that represents amounts held for the protection of subscribers to assure that come what may, their claims will be paid.

Let me observe at the outset that we are not here today for a routine hearing that is part of a regular long-established process. We are here under a new law in the District called the Medical Insurance Empowerment Act, MIEAA of 2008, which requires the Commissioner, as the Commissioner has already said, to review a portion of GHMSI's surplus attributable to the District, and to determine if that surplus is excessive under

the act.

It is important to note that so far as we know, there are only two states in the country that actively seek to monitor the upper surplus limits of an insurer, and neither state's approach is even remotely comparable to the District's framework under MIEAA.

It is apparent that this hearing, indeed, the entire framework established by the MIEAA, is the culmination of nearly a decade of intense work on the part of D.C. Appleseed Center for Law and Justice, a Washington-based advocacy group. Appleseed has operated with a theory in mind that lies behind all of its arguments and efforts. To start, I would like to summarize this theory, since I believe it illuminates important background and context for the issues that come before you today.

It is Appleseed's view that GHMSI is a charitable and benevolent institution

that has, as its primary mission, service to the public to promote general health of the community. Indeed, Appleseed has said that GHMSI's assets belong to the public, that GHMSI exists to serve the public, and if GHMSI were a for-profit company, its profits and surpluses would benefit its shareholders, and that residents of GHMSI service area are the company shareholders. Appleseed argues that this entitles the public to the equivalent of dividends to be paid out of GHMSI's surplus. It calls these dividends Community Health Reinvestment.

These elements of Appleseed's theory find expression in its interpretation of the MIEAA. The Act seeks to impose an obligation on GHMSI to engage in Community Health Reinvestment to the maximum extent feasible consistent with financial soundness and efficiency. According to Appleseed, that means GHMSI must use its resources to promote the general public's health.

In the context of the MIEAA, the Appleseed theory holds that GHMSI should maintain a reserve consistent with financial soundness, but, Appleseed argues, this is a reserve that is well below where it presently is. It says that if the company fails to keep reserves to a absolute minimum, it is not doing what it can to the maximum extent feasible in meeting its obligations to the public.

There is a clear object, we believe, of the Appleseed theory, to cause GHMSI to expend as much of its reserves and resources as possible for the public benefit, and cause this to happen continuously. To put this in concrete terms, Appleseed has said that GHMSI should be able on a sustained basis to provide as much as $60-100 million per year for the public benefit. And Appleseed claims that GHMSI's current aggregate reserve level is excessive by hundreds of millions of dollars. These themes are central to the pre-

hearing reports filed by Appleseed a week or so ago.

Naturally, the idea that such sums might be available for District programs, which otherwise cannot be funded out of the District's budget, has caught the eye of some District officials. What government jurisdiction would not be attracted to the idea that such large sums could be raised without having to face the ire of the taxpayer, or could be obtained through an esoteric regulatory process few in the public follow. Further, who would rise to the defense of an insurance company, even if it is a local one, that sought to resist this idea?

This creates the real possibility of a dangerous perversion in the regulatory process. The desire to obtain the funds causes a strong incentive to deem GHMSI's surplus "excessive", and to demand a plan for its distribution to the general public. And the political incentives are especially

skewed, we believe, because the source of the funds is overwhelmingly from residents of other jurisdictions, not District residents, themselves. As noted earlier, District residents comprise only 10 percent of GHMSI's membership.

Nevertheless, we find ourselves here today to carry out the dictates of the MIEAA legislation that was crafted, we believe, to advance Appleseed's theory. So, let me start with the essential facts of the matter, and see if they fit the theory. Let me speak to GHMSI's Congressional Charter, what does it say, and whose money is it?

Among the things that make GHMSI unique, as has already been noted, is the fact that it is the only Blue Cross and Blue Shield plan established and governed by an enabling charter from the U.S. Congress. It is also the single-most important Blue plan in the operation and support of the Federal Employee Benefits program, a role of continuing great

interest to the Congress. This causes Congress to have a special concern with, among other things, the financial viability of GHMSI.

GHMSI's charter, established by an act of Congress in 1939, sets forth its mission in very succinct, clear terms. GHMSI, "Shall not be conducted for profit, but shall be conducted for the benefit of the certificate holders." And that, "GHMSI is authorized and empowered to enter into contracts with individuals or groups of individuals to provide for hospitalization and medical care of such individuals upon payment of specified rates or premiums, and to issue to such individuals appropriate certificates evidencing such contracts."

The charter, in other words, says GHMSI's mission is to provide healthcare coverage to subscribers, and that its duty is to those subscribers. It is as simple and direct as that. To assure the mission would

be carried out, the Congress placed the company under a Board of Trustees who would oversee the business of the company. And, to this day, 70 years later almost to the month, that is exactly the way the company operates.

To be sure, the charter goes on to say that the company, "Is hereby declared to be a charitable and benevolent institution, and all of its funds and property shall be exempt from taxation." But this charitable and benevolent language is all about tax status. At the time of its charter, the idea of health insurance was still novel, and the American Hospital Association had drafted model language to guide states who were in the process of setting up organizations like GHMSI.

It was widely believed that there was no commercial market in these services, but that they would do a lot of public good by covering people for hospitalization expenses, while insuring the viability of hospitals.

This justified their non-profit status and exemption from taxes; that is, the company's services to subscribers were seen to be of such value to society that by themselves, they justified the company's charitable and benevolent non-profit, non-taxable status. Congress drew this section of GHMSI's charter directly from the model act.

What Appleseed has done is take the language applicable to the tax status of the company to justify its view that the company has far broader, indeed, primary obligations to the public at-large. From this, in Appleseed's view, all else is derived, including its concerns with the size and the use of surplus.

It is noteworthy, if one reads the various reports issued by Appleseed over the years, including the ones prepared for this hearing, that the clear, Congressionally intended purpose of the company is rarely cited, or even referred to. It was only a few

years ago that the last round of hearings were held here in the District by then Commissioner Larry Mirel on these very issues.

Appleseed liberally refers to this in its pre-hearing report in support of its theory. However, Appleseed fails to mention the actual conclusion reached by Commissioner Mirel, or the accompanying opinion issued by then Attorney General, Robert Spagnoletti. I briefly summarize them here.

Commissioner Mirel wrote, "The Department finds that although GHMSI may meets its legal obligation to engage in charitable activity solely through the provision of health insurance in its service area, GHMSI has an additional responsibility to engage in charitable activities in the District of Columbia which advance the public health. The Department finds that it is the responsibility of the Board of Directors, in the first instance, to determine the amount of additional charitable contributions which will

be made, and the manner in which the contributions will be made."

Attorney General Spagnoletti in an opinion issued on March 4th, 2005, made a series of important statements. I refer to just a few here. "D.C. Appleseed fails to recognize that GHMSI can be faithful to its charitable and benevolent designation by operating its non-profit health plans for the purpose of promoting better public health. Indeed, by providing or improving non-profit health plan benefits for as many subscribers as possible, GHMSI can do much to promote better health in its service area. GHMSI may even choose to fulfill its charitable mission by devoting all of its resources, including profits and excess surplus to maximizing the quality, benefits, affordable, and accessibility of its health plans, while maintaining fiscal soundness. GHMSI may meet its obligation under its charter through the operation of non-profit health plans, even if

the only direct beneficiaries are the plan's past, current, and future paying subscribers. With hundreds of thousands of paying subscribers, and the potential to enroll hundreds of thousands more, GHMSI can have a broad and positive impact on the public health, if it conducts itself for the benefit of subscribers, as its charter requires."

None of the cases cited by D.C. Appleseed undermine the conclusions derived from General Charitable Trust Principles that GHMSI may fulfill its obligations as a charitable and benevolent institution through the provision of health plan services to paying subscribers, and that GHMSI has no obligation to divert the profits generated by its health plan services to other charitable activities.

In other words, this very agency, and the District's top law enforcement official adopted our understanding of the company's charter, and rejected Appleseed's

idea that GHMSI has a legal obligation to turn over its subscribers' premium payments to the public. They also make clear that GHMSI's Board of Trustees is authorized to make decisions on how much subscriber money should be diverted to the general public's needs, but these holdings do not fit the Appleseed theory, and, therefore, they were not mentioned in the pre-hearing report.

So, in plain language, we believe the surplus and reserves of the company are held for the protection and the benefit of subscribers, and that GHMSI Board must find a particular community need to be of such value and benefit that it justifies using subscriber funds for other than the subscribers' direct benefit. Indeed, the Board gives generously, but always with this in mind. Simply put, the funds held in reserve by GHMSI are for the benefit of the subscribers, not for the general public.

Appleseed turns this all on its

head, and states that the company has repeatedly violated its core obligation by doing the very thing charter commands it to do. And, in this regard, it is worth noting that the charter uses a command in the word "shall" in connection with serving subscribers, and never mentions a word about the general public.

Let's now turn to another way to look at it, and let's deal with the issue of affordability, which we believe is a crisis in the making for subscribers. As Commissioner Mirel and Attorney General Spagnoletti wrote in 2005, "It is up to the Board of Trustees to balance how much GHMSI can afford to invest in the community at-large, after meeting the needs of subscribers. In doing so, the most important consideration for the trustees, all of whom are residents of the community, is how affordable premiums are for paying subscribers. Stated another way, the central question the Trustees must address is, when

GHMSI gives a dollar to others, is this a burden our subscribers can bear, or is that dollar better spent more directly on their behalf? It would be a contorted reading of the charter to ask the question the other way around. What is the maximum extent that can be given to the public before considering the needs of the subscribers?"

Appleseed's and MIEAA's test for the limit of community health reinvestment is the financial soundness of the company, not the burden on the subscribers who contribute the money to make it financially sound. But, in our view, financial soundness must include the concept of affordability to the subscriber, not just consider whether the company can minimally cover its claims costs. Without this focus on subscribers, there is no real meaning in the command that the corporation shall be "conducted for the benefit of the certificate holders."

On this issue of affordability, a

full fledged crisis is emerging. Indeed, the unaffordability of health coverage has reached alarming levels. This was the essence of the President's message last night. The signs are everywhere. We live with this daily, and a few statistics clearly illustrate this.

D.C. mirrors national trends in that the number of small employers who offer health coverage is steadily declining, and is now at 60 percent, meaning 40 percent don't. So far in 2009, more than three-quarters of small employers who left Care First coverage, left because the cost of providing coverage was no longer affordable. Many just dropped the coverage all together, rather than going to a competitor.

Together, GHMSI and Care First provide coverage to the majority of employer groups in the region, which suggests that small and medium groups see the most value in the company's offerings. Yet, even these groups have found these offerings increasingly

unaffordable. More than half of the members in small groups who left GHMSI coverage did so because they lost their job, the highest since we started keeping such records.

Substantial numbers of these members go into the ranks of the uninsured because they cannot afford coverage. Premiums have been rising in lockstep with health care costs at an average rate of over 10 percent a year. At this rate, costs double every seven years. These costs are rising at three to five times the increase in family income in this region, and are consuming an ever-larger share of disposable income.

Small employers who are not dropping coverage, and this is significant, are moving with lightening speed to high deductible health plans as a way to lower costs for themselves, but in the process, shifting huge burdens onto employees and their dependents. From a position of nearly no market penetration for these plans in 2005,

now more than half of all small employer groups in Maryland are covered by these designs, with groups in the District rapidly following suit.

In addition to the cost shift caused by high deductible health plan designs, employers are steadily and more rapidly of late reducing the portion of premiums they pay for. This decline has reached the point where the portion of premium paid by small and medium employers is now at the 50 percent mark for the first time, an historic low. These are but some of the indicia of the emerging crisis in the health care, health insurance marketplace. It is even worse for individuals who have no employer to arrange and partially pay their premiums.

In response, Care First has re-doubled its efforts at cost containment, and has operated at extremely small operating and underwriting margins in its overall product portfolio, averaging a total bottom line for

underwriting of between 1 and 2 percent over the entire last decade, and a fraction of 1 percent last year. The company's Board of Trustees has laid out a plan to continue with these small margins over the foreseeable future, but the demographic forces pushing healthcare costs and usage higher are extremely powerful, and we see no sign of abatement.

Given these facts, it is well to remember where GHMSI's reserves come from. They come directly from individuals and small and medium group policy holders, and only from them. Large groups self-insure and typically contribute minimally to reserves. To ease the burden, GHMSI targets the earnings of its reserves for the benefit of individuals and small group premium payers in order to help moderate premium increases on their behalf. In effect, it seeks to target a dividend to them as a benefit to those who are most in need among its subscribers.

We know of no individual, or employer group that ever paid its premium thinking that the payments that they would make would be used for anything other than their benefit, particularly in these trying times. If we lose the battle for healthcare affordability among the working population, no government program can step in to fill the void. Keeping premiums as low as possible is the most essential good we can do for the general community, and is certainly the thing most sought after by our premium rate payers, particularly individuals and small groups. Indeed, it is the essential intent of our Congressional charter.

It is precisely these individuals and groups who will be most harmed if Appleseed's theory is put into practice. It is they who most built the company's reserves, and they who should benefit from them. In so doing, the whole economy of the region is helped, and the greater good is achieved.

If, on the other hand, a large portion of reserves is taken from subscribers, as if their needs were secondary to the general public's, they not only suffer a loss in the degree of their protection, but also an important source of rate moderation. In effect, Appleseed's logic is that others in the public, not subscribers, are the real targeted beneficiaries. We do not agree. The reserves of the company are held for the benefit of subscribers, not others among the public.

To put things in perspective, if $100 million were taken out of the reserve, this equates to about $300 per member for all individuals and small groups in the GHMSI service area.

I'd like to speak a little bit about community health reinvestment, and ask the question how much is enough? The facts on this question are telling. Let us start with the observation that the level of community

health reinvestment is possible only -- and that is possible at any point in time by a company such as GHMSI is directly affected by the premium tax policies of the various local jurisdictions in which GHMSI operates.

Much attention has been given by Appleseed to the Pennsylvania model, which very explicitly uses the concept of community health reinvestment with regard to Blue Cross and Blue Shield plans. However, Pennsylvania law allows a premium tax offset against any community health reinvestment obligation.

The Commonwealth has set community health reinvestment obligation at 1.6 percent of commercial premiums, and 1 percent of Medicare Advantage premiums, but allows a dollar-for-dollar offset for premium taxes paid. In effect, the Blues plans in the state pay the difference between these percentages, and what they pay in taxes into the community health reinvestment program. This is not a novel concept to the other jurisdictions in

which GHMSI does business.

Maryland law establishes a 2 percent premium tax, and then waives it to the degree that the plans, Care First of Maryland, Inc. and GHMSI, contribute to worthy community programs identified by the state. Virginia provides a partial premium tax offset for open enrollment program losses experienced by GHMSI in that state. Only the District of Columbia imposes premium tax at 2 percent of premium revenue with no offset for community giving. Who pays this tax? The answer is, only those who pay premiums, individuals, and small groups. This means that all giving by GHMSI in the District is in addition to this tax, and on the backs of premium payers.

So, to get an apples-to-apples comparison among the three jurisdictions GHMSI serves, one needs to add up three categories of payments, premium taxes, community giving, and subsidies, planned losses on open enrollment products. When all three are added

up for GHMSI, here is the bottom line. Approximately 3.3 percent of its total premium revenue is given over by GHMSI for these three purposes combined in the District, while this total is 2.3 percent in Virginia, and only 1.7 percent in Maryland. In dollar terms, GHMSI contributes $14 million to the District for these three purposes, while contributing $6.9 million to Maryland, and $10.3 million to Virginia, which account for substantially higher subscriber counts.

Expressed another way, of all the GHMSI expends for these three purposes in its service area, 45 percent goes to the District, despite the fact that it has only 10 percent of GHMSI's membership. The reverse is true for Maryland, which has 44 percent of GHMSI's membership, and receives 22 percent of all GHMSI payments for these three purposes combined.

This, however, is not the end of the story. The MIEAA contains an open

enrollment program requirement that would cause GHMSI to lose between $20-30 million annually in each of the next five years. And this is due to the fact that this open enrollment product would be required to be sold at well below cost. This provision is now temporarily suspended while GHMSI seeks to work out a public/private partnership with the District. But if it were to take effect, the portion of GHMSI's premium revenue that would go for the combination of District taxes giving in subsidies would rise to approximately 7.5 percent of premium income, and consumer nearly two-thirds of all GHMSI contributions for these purposes among the three jurisdictions. This is a level that is at least triple the level of all of the surrounding jurisdictions.

From our members' perspective, this would mean adding approximately $100 a month to the average monthly family premium of $1,800, just for the difference between the 2

percent average of the other two jurisdictions, and the 7.5 percent in the District.

The City Council has deliberately left the open enrollment provision in the MIEAA as an assurance that GHMSI would be more inclined to a favorable, from their perspective, outcome in the negotiations on the public/private partnership. GHMSI has been explicitly informed by the City Council that the MIEAA open enrollment requirement will be a feature in any permanent legislation going forward for this purpose.

It should be noted that while more modest in comparison, the proposed public/private partnership would still cause the combined total of GHMSI contributions for taxes, giving, and subsidies to be in the 5.5 percent range, or approximately 50 percent of all GHMSI payments for these purposes in these three jurisdictions. This level is well more than double the rate of surrounding

jurisdictions, and would cause GHMSI's spending for these three purposes to exceed $23 million annually.

I would ask a disinterested observer, is this too little in the way of community health reinvestment on GHMSI's part? Compare these percentages to what GHMSI seeks to put away in reserves for its subscribers each year, an average of 1-2 percent annually. How much is enough?

To further put these numbers in perspective, we researched other jurisdictions around the country. Only a handful, most notably those in neighboring jurisdictions, even require or measure community giving, and the combined burden is usually 2 percent or less after tax offset, as is the case in Pennsylvania.

The District is a distinct anomaly in this regard, substantially higher than any other jurisdiction we could find, and heading sharply to higher levels yet. Further, since

these burdens are borne only by GHMSI's premium payers, no other insurer operating in the District has this mandated burden. They force up rates to cover the cost. This includes rates paid by the 90 percent of members who reside in Maryland and Virginia, or elsewhere. Hence, the interest of these other jurisdictions in this proceeding, and what its outcome will be.

If Appleseed gets its way, and the theory were to prevail, meaning that GHMSI is ordered to pay out a portion of its reserves to the public, then a taking of reserves will have occurred in addition to the 5 to 7 percent annual contribution that GHMSI makes for taxes, subsidies, and giving. And there will be harm to premium payers.

Further, the means to moderate future premiums through earnings on our reserves will be sharply reduced. There could scarcely be worse news for premium payers if that should come to pass. In a broader sense,

there could scarcely be a more discouraging message to the business community in the District and the region at a time of deep and prolonged financial and economic distress. And all of this is occurring before the outlines, contours, and demands of Federal Health Reform are known. It appears likely, especially based on what the President said last night, that these reforms will place additional taxes and fees on insurers, further adding to the burden on subscribers.

Just one other further perspective on GHMSI's reserves. In its reports of July 31st and August 31st to the Commissioner, GHMSI presented how it determines overall reserve levels, and how it believes the requirement of MIEAA to attribute a portion of the reserves should be carried out. There is no need to repeat those key points here. But we wish it understood that we have carefully reviewed the statements made regarding GHMSI's reserves by Appleseed, ARM, and Mathematica, and find them

replete with error, mischaracterization, and misunderstanding. Just a few examples are offered now to point this out. Milliman will speak to this further in its testimony in a more complete listing in a separate submission that will be made following this hearing.

With regard to the statements made about the RBC ranges used in Pennsylvania, it is not fair or correct to say, as the Appleseed family of reports do, that the Commonwealth approved RBC ranges that are far below GHMSI's current range. The Pennsylvania legislature adopted ranges for a different purposes, and did, indeed, assign a lower range to the largest plan in the state. However, for the plan that is most like GHMSI in size, Capital Blue Cross and Blue Shield, it approved a range that is virtually identical to the range GHMSI currently uses on the advice of Milliman. Nor among a long list of criticisms of Milliman's work is it fair or

correct to say that the Milliman report excluded FEP, and administrative services lines of business that have low-risk profile, and investment income. It did not. This is flat wrong.

The ARM reports that GHMSI surplus was reduced by a large amount due to a large increased in non-admitted assets, implying that without this the company would have much larger reserves. As a matter of fact, the change had no impact on surplus, and was agreed to by GHMSI's external auditors, and by the DISB in their separate audit of GHMSI's financial filings.

The combined criticisms of the Milliman report are virtually all unfounded, and we, and they, intend to respond to this on a point by point basis. We do not wish to let stand the misleading impression that Appleseed's reports seek to create; namely, that there is no creditable basis for the range Milliman developed. The Lewin Group's

review came to essentially the same conclusion as Milliman, using a different analytical approach.

Lewin, it should be noted, was the advisory to the Pennsylvania General Assembly's Legislative Budget and Finance Committee in reviewing the surplus levels and company benefit activities of the four Blues plans, including a review of the Pennsylvania Insurance Department's order, which established surplus ranges for the Blue plans. Additionally, as a Lewin representative will tell you, Lewin has served as an advisor to the District on a variety of health-related issues.

It is also worth emphasizing that the mandate to the Commissioner under the MIEAA is not ultimately to judge whether GHMSI's total reserves are excessive, or unreasonably large, but just that portion of the reserves attributable to the District. We reiterate our position that it is the

residents of the other jurisdictions who mostly built GHMSI's reserves by incurring over time less in claims where they live, than what they paid in premiums. The portion left to the District is essentially proportionate to the share of the District's portion of total membership.

So, in conclusion, we believe that the facts do not fit Appleseed's theory; yet, the theory has shaped much of the perception, and, unfortunately, the law in the District. GHMSI, by command of its Congressional charter, exists to serve its subscribers. It best fulfills this command to conduct its business for their benefit by offering the best possible value to its subscribers. To succeed in this purpose, which, at its heart, means providing affordable access to healthcare for subscribers is to serve the whole community well. We believe no other interpretation of the charter can be made, nor do we believe that District law can modify, or

override the mandate in the charter.

GHMSI subscribers are struggling greatly to pay premiums that are escalating faster than their incomes, and their ability to pay for them. This is made worse by the shift of cost to them by the advent of high deductible health plans, and lower contributions from employers, who find themselves struggling to offer coverage at all. Our subscribers are the working backbone of the community, of the District, and of the larger region.

If Appleseed's approach is adopted, and premiums are driven up still further, more and more of our subscribers will be unable to afford their premium payments. This does no one any good, and no local government program will be able to offset the harm that results. The reserves that GHMSI maintains are in a range that is appropriate for a plan of its size and characteristics. The Pennsylvania approach validates this.

The company, by its own policy, and track record, has never exceeded this range, nor even risen above the midpoint of the range. And the company's subscribers already bear a community health reinvestment obligation that is, by far, the highest in the nation. And that under any foreseeable scenario will increase, given actions pending with the City Council. Certainly, this burden is already far higher than the neighboring jurisdictions GHMSI serves, and far higher than that imposed in Pennsylvania, the jurisdiction held up by Appleseed as a model.

GHMSI has never sought a confrontation over these issues raised by Appleseed's theory, nor does it now. It believes that the opinions rendered four years ago by both the Commissioner and the Attorney General were essentially on the mark, and the company has acted in accordance with this belief. But according to what theory, and in what context will the requirements of MIEAA

now be carried out?

We seek an interpretation of the MIEAA that is consistent with our charter, one that recognizes that by doing right by our subscribers, we do right by the whole community. We intend to continue our community giving, which has consistently exceeded all other non-profit organizations combined on a regional basis, but we wish to do so under the guidance and oversight of our Board of Trustees, as charged by Congress, not have community giving determined by a District-only regulatory process.

We believe the company holds no excess in its reserves, particularly with regard to any portion that is attributable to the District. And any order to GHMSI by the Commissioner to expend any portion of its reserves to other than subscribers is nothing more than a government taking of subscriber money for District purposes. Worse, it is a taking of subscriber money from neighboring

jurisdictions. So, our view, in closing, can be stated simply as follows.

If any legitimate excess is ever found on a different set of facts than those present here, it can mean only one thing, that subscribers were overcharged, and are due a return of excess. It does not mean that they should have their funds taken based on a theory not supported by the charter, or the facts. In such a circumstance, the only remedy the company can and would pursue is to do what its charter commands, to return the excess to its subscribers.

We hope the MIEAA will be implemented in a way that allows us to carry out the central command of our charter, and we are deeply concerned with the regional consequences, if this is not to be the case.

Commissioner Purcell, we recognize and respect your new responsibilities to reach a decision on these critical issues in a few weeks time, but for the sake of all involved,

mostly for our subscribers, including those in other jurisdictions, we urge you to take care in your decision, and we stand ready to offer any assistance you may need in doing so.

In this connection, we strongly suggest that you coordinate your review and decision on the surplus with the Insurance Commissioner of Maryland, who is currently engaged in an in-depth review of GHMSI's surplus. Thank you very much.

COMMISSIONER PURCELL: Thank you.

MR. BURRELL: Okay. With that, I would like to turn it over to Robert Dobson from Milliman.

MR. DOBSON: Is that fine?

COMMISSIONER PURCELL: That's fine.

MR. DOBSON: Okay. Hello. My name is Bob Dobson. I'm a Consulting Actuary with Milliman, and I'm here at the request of our client, Care First. I'm one of the authors of several Milliman reports for Group

Hospitalization and Medical Services, Inc., or GHMSI, a Blue Cross and Blue Shield licensee that is an affiliate of Care First, Inc., and is domiciled in the District of Columbia.

Three of these studies are the subject of my comments today, and I will refer to these three as the 2005 Optimal Surplus Study, the 2008 Optimal Surplus Study, and the Attribution Study, which was just completed in 2009.

COMMISSIONER BARLOW: Excuse me, Mr. Dobson. I'm sorry. Do we have copies of your testimony? Are there copies available? I don't think we have them up here.

COMMISSIONER PURCELL: Just pause the time for one moment, please.

COMMISSIONER BARLOW: You don't have one?

COMMISSIONER PURCELL: Do you have prepared written testimony for the rest of the panel, as well? Okay. Thank you.

MR. DOBSON: Shall I continue?

COMMISSIONER PURCELL: You may continue.

MR. DOBSON: Thank you. Although the reports and these studies are lengthy and highly technical, the results can be summarized very simply. In the 2005 Optimal Surplus Study, Milliman recommended that GHMSI, which I refer to sometimes as the Plan, operate with surplus which was simply the difference between assets and liabilities in a range of 800-1,100 percent of authorized control level risk-based capital, or RBC, for short.

In the 2008 Optimal Surplus Study, based on changes to GHMSI's risk profile between the two studies, we recommended that the plan operate with surplus in the range of 750-1,050 percent of RBC. In the Attribution Study, we opined that a reasonable way to allocate surplus, based on our understanding of the legislation that requires attribution, is residency of the subscribers. The

calculations resulting from this approach were actually quite involved, but the end result is that some 11.6 percent of GHMSI's surplus would be considered attributable to the District of Columbia.

Note that the legislation, as has been said, requires the D.C. Insurance Commissioner to review the portion of GHMSI's surplus that is attributable to the District, and to determine whether the surplus is excessive.

The reports related to Optimal Surplus Studies recommend ranges of surplus measured by a percentage of RBC. RBC is the measuring stick we use, but the ultimate issue relates to the actual surplus of GHMSI, which, as I mentioned, is simply the difference between assets and liabilities.

Before providing a brief description of the approach that we followed, I'd like to address the claim by D.C. Appleseed, and others, that our model is a

black box. Our modeling involves a highly technical process involving a significant degree of detail, which reflects the complexity of the financial operations of an organization such as GHMSI.

It's not a process that can be readily described in a report of the type that we prepared for GHMSI. Nevertheless, we have prepared detailed documentation of all assumptions, methods, formulas, and resolves, and have subjected the process to rigorous review among Milliman consultants. We also have taken this detailed documentation and presented it to the consultants working with the Maryland Insurance Administration, or the MIA, and the District of Columbia Department of Insurance, Security, and Banking, DISB during on-site meetings at our offices.

During these meetings, we described our processes in detail, provided copies of documentation, and responded to questions. In addition, we provided follow-up

information, as requested. The details of the description that I am going to outline have been addressed in our documentation, and our discussion with these consultants.

Our approach to the Optimal Surplus Studies involves the identification and evaluation of major risk that GHMSI faces now, and into the future. We considered seven major risk categories, as follows. First, rating adequacy and fluctuation. That means the risk that actual claims and expenses differ from the assumptions made in setting the premium rates. This is the most significant of the risks, but the others are important, as well.

The second is the unpaid claim liabilities, and other estimates, which considers the risk that the reported liabilities, which were estimates subject to uncertainty, do not make adequate provision for unpaid claims, and other items.

Third, interest rate, and

portfolio asset value fluctuations involving risks associated with the investment portfolio, and the implications for reported surplus levels.

Four, overhead expense recovery risk. This one reflects the implications of a decrease in business, and the inability to cover overhead in the short term before adequate adjustments to the operation can be made.

Other business risks, number five, such as the potential for default among large administrative services, or ASC groups, leaving GHMSI to pay claims with no premium collection for the group.

Six, catastrophic events, such as epidemics and pandemics, natural or public health disaster, terrorist attacks. And, seven, provision for unidentified development and growth. This reflects the possibility of unanticipated investment needs, such as new systems, or administrative processes,

development of new products, or response to legislation.

For each of these categories, all of which reflect potential cost, it could reduce GHMSI's surplus. We developed a distribution of potential outcomes, both favorable, and unfavorable, where applicable. To evaluate the financial implications of these possible outcomes, we used an automated process to simulate the tens of millions of possible combinations of all these different assumptions produced by our distributions. To accomplish this, we employ a simulation methodology that's commonly applied in financial modeling.

Based on these simulations, we identified the levels of cumulative, multi-year losses that represent the 90th, 95th, and 98th percentile, respectively, of all possible losses. Again, this is looking forward. The 90th percentile, for example, means that 90 percent of the simulated losses are at or

below that level. These identified loss amounts were used to develop surplus targets that meet our criteria, and I'll describe those criteria now.

The first one is that we wanted to provide a very high likelihood that the overall surplus level for GHMSI will remain above the Blue Cross/Blue Shield Association early warning monitoring threshold of 375 percent of RBC. This would be even after a particularly adverse period of multi-year operating losses, underwriting losses, and/or capital market losses. In order to meet this goal, the surplus target must be high enough to cover 90-95 percent of all the projected loss cycles without allowing the surplus level to drop below the early warning monitoring threshold, the 375 percent.

And then, second, and also very important, we're going to assure with virtual certainty that surplus will remain above the PCBSA loss of trademark threshold of 200

percent of RBC, even if a severely adverse period of multi-year losses were experienced. In order to meet this goal, the surplus target must be sufficiently higher to cover 98 percent of all projected loss cycles, without allowing the surplus level to drop below the loss of trademark threshold.

We also analyzed historical underwriting loss cycles for GHMSI in a comparison set of Blue Cross/Blue Shield plans. We did not use these historical results directly in our analysis, though. Rather, we used them to evaluate the reasonableness of the cycle losses developed through the simulation process that I just described.

Based on a comparison, we found that the historical loss cycles were materially greater in severity than those produced by our simulations. From this, we concluded that our simulated loss cycles were reasonable, considering the recent changes in

health plan loss patterns and operating environment.

In order to carry out our surplus modeling, we developed an initialized pro forma projection model, which is based on GHMSI's own internal financial forecasting. This model reflects the overall financial characteristics of the company's operation, including the profits generated by the Federal Employee program, the treatment of AFC business, and the investment income generated by surplus, and other funds.

We then developed the surplus target range by effectively stress testing the selected loss cycles against a range of surplus thresholds. This allows us to assess the surplus levels that are necessary to withstand the cycle losses.

Let me emphasize that the reports and these studies say a lot more than this, and a thorough reading of each of them is necessary to understand them. I'm not going

to attempt to summarize the major points of these studies, because it would impossible to do them justice in the allotted time. Each of these reports, of course, is available to the public, and I will, of course, be happy to respond to questions related to the reports, either following this testimony, or following the hearing.

These assignments for Care First and GHMSI are very important to me, personally, and to Milliman. I want to make it clear that we don't take our responsibilities to the Board of Trustees of GHMSI, and, ultimately, GHMSI subscribers, the public, and the regulators, lightly. Our work on all three of these studies involved many hours of detailed financial analysis, interviewing all levels of management, and asking many probing questions. All of our work was thoroughly peer reviewed. This is a long-established practice at Milliman, resulting in more products that involve at

least two fully qualified professionals.

In the case of the 2008 Optimal Surplus Study, five fully qualified professionals were involved. Every assumption, formula, and conclusion was discussed, understood, and agreed upon by a minimum of two of these consultants, and in many cases as many as four. We at Milliman are proud of the work that we've done on these assignments, and we stand solidly behind our work.

I'll give you more background on myself, and on Milliman in a minute, but first I want to mention a group that I chaired way back in the late `70s, and early `80s, showing my age here, and this was a Technical Advisory Committee to the NAIC, the National Association of Insurance Commissioners, on the subject of Loss Reserves and Contingency Reserves, or Surplus for Hospital and Medical Service Corporations. That includes Blue Cross and Blue Shield plans, similar entities,

and HMOs, or health maintenance organizations. This, of course, was well before risk-based capital was implemented.

The first conclusion from our report that was presented to and adopted by the NAIC read, in part, "The nature and magnitude of the risk will vary for each corporation, but the risk must be recognized, and provision must always be made to minimize the ultimate risk of financial failure. One of themes was that no rule of thumb level for appropriate surplus could be developed. Rather, the specific characteristics of each entity must be studied and evaluated, and an appropriate range of surplus developed." This is what we still believe in how we approached our work for GHMSI, and for the other entities for which we provide consulting services.

Many Blue Cross and Blue Shield plans have encountered financial difficulty over the years, including GHMSI. While only one Blue Cross/Blue Shield plan has ever gone

all the way to bankruptcy, many HMOs, and similar organizations have. I've been involved in efforts to resolve many of these situations, and many of them I've studied after-the-fact.

When a corporation of this type goes bankrupt, the consequences are dire. Real people suffer, subscribers, doctors, hospital employees, business owners, and others all lose money, coverage, or access to treatment. In fact, I don't think it's an overstatement to say that the public at-large is disadvantaged when that happens.

I've actually sat in courtrooms and galleries with galleries of subscribers, and providers waiting to hear a judge declare how the limited proceeds from bankruptcy will be distributed. I've sat with Insurance Commissioners while they agonized over a decision among many undesirable alternatives to deal with a potential insolvency. I've observed first-hand that there are many worse

problems to have than a financially stable Blue Cross and Blue Shield plan.

I'll now give you some background on myself, not Milliman. I'm a graduate of MIT and fully accredited actuary holding professional designations of Federal August Society of Actuaries, member of the American Academy of Actuaries. I first joined Milliman, which was then known as Milliman and Robertson, in 1973. I've been a consulting actuary ever since, with the exception of three years that I spent in the early 1980s serving as Chief Financial Officer of Blue Cross and Blue Shield of Alabama.

In addition to chairing the NAIC Advisory Committee that I mentioned earlier, I've served as President of two actuarial organizations, and as a Vice President of the American Academy of Actuaries. I also served on a Technical Advisory Group on Medicare, and was a member of a Blue Ribbon Panel on Solvency for the American Academy of

Actuaries. I've been involved in regulatory issues for many years, and consulted for at least 12 different State Insurance Departments over the years, as well as the NAIC.

In addition, and in particular relevance to my understanding of the operating environment of GHMSI, I've served as a consulting actuary for the Blue Cross/Blue Shield Association and Federal Employee program for over 15 years now. Prior to that, I was one of the principal authors of a comprehensive study of the Federal Employees Health Benefits program. That study was performed directly for the United States Office of Personnel Management. So, that's a quick description of my background and qualifications.

Milliman has some 200 fully qualified health actuaries, many with equally strong or stronger credentials than mine, in a variety of sub-specialties. In fact, one of my partners led the group that developed the

formulas and factors currently used by the NAIC for health-based risk capital calculations. Founded in 1947 by Wendel Milliman, the firm just announced the opening of our 50th office worldwide in San Juan, Puerto Rico. Milliman has over 1,100 qualified consultants and actuaries in all specialties. We're independent, and we're beholding to no outside ownership or shareholders. The firm is owned by 300 principals, each of whom is actively employed with the firm.

We believe that this ownership and our financial structure allow us to attract and retain the best talent there is. I think it's safe to say that we are recognized in the healthcare industry as a premier actuarial firm. Our opinions are our own, and they're formed on the basis of absolute integrity.

We work for the majority of Blue Cross and Blue Shield plans, and other health insurance companies, and perform numerous

surplus evaluations, in addition to advising companies on surplus-related issues. We have an outstanding reputation that we strive diligently to protect.

I want to close by saying a few words about the criticisms that have been directed at Milliman, primarily by D.C. Appleseed, and the actuaries and Actuarial Risk Management, or ARM. Many, if not all of the assertions made are simply wrong, whether our of lack of understanding, or otherwise. Here are some examples of the errors, misunderstandings, and mischaracterizations contained in the report.

First, it's not true that we exclude gains from the Federal Employee program, or investment income on surplus, and other funds. These items are directly reflected in our analysis as an offset to potential underwriting losses on non-FEB business.

Second, we do not directly use the

prior loss cycle experience. The loss cycle assumptions that we used are substantially lower than the historical cycles, as demonstrated in tables on page 51 of the report on the 2008 Optimal Surplus Study. If we had used the prior loss cycles, our cumulative loss scenarios would have been higher, resulting in higher target surplus levels.

Three, we can demonstrate that our premium growth assumptions are consistent with past experience. It appears to us that in citing a 7 to 8 percent growth rate, ARM may have failed to consider the premium growth of Care First, Blue Choice, GHMSI's jointly owned subsidiary. ARM states that Milliman most likely used a four-year loss period, and criticizes our use of four, rather than three years. In fact, we used both three and four-year loss periods. But, in Milliman's methodology, the four-year loss period actually produces a smaller surplus

requirement than the three-year period, because cumulative loss in the projection is the same prior to pricing margins, whereas, there is one additional year of margin to offset that loss.

Five, we tested the use of an 8 percent growth rate with a three-year loss period, which ARM estimates would reduce the surplus target ranges by 22.5 to 26 percent. We found that these assumptions would not change the lower end of our range. In any event, we stand by our assumption, and do not believe that 7 to 8 percent is a reasonable growth rate assumption.

Six, Appleseed and ARM characterize the Blue Cross/Blue Shield Association, or BCBSA, early warning monitoring level of 375 percent RBC as nothing more than some additional reporting requirements, implying that its inclusion of the key measurement of financial soundness by Milliman is inappropriate. Their position is

overly simplistic representation of the insurance marketplace sensitivity to having coverage with a financially strong company, especially given the events of the past year. Furthermore, they underestimate the responsibility that BCBSA has to all Blue plans to aggressively protect the value of one of the most respected and recognized brands in the nation.

Seven, Appleseed mischaracterizes the conclusions of the Pennsylvania Insurance Commissioner with regard to the analysis carried out by Milliman. Appleseed claims that the Pennsylvania Commissioner, "rejected Milliman's methodology." That simply is not so. Rather, the Pennsylvania Commissioner merely disagreed with a few of the assumptions Milliman used, out of many. Appleseed has quoted quotes from the Pennsylvania report out of context, to improperly suggest that this constituted a wholesale rejection.

The Pennsylvania Commissioner did

disagree with Milliman over whether to account for low probability, high loss events like terrorist attacks. She concluded that it was not appropriate to do so, because, "They are most efficiently prepared for through a combination of government, industry-wide, societal, and individual company-specific initiatives." We respectfully question that conclusion.

Where appropriate, other assumptions that were questioned by the Commissioner in Pennsylvania have been dealt with through refinements to our methodology, as applied in the 2008 GHMSI Optimal Surplus Study.

Milliman intends to vigorously defend our work. We stand behind it. We will provide further detail in the post-hearing submission process. Although I've been involved in many adversarial proceedings over the years, I must say that the attacks leveled against us in this case are the most

unfounded, and unprofessional that I've seen in my 40-year career.

Questions about our work are certainly welcome, but uninformed allegations presented as fact do a disservice to the Commissioner, the District Council, GHMSI subscribers, and the citizens of the District, as this important, but complex matter is considered. Thank you for your time and attention, and I'll be happy to respond to any questions at the appropriate time.

COMMISSIONER PURCELL: Thank you.

MR. CARLSON: Hi, my name is Tom Carlson. I'm an FSA and an NMA, and I work for the Lewin Group.

The Lewin Group, Lewin is a member -- is a premier national health and human services consulting firm, which has delivered objective analysis, and strategic counsel to public agencies, non-profit organizations, and private companies across the United States since 1970. The value we place on accuracy,

independence, and objectivity is reflected in the trust our clients place in the Lewin Group.

As a subsidiary of Ingenix, and its parent, UnitedHealth Group, the Lewin Group safeguards its integrity by maintaining separate business and technical practices, while operating under editorial independence. We have delivered objective analysis and insight to 39 states, and the District of Columbia on issues related to Medicaid, health insurance coverage, health reform, long-term care, and other related issues. We also have extensive experience working with private payers, and federal agencies, including the Centers for Medicare and Medicaid Services, CMS, the Department of Defense, DOD, on a wide range of health and human services priorities.

Finally, we have conducted projects on behalf of the District of Columbia, or D.C., such as our work in assisting the D.C. Department of Health on

D.C. Alliance, which is a public program aimed at providing insurance coverage for D.C. residents not qualifying for Medicaid.

We have several other projects currently underway in the District that are assisting both private and public organizations in improving children's access to healthcare, and education.

With regard to the issue at hand, Lewin has extensive experience in evaluating, and analyzing insurance surplus. We assisted the Pennsylvania General Assemblies Legislative Finance and Budget Committee in reviewing the surplus levels and community benefit activities of the four Blue Cross/Blue Shield plans operating in Pennsylvania.

This assessment included a review of the determination and order issued by the Pennsylvania Insurance Department, which implemented target surplus ranges for the BCBS plans operating in that state.

We have worked on behalf of the

Insurance Commissioners in Rhode Island and Washington to assist and provide expert guidance in evaluating options for regulating surplus. We've also worked on behalf of several private health plans, primarily, Blue Cross/Blue Shield plans, which have required our assistance in either addressing the regulator concerns about surplus, or in establishing internal surplus targets. Our experience working for both regulators, and insurers, provides us with a unique perspective on how to evaluate surplus, as well as public policy options for regulating surplus.

I am here to explain Lewin's findings regarding some questions that GHMSI asked us to comment us, as well as comment on treatment of surplus limits in other states, and conclusions from the work we did for the Commonwealth of Pennsylvania. Before diving in, it is important to define both surplus, and risk-based capital, or RBC.

Surplus is generally defined as an insurer's retained earnings, or funds on hand to protect the company and its customers against adverse business conditions, and to support investment needs. Since surplus amounts do not provide perspective on a health plan's risk profile and organizational structure, state regulator commonly use RBC to assess an insurer's level of risk.

RBC is a measure generally used by regulators to establish the minimal amount of capital appropriate for a health plan to support its overall business operations during a period of adverse conditions. In D.C, if RBC drops below 200 percent, an insurer is required to present a plan to the D.C. DISB for improving its surplus. Blue Cross/Blue Shield plans have similar, but more stringent, RBC requirements imposed by the Blue Cross/Blue Shield Association. The Association requirements generally call for a licensee to maintain an RBC ratio of at least

375 percent as a threshold below which additional reporting and monitoring with regard to surplus levels is required.

The 375 percent level to maintain good standing within the Blue Cross/Blue Shield Association, is important to keep the trust and confidence of employers and subscribers who place a premium on the financial stability of their vendors and insurers.

The Lewin Group's findings regarding GHMSI. I will now discuss Lewin's findings regarding Care First's D.C. affiliate, GHMSI. Lewin was retained by Care First to perform an independent assessment of the RBC suggested by Milliman for GHMSI. Lewin produced a report with findings in response to three key questions. Those key questions are, question one, is the approach used and the range of RBC set forth by the Milliman Report appropriate? Number two, is RBC an appropriate mechanism for assessing

upper limits of insurer's surplus? And, three, is the concept of attributing excess surplus to a geographic area reasonable?

To answer these questions, Lewin relied on several sources of information to conduct this assessment. First, we relied on our experience in having conducted similar analyses on behalf of states and other health insurers. Second, we used statutory financial statements as the basis for much of our review of GHMSI's financial condition. Finally, we used publicly available reports and documents, such as Milliman's December 4, 2008 report to Care First executives, and the documents publicly available on the D.C. Department of Insurance, Securities, and Banking website.

We did not perform extensive modeling, or GHMSI-specific research for this analysis, but we did carefully review Milliman's report, and we did independent testing with our own models and tools to verify that Milliman's outputs were within

reasonable range.

Our findings from our review are as follows. First, our review of the development of surplus targets set forth by the Milliman Report suggests that the approach and range of potential targets developed is generally reasonable based on our understanding of their model, and our consideration of their assumptions, as discussed in their report.

We have several models that we might apply, exercises such as loss cycle model can produce a range of answers based on input assumptions, and output parameters. Therefore, our answers may differ as to the precise RBC percentages recommended. However, the model Milliman applied is consistent with an approach that we would consider. The outcomes do not differ significantly from those we might expect, and the choice of probability for sufficiency among potential outcomes seems appropriate. Specifically, the

90 to 95 percent confidence that surplus would not go below the 375 percent RBC levels, and the 98 percent confidence that surplus would not go below the 200 percent RBC levels.

Here, I would like to make a comment on our experience with Milliman. As actuaries and consultants, we often encounter Milliman both as a competitor, and a colleague in our client engagements. It is our experience that Milliman always maintains its professionalism and technical competence, and as a firm, it is highly respected in the actuarial arena, as Bob just discussed. Their tools and models are well known and respected throughout the industry, in our experience. We were very taken aback by the unprofessional nature of some of the commentary filed by others.

Second, the RBC calculation was never designed to regulate the upper limit of insurer surplus. RBC calculations should be applied as an element in determining minimum

regulatory solvency consistent with the purpose for which they were developed. In recent years, regulators and insurers alike have used RBC beyond its original intent. Insurers want to provide an adequate margin of safety, so that the company can endure periods of adverse experience, without triggering any form of regulatory intervention, while maintaining operational vitality, and the ability to nimbly respond to unfolding market conditions.

Many insurers, including GHMSI, use RBC as one tool by which that margin of safety can be measured. However, the use of RBC as a regulatory mechanism is much more controversial, as it can lead to several unintended consequences within the marketplace, which we will discuss later in our testimony.

Third, the attribution of any excess surplus to a geographic area is not a straightforward, or easily determined outcome.

Regarding other states' actions, I now will discuss other states' actions. Two states currently enforce upper limits on the amount of surplus Blue Cross/Blue Shield companies can hold, while two other states have recently repealed surplus limits. Minnesota repealed its surplus cap in 2005, when it enacted NAIC's Model Health RBC Act. Hawaii repealed its cap, which applied to all non-profit insurers several years ago. The two states that currently enforce upper limits on surplus are Pennsylvania, and Michigan. I'll discuss Pennsylvania in more detail later.

Michigan, the other state, passed a law in 2003 that stipulates that the Blue Cross/Blue Shield insurer operating in that state shall not maintain an RBC ratio greater than 1,000 percent. A few other states have considered action to set upper surplus limits. Three to four years ago, several states, including Rhode Island, Washington, Minnesota, North Carolina, and New Jersey considered

action to either limit the accumulation of surplus, or force the plans to draw down on surplus levels. There were two common themes that led to this interest.

First, each state has a Blue Cross/Blue Shield plan, and those Blues plans started seeing large increases in their earnings. Second, the economy softened at the same time that healthcare costs swelled. This increased the numbers of uninsured, and made it harder for those having insurance to afford it. Some stakeholders argued that the Blue Cross/Blue Shield plans in each state should give up portions of their surpluses to help make health coverage more affordable. However, in each instance, these states elected not to set upper limits on insurers surplus levels. In some instances, changes in the underwriting cycle limited future surplus levels, and as the surplus levels declined, other matters became more pressing. In other instances, such as Rhode Island, the Insurance

Commissioner has been using more traditional mechanisms for managing insurer surplus, such as denying premium rate increases.

Another reason often cited for not placing limits on surplus is the potential for market disruption. When a regulation limits the amount of surplus that a company can hold with a potential of losing their surplus, they likely will respond by lowering premium rates temporarily to get rid of the excess. The resulting lower premiums would likely harm other carriers in the market, and discourage new carriers from entering the market. If limits were followed by a prolonged decline in underwriting profit, the solvency of the company may also be threatened, which would impact the ability of providers in the market to be reimbursed for services, as well as disrupt the subscribers of the health plan.

Most recently, in addition to the focus on GHMSI's surplus, we have seen renewed interest in insurer surplus in a few states,

including Massachusetts and Washington. This new focus is not surprising, given the state budgetary shortfalls, as well as the current economic crisis. However, much of this recent scrutiny is on insuring the solvency of health insurers, and the affordability of healthcare to subscribers, rather than setting maximum levels on surplus.

The Pennsylvania background. As previously mentioned, Pennsylvania is one of the two states that actively set limits on surplus accumulation. Lewin was engaged by Pennsylvania's Legislative Budget and Finance Committee to examine options and alternatives available to the Commonwealth with respect to the regulation, oversight, and disposition of reserves and surpluses of health insurers.

Lewin's report focuses on other states' surplus regulation, the capping of surplus, determining an optimal amount of surplus, and action needed regarding Pennsylvania Blue plans' surplus.

In February 2005, the Pennsylvania Insurance Department defined acceptable ranges for the Blue plans' level of surplus capital, giving a lower range of 550 to 750 percent of RBC for the largest two plans. Those are Independence and High Mark, and giving a higher range of 750 to 950 for the two smaller plans, Capital Blue Cross, and Blue Cross of Northeastern Pennsylvania.

None of the plans were above the range. However, three of the plans were deemed as having sufficient capital, which precluded these three plans from including risk and contingency factors in future rate requests. In other words, the plan's moderated rate increases to their subscribers in light of their healthy reserve levels.

The Commonwealth also executed an agreement on community health reinvestment with the four Blue plans, setting forth a program by which the Blues pledged somewhat more than 1 percent of their premium revenues

to community benefits for the years 2005 to 2010.

Making a high level comparison of the Pennsylvania Blue plans with GHMSI, we observed that Capital Blue Cross, CBC, is the most similar to GHMSI with respect to premium and enrollment. Of course, there are a number of additional risk factors and individual market considerations that should be considered when comparing surplus needs, but GHMSI is a similar-sized plan in terms of premium and enrollment, and they are currently within the Pennsylvania recommended surplus range for Capital Blue Cross in Pennsylvania.

Lewin's Pennsylvania analysis concluded that the Commissioner's ruling set reasonable bounds on the Blue plans' accumulation of surplus. We found that it is not likely that the ruling will disrupt the Pennsylvania insurance market, as the process set forth for managing surplus offers both the Blues and the Commissioner sufficient latitude

to act prudently.

The upper limits on surplus that the Commissioner chose, again, it's 950 for Blue Cross of Northeastern Pennsylvania and Capital Blue Cross, and 750 for High Mark and Independence Blue Cross, will slow premium growth somewhat, because no risk contingencies are allowed, but not trigger large premium reductions that might have disrupted the competitive landscape.

For Blue plans found to have sufficient reserves, the Department will not approve premium rates which include any risk and contingency factors. This policy change should have the effect of slowing premium growth, while still assuring a reasonably competitive market.

The Commonwealth's surplus limits also reflect the fact that less diversified plans experience more volatility with respect to their annual profits and losses, and, therefore, holding a higher reserve is

appropriate.

Furthermore, we found that it would be unproductive to require a Blue plan to return surplus to customers due to potential market disruption, which I discussed above. Prudent accumulation of surplus within reasonable limits, plus long-term rate stabilization for customers, is both sound business strategy for Blues, and good public policy.

Our quantitative analysis suggests that the surpluses of the four Pennsylvania Blue plans could be justified in order to maintain a high degree of confidence that they could withstand an extended period of adverse underwriting experience.

In summary, Milliman's approach and range seem reasonable. RBC is not an appropriate mechanism for assessing upper limits of insurer's surplus, and attributing surplus to a specific geographic region is not a straightforward process.

In closing, we appreciate the opportunity to provide testimony to you today on this issue, and look forward to any questions you may have on our report, or on our experience working on this important issue with other states.

COMMISSIONER PURCELL: Thank you. Does the conclude the prepared testimony? Thank you. I'm going to start with you, Mr. Burrell.

You stated in your testimony that in your opinion, GHMSI's charter mission is to provide healthcare coverage to its subscribers, and that your duty is to those subscribers. I think you said it was simple, and it wasn't as direct as that.

In light of the media, however, how do you, and the mandate, specifically, to engage in community health reinvestment, how do you reconcile that new obligation, or that continuing obligation in some people's mind?

MR. BURRELL: Well, I think the

thought we would have on that is that the -- as I said in my testimony, the Board of the company, the Board of Trustees, has to weigh how much it gives to the community to a variety of worthy causes, and there are many, versus how those dollars otherwise could have been spent for the benefit of the subscribers. And in doing so, they have to weigh the affordability of coverage, and the access to care that subscribers, themselves, have.

As a matter of record, the level of giving of the company in the community has been rising. And over the last 20 months since I have been CEO, has been rising steadily, but it was rising before I got to the company. And, so, the company has done substantial, and intends to continue to do, substantial community giving. A lot of it is for universities, for low-income people who are otherwise unable to afford coverage, and for what we call catalytic giving, which is fostering, or sponsoring approaches that in

the long-term help, or encourage the control of healthcare costs.

COMMISSIONER PURCELL: Can you tell me about the Board Mission and Oversight Committee, how they function, what their role is?

MR. BURRELL: Yes. There is a committee of the Board composed of representatives of both GHMSI and CFMI, and there is a dedicated staff that reviews a series of funding requests. We get hundreds of funding requests in any given year.

The perspective that is brought by the Board Committee is to look at those kinds of community health reinvestments that would likely have the greatest beneficial impact on the community. So, we have developed, or they have developed a, what we call our giving triangle. And where the bulk of the giving is, is on the base of the triangle. That base is, essentially, mostly oriented towards, or completely oriented towards subsidies for low-

income people who would otherwise not have access, or subsidies on premiums that make healthcare more affordable. This is true in Maryland, this is true in the District.

And the second biggest area of giving is on catalytic types of changes in the system. So, for example, we sponsored a electronic connection between academic center, medical, intensive care units with community-based hospitals. We enabled that to happen. The idea was that the real specialists on a lot of cases for ICU cases are best in the academic centers, and a lot of the community hospitals didn't have these capabilities. By connecting them electronically, enabling the experts in the academic center to see what was going on in the ICU that we could get better care outcomes, and that, hopefully, what this would also do is improve costs results. I just use this as an example.

COMMISSIONER PURCELL: Right.

MR. BURRELL: We sponsored that in

the hope that this would help improve the healthcare system over a long period of time. It wasn't specific to our subscribers. It was generic to the healthcare system, as a whole. So, what the Board Committee does, is it looks at funding requests, or can initiate funding for projects that are consistent with these general parameters.

COMMISSIONER PURCELL: Is there a budget determined by the Committee, or a -

MR. BURRELL: There is in the Financial -- yes. In the financial plan of the company, and by that I mean the entire regional company, CFI, the parent.

COMMISSIONER PURCELL: Right. So, this is something that's set out at the beginning of each budget year, or fiscal year?

MR. BURRELL: It is, actually, yes. So, the -- as I say, the giving levels have gone up. Our target for 2009 is $46 million in the region, and we are on pace to do $46 million worth of community giving.

Each year, obviously, is looked at as part of the overall budget cycle as to what is the appropriate number. If I remember correctly from last year, it was more in the $40 million range, and prior to that, in the 30 something million range, so it has been climbing.

COMMISSIONER PURCELL: So, do you feel that by virtue of this Board, and the services that they provide, and I assume there's a workflow where decisions are arrived, and they sort of describe those decisions. Is there anyone at the executive level sitting on this Board, or is it -- Committee, rather?

MR. BURRELL: The Committee is only -- that can make the decision is only Board members.

COMMISSIONER PURCELL: Okay.

MR. BURRELL: However, the Committee -- I go to every single Committee meeting.

COMMISSIONER PURCELL: Okay.

MR. BURRELL: And our Senior Vice President for Community Affairs, Maria Tilden, does, as well, and Staff that support the Committee. So, what is done is a fairly extensive process of preparation goes on before the Committee is asked to make a decision.

COMMISSIONER PURCELL: So, in your opinion, Mr. Burrell, do you feel that the Board has developed a clear enough framework to support its charitable mission?

MR. BURRELL: I actually believe that the Board has developed a very clear framework that has guided its giving. What we didn't want to do, and I think what the Board didn't want to do is take what one would consider to be dear subscriber money, and not know what focus would have best impact for the general community. Where can you have the biggest effect, positive effect?

COMMISSIONER PURCELL: But why such loud and consistent criticism then of

your level of investment in the community?

MR. BURRELL: I think -- my own perception, and I have been with the company 20 months, and one of the reasons, I might add, that I came to the company, perhaps the principal reason I did, was by being attracted to its mission, and, particularly, to its not-for-profit mission. Could it have a positive effect in the community? I believed it could, and should, and that if I were ever the CEO, I would be dedicated to that proposition.

My perception is that the experiences of the company going back to the failed well point attempt, and perhaps prior to that, linger on, and color the opinions of people, in some cases, key decision makers, about what the company is all about, and do not adequately take into account the degree to which the company has actually changed, and the seriousness with which the company takes its mission.

I know every Board member

personally, but I specifically know very well the Board members that are on the Mission Oversight Committee, and I know that they all take it very, very seriously.

COMMISSIONER PURCELL: How would you, in your own words, characterize GHMSI's duty to the residents that purchase the products?

MR. BURRELL: That purchase our products?

COMMISSIONER PURCELL: That's right.

MR. BURRELL: Which means our insurance plans.

COMMISSIONER PURCELL: Your insurance plans.

MR. BURRELL: Yes.

COMMISSIONER PURCELL: Correct.

MR. BURRELL: That is our principal duty, and the whole goal of the company is to give them the highest possible value, which, essentially, means broad and

affordable coverage with the broadest possible access to network providers, and the strongest possible service when they do get ill. I have said to our own management team, our whole philosophy would be -- mine, all the way down through the company is that when you need us most, we are most there for you.

COMMISSIONER PURCELL: Let's talk about surplus for a minute. In general terms, can you explain the need for surplus at a Board level, as determined by the Board of Directors?

MR. BURRELL: Yes. The surplus level of the company, or the reserves of the company are really there, as has been said already, for, principally, the protection of the subscribers, but it's also the only source of working capital the company has. And it's there to take into account, and assure that the company is there to pay the bills.

COMMISSIONER PURCELL: Other than to address regulatory issues, has the Board

ever formally sought to determine an appropriate level of surplus for GHMSI?

MR. BURRELL: Yes, they have. This has been a major area of attention for the Board, and to that end, they have developed, and adopted, and approved a formal policy on reserves, and the whole essence of which I can capsulize very briefly, which is that the Board seeks to have the company hold an optimal level of reserves, a reserve range that is considered to be neither too much, nor too little. And that if it appeared to the Board that by increasing rates the company were to build surplus that was heading towards the upper end of that range, or even outside of that range, it would moderate or not make rate filings. It would bring down the reserve first.

If, on the other hand, the company were to drop below the reserve range that was optimal, then it would take another approach, which is to gradually, as gradually as is

possible, increase premiums to get it back into the range, and only into the range, not above the range.

As a matter of fact, the company has operated at the midpoint or less of the range that has been established since I've been with the company, and for basically the entire last decade. So, the problem I think the Board faces, and these are very dedicated community people, is how does one know enough to establish what the optimal range is?

In the case of our Board, they did not want to, and Mark is our Chief Financial Officer, say that they would determine that level simply by what the management said. We have actuaries on our staff, simply by what those actuaries said. And it wasn't so much that they were questioning the competency of those actuaries, as to say rather that because of the complexity of it, that it was wise to get the best possible advice you could get externally.

We believe that the one with the best reputation in this field, and the one that is most creditable and established in this field, independent of us, they do believe this, is Milliman. So, they retained Milliman, and they asked Milliman, given all the risks that the company faces, and all of its needs, and the possibilities of unforeseen events, and so on, what would you say to us is the optimum range we should have? And Milliman came back first in 2005, they were asked to come back again in 2008, and they did tell the Board what the range out to be, and they told the Board what the reasons for that range ought to be.

The Board then had to consider all that in light of the circumstances of the company, and what they wound up doing was formally adopting that range. What they thought they did, and this is very important, is they thought that it would guide two things. It would guide what the rate increase

requests or not would be of the company, because they never wanted the company to build up too much surplus, or, on the other side, it would gradually give them guidance as to how much they ought to increase rates, as moderately as possible. And it would also guide them on how much community health reinvestment to make. So, when I say that the Board adopted a plan in 2009, that the company would give $46 million, it was done in the context of well, where is the company's reserve? Is it high, or low against an optimal range? And by paying that, what would it do to the company's reserve position? The goal being -- frankly, there is the range, but the company has stayed within the bottom half of that range consistently. To my knowledge, there is no one on the Board that is in the least interested in having the company even go to the upper half of the range, or certainly outside of the range.

COMMISSIONER PURCELL: But there

is an understanding, or an opinion that you can do more, and that the surplus that is there, even though it's based on your actuarial models certified by Milliman, a very reputable firm, and can be justified, as we saw in your reports, that still the excess -- there is an excess there. There is a large amount of surplus that is, perhaps, not needed.

MR. BURRELL: Well, I think the perspective we would bring to that, and I think the way the Board thinks of it is, if one were to define excess as above the regulatory minimums, indeed, there is excess in that sense. Nobody wants to be at the minimum.

COMMISSIONER PURCELL: Right.

MR. BURRELL: That is not the place to be.

COMMISSIONER PURCELL: Right. And I think that's understood. We know what RBC is there for, and anything over RBC -

mR. BURRELL: Right. So, then the question becomes how much above that do you really think you need to be?

COMMISSIONER PURCELL: Right. And how much above that do you really think you need to be?

MR. BURRELL: Well, the bottom line for that came down to getting expert outside advice, and to get it repeatedly, and to get it with a second opinion, in this case with Lewin. And to be so advised. That's part of the Board's fiduciary obligation, and responsibility, not to invent the number themselves.

COMMISSIONER PURCELL: So, the surplus is there. That's agreed. To whom does this GHMSI surplus belong?

MR. BURRELL: We believe that as long as the company is an ongoing operating company, those funds are held for the benefit of the subscribers. And as I tried to say in my testimony, and I think this is a difficult

thing for anyone to say when there are funds available, is it the subscribers that should benefit who paid in, or is it the community that should benefit?

COMMISSIONER PURCELL: And your opinion on that is?

MR. BURRELL: And then it's really a challenge as to how does one strike the right balance. That's not an easy thing to do under any circumstance, and it's constantly shifting. In the last 10 years, GHMSI RBC levels have gone up and down 50 percent based on the fortunes of the market, and the trends in the medical field, and so on, so that they try, the Board tries to balance this as best they can with outside expert advice. But my basic answer is, these monies have been paid in by subscribers. They expect, particularly -- and the whole point about affordability, expect that with costs rising the way they are, that the funds will be used to help them, and the way we read the charter is that that's

what Congress, in fact, intended.

COMMISSIONER PURCELL: so, what are some of the ways that you've used the funds to help your subscribers?

MR. BURRELL: By keeping rates as low as possible, and by -- basically, that, and by providing other services to subscribers that help moderate trends, that induce wise use of access of healthcare services, and that support subscribers with the best possible service.

COMMISSIONER PURCELL: What other types of services?

MR. BURRELL: And then there are community services. And, as I say, $46 million has been budgeted for that, and will be spent this year.

COMMISSIONER PURCELL: Now, a portion of that $46 million is the premium tax that is paid by GHMSI. Correct?

MR. BURRELL: No, that is just $46 million in giving.

COMMISSIONER PURCELL: In giving, so that's not considering -

mR. BURRELL: It doesn't count tax.

COMMISSIONER PURCELL: Okay.

MR. BURRELL: Tax is on top of that.

COMMISSIONER PURCELL: Okay. Does the need for additional surplus, or to keep your surplus at the rate that your actuaries have suggested keep the premium rates high, or higher?

MR. BURRELL: Well, I think the answer to that is very direct, and very obvious. We want premium rates that cover costs. We're non-profit. We are not in this to make a profit. For-profit insurance companies typically run profit ranges of 6 to 10 percent. In the last decade, we have averaged a percent to 2 percent. We operate on extremely skinny margins. In fact, I often say to people, if you ever ran a multi-billion

dollar company on which you take 100 percent risk, and the best you could hope for was a 1 percent margin, you would think you would be ill-advised. But that's what we do.

In the last year, our operating margin, our net bottom line from underwriting was two-tenths of 1 percent. This year, we think it will be something, perhaps, 1 or less, we're not finished with the year yet. We're worried, just as an example, as anybody would be, that would be, I guess in my position, or the management's position, that with the advent and the worry about the flu season, I'll just take that as one example. If that were to have some much as a 1 percent impact, and who is to say what impact it will have, but if it were that, it could hit the company's bottom line $50 million. So, the company tends to operate with extremely thin margins, and anything that it earns on those margins, any money that is actually retained, where does that go? It goes into the reserve.

And whose benefit is that for? For the policy holders, or for the community, as the Board decides what the giving level should be in light, first, of what the subscribers needs are.

COMMISSIONER PURCELL: And does your description of policy holders or subscribers include future subscribers, or future policy holders at all?

MR. BURRELL: Current subscribers.

COMMISSIONER PURCELL: Only current subscribers.

MR. BURRELL: Only current subscribers, because anybody that is not a current subscriber is in the public.

COMMISSIONER PURCELL: And a community member.

MR. BURRELL: And a member of the community, and we do give to the community. But the -- when you ask about who is a subscriber, it is somebody that is covered by a policy of our's that is paying premium.

COMMISSIONER PURCELL: So, you distinguish between your duty, and your -- the giving side of what GHMSI does, because you give to the community, and through these various means that you just described, but you restrict your duty to only your current subscribers.

MR. BURRELL: I don't know that it's -- no, I'm not trying to convey that.

COMMISSIONER PURCELL: Okay.

MR. BURRELL: I'm trying to convey a balance.

COMMISSIONER PURCELL: Okay.

MR. BURRELL: The right balance. That's all. And I am saying that the command in the charter is clear in one sentence, Thou shalt exist to serve your certificate holders. It's not a maybe, it's not discretionary, it's a command.

COMMISSIONER PURCELL: Right. But there's also the MIEAA Act, which exists, and which is law, and which is -

mR. BURRELL: And then there's the MIEAA Act. And, in principle, as a concept, we agree. And that's what we think we do. And we think that's what the Board's responsibility really is.

COMMISSIONER PURCELL: As a concept, you agree to the community reinvestment mandate?

MR. BURRELL: As a larger community role.

COMMISSIONER PURCELL: Okay.

MR. BURRELL: But I would also say, and, again, in the context of balance, that if - and this was what we -- the reason I put the quotes in from the prior Commissioner Mirel, and from the Attorney General in 2005, if we best carry out the goal of giving high value to our subscribers since we cover millions of people, that has a huge benefit to the general community, as a community. It also has a huge benefit to the economy of the region, and helps small

employers and medium-sized employers make ends meet. It has a huge value by itself. And, as I say, the tradeoff then is, do you put your complete emphasis there, because that has huge value, or do you balance that somehow with other giving to the community? That's what the Mission Oversight Committee does, that's what the Board does, that's why they set a plan this year to do $46 million in giving. And, basically, what they're saying is, we deem that that's the right level, given the needs of our subscribers.

What's particularly worrisome in the affordability equation here in this region, but this is true, this is what the President spoke to last night, is that the costs are rising so rapidly in healthcare that it's disenfranchising. It's cutting people off from access to healthcare, and the statistics I cited are all from this region. If you sit where we sit, and hear the demands of employers, and the worries of employers,

and watch them move to high deductible health plans, and try to cut their expense down, you begin to get really worried about what the affordability is.

COMMISSIONER PURCELL: So, this worry of affordability, and the crisis, I think you described in your testimony, does that not cycle back around, in your opinion, to GHMSI? Yes, you provide health insurance, you provide coverage for subscribers at a discounted rate, an affordable product, in your opinion, so that in light of the way healthcare costs have risen, and continue to rise, and in light of what's on the forefront federally, which we don't know, but, certainly, there's uncertainty there, isn't there a circling back that then greets itself in your community mission, and your charitable obligation, that then requires you to reinvest, just as the word that's used in the statute, to then reinvest in the community? And how do you -- what is your opinion on

that, and how do you think that you fulfill that, if you agree?

MR. BURRELL: Well, again, I think it's all a matter of balance. If I could, or we could know that by investing in a certain way, we could cause subscriber premiums to be 1, 2, 5 percent less by doing certain things, and I include not in that list cutting them off from benefits, but things that would actually productively restrain the rise in healthcare costs, on the one hand, and know what those investments would look like, and on the other hand, say let's give to worthy causes in the community, this, on lowering the trend in healthcare costs may be, probably is the single-most important thing we could do. Because without doing it, we think that in a few years time, it becomes flat out unaffordable for everyone. And I would put this in concrete terms, $1,800 family premium in the District of Columbia right now, our most common product for a family of four.

If healthcare costs keep going up 10 percent a year, in seven years that number will double. Who affords $3,600 a year, a month? Who? And what degree of cost shift will have occurred at that stage? And what small employer group is going to pay that premium, or 60 percent of that premium? And what individual subscriber will pay a $10,000 deductible, if we see the rise of deductibles continuing the way they are? So, the concern we have is that that's the fundamental challenge.

We view our role not simply as a passive insurer, but as a proactive force to try to deal with that situation.

COMMISSIONER PURCELL: And what are some of the ways that you've dealt with them?

MR. BURRELL: There are many ways, and there -- and, unfortunately, for us, as a society, there is no single way, but let me give you some examples.

COMMISSIONER PURCELL: Please.

MR. BURRELL: We are actively developing, and will soon roll out, this requires regulator approval, your approval, what I would call a healthy choice product line. What ways could you induce people to -- encourage them to live healthier lifestyles? We know there is a rise of chronic disease. We know there is a rise of diabetes, and obesity, lack of fitness, poor diet. What ways could individuals be induced to live healthier lifestyles? And then when they do get sick, are there better ways to have their care coordinated, not necessarily by us, but by providers who are in networks that we contract with.

Today, as you've heard so often in the public press, everything is oriented around a fee for service system of payment. We're looking at ways that we could provide incentives to providers to better coordinate care, develop care plans for people that have

incipient high risk for future disease. It's the connection of the provider contracting strategy with the way the benefits are designed, with the way that they are all administered, which requires more sophisticated data systems, all of that knit together, explained, supported, serviced, and convincing employers that they ought to go in that direction. That's our challenge. That is the core of what we see as our challenge. And that takes investment. That's probably investment on an order that we have not seen before, and I'm not speaking just for ourselves. And when you ask about how does that compare with community health reinvestment, I'm telling you that that is a very difficult judgment to make, because this side on investment, dealing with the bending of the cost curve, is very substantial. So, that's what the Board has to weigh. And that decision, and that framework is weighed virtually at every meeting, and certainly on

an annual basis, as each annual plan is approved by the Board with the level of giving to the community involved.

COMMISSIONER PURCELL: What does maximum feasible consistent with financial soundness and efficiency mean to you?

MR. BURRELL: It means to me that it is not simply financially feasible for the company out of its reserves to pay its claims. What it means is, that the people who actually build the reserve are finding the products that we offer affordable. That, to me, is the ultimate test. And if the company cannot make its products affordable, then -- especially, a company like this, that is so prevalent in the community, then the community really suffers. And that, to me, is the ultimate test, is a test of affordability. And then if you can meet that test, which is extremely difficult, and we, as a society, are not meeting it, and I would say "we" as a company are not meeting it, what is it that's left for

the general community?

COMMISSIONER PURCELL: But, to me, that term is indicating something that's required of the company, not required of the -- none in the sense of the subscribers, so maximum feasible -- it's calling for an amount, or for a level, in my opinion, that phrase, maximum feasible consistent with financial soundness and efficiency. So, that's a sort of a self-imposed, if you will, analysis that you have to do, and then come up with an amount. I mean, I'm not asking you to come up with an amount, but I'm asking you for maybe a summary of what it means to the company, maximum feasible, you said affordability for the subscriber, but -

mR. BURRELL: I think we've already stated our view, or I've stated mine.

COMMISSIONER PURCELL: Okay.

MR. BURRELL: And we, as a company have stated it, which is, essentially, the company ought to operate within an optimal

range of reserve, not a minimum, and not an excess. In order to do that, it ought to get the best advice it can, and it ought to have used that range to have guided what it's premium increase or changes ought to be.

Now, having said that, then the question becomes a challenge of how do you design the products and services that make healthcare more affordable, and more accessible to the general public of the area, or to the subscribers, the present subscribers that we have, 3.4 million people in the region as a whole. And that is the essential challenge of the company, and we think that's what the charter had in mind. And I think that's our answer.

COMMISSIONER BARLOW: I have a couple of questions from your testimony, and then I may get into some more general questions.

MR. BURRELL: Sure.

COMMISSIONER BARLOW: On page 2 of

your testimony kind of in the middle of the paragraph that starts with "naturally," it kind of seems like you're saying that your community reinvestment would be a substitute for government spending. Is that what you -- am I reading that correctly, and is that the way you interpret it?

MR. BURRELL: I think what we meant to convey is if the thought exists that by finding excess a very large amount of money can be, in effect, demanded out of the company, presumably to be used for good purposes in the community, but at the direction ultimately of the government, does it, in effect, serve as a supplemental budget? Doe sit affect fund programs that in this case the District itself could not fund?

And when you're talking about the money that we're talking about, 60 to $100 million or whatever it is, it's pretty tempting.

And so is there an incentive to

find excess in order to actually get the money? And that's what I was addressing.

That's a very different situation if the money goes back to the policy holders as their money.

COMMISSIONER BARLOW: Okay, but in the law, I believe, if it were determined that there was an excess, you would present us a plan on how to utilize that. That could be done through --

MR. BURRELL: Yes.

COMMISSIONER BARLOW: I mean, we wouldn't direct how that's given. You could decide that.

MR. BURRELL: Well, you have the power to approve, and we would take the view, as I did in my testimony that if any excess were actually legitimately found, it would in our view must go back to the subscribers, and the question is how would that be done, and that's what a plan would entail, but not in effect be taken from subscribers. And I think

that's what we're trying to give voice to.

COMMISSIONER BARLOW: Okay. On page 7 of your testimony you talk about the community health reinvestment obligation from Pennsylvania, and then you talk about the similar kind of thing from Maryland where it seems like those jurisdictions are directing you to make a certain amount of charitable contributions, but those contributions are based on premium volume rather than surplus.

Can you explain the difference in those two things?

MR. BURRELL: Well, I think that in the case of take our neighboring jurisdiction, Maryland, there's an in lieu of situation there. To the extent that we give to a variety of worthy causes in the community, we do not pay tax, premium tax, up to two percent.

So the premium tax is a two percent tax, two percent of premium income, premium revenue, dollar for dollar offset. So

that if we give to various causes in the community, the state does identify certain ones of those. We do give to those causes and give more, I might add, but we do give to those.

Then there's a dollar-for-dollar offset against the tax liability. The company has always given at or higher than what the tax liability is. If we were not to give up to the full tax extent, liability, then presumably we would pay some difference in the form of a tax, the rest of what was due on the premium tax. But we always have given at or above the tax level.

So it's an in lieu of situation. Community health reinvestment in Pennsylvania is largely the same thing. It sets a 1.6 percent giving level for commercial business and a one percent level of premium for Medicare business, and then it allows a dollar-for-dollar offset for tax obligations in that state.

The thing I was trying to make clear in my testimony was that in the District there is no offset. It's two percent tax, and then any giving is on top of that, and that's presumably government saying, "We think we know better what to do with the premium revenue, and we will take that two percent and use it."

And so there is no in lieu of in the District. Any giving is on top, and then there are two forms of giving in our view. One form is giving to worthy causes, which we do, and the other is subsidies, known, deliberate losses on certain products that are geared -- like open enrollment products -- that are geared towards people who otherwise couldn't get coverage, which is the whole essence of what the President was trying to say last night, except he wasn't saying it to be on just one company, but we do run those loses.

COMMISSIONER BARLOW: Right. I

understand that, but what I don't understand, there is a requirement from Maryland that you give two percent premium to charitable contributions or you pay premium tax. So theirs is a requirement based on premium. Ours determines a requirement based on surplus.

I mean, other than the thing that's used to determine the amount, is there a difference?

MR. BURRELL: I don't think there is a requirement to give in Maryland. I think there's a tax in Maryland, and if you give, that tax is abated in lieu of, and I think that's a key distinction.

COMMISSIONER BARLOW: Okay, and then on page 9 of your testimony you talk about how if there was a community reinvestment, it would force up rates for all subscribers of GHMSI regardless of jurisdiction.

Could you explain that to me?

Because it seems like it would only need to drive up rates if your intent was to restore the surplus to the level that it was prior to the community reinvestment.

MR. BURRELL: Well, in certain sense, that's true if you go back to what I said. The company seeks to operate within an optimal range, not below an optimal range. It doesn't seek to be put in the position of every year its surplus goes down below an optimal range.

I think our board feels that that would not be the proper fulfillment of their responsibility is to allow such a thing to happen.

So you want to stay within the optimal range. If you want to stay within the optimal range and you have to pay premium tax plus losses, you know, defined losses and subsidies, plus giving, that total burden is what has to be built into premiums which escalates premiums in order to keep the

company in the optimal range.

And as I say, we've always stayed within the lower end of that range. We don't really seek to be in the upper end of that range or certainly over the range.

COMMISSIONER PURCELL: And so what level in that optimal range developed by Milliman will the company stop building surplus?

MR. BURRELL: We were at 845 percent RBC in 2008. We're projecting we will be at 825 this year. This is a projection. We don't seek to build it beyond that. We just want to stay within that lower end of the range.

And then the question becomes what rates do you need to do that. What are the minimal rates that get you there? That's the only question that I think we grapple with.

There's no aspiration to build that higher, no need to build it higher as long as you are in the optimal range, even if

you're at the lower end of the range.

COMMISSIONER BARLOW: Okay. Did GHMSI make any changes as a result of the 2005 hearing chaired by Commissioner Mirel?

MR. BURRELL: I think what the company did was very deliberately and very consciously put a process together. This is when the Mission Oversight Committed of the board was established. This is when a real focus was made on community health reinvestment, if you want to use those, you know, words. This is when the ideas for catalytic giving and other giving, you know, began to get more focused, and this is when there was more of a deliberate planning process to actually give more, which has happened, I might add, in every single year since 2005.

Six was higher than five. Seven was higher than six. Eight was higher than seven, and nine is higher than eight.

COMMISSIONER BARLOW: Okay. I had

a couple of questions to just get a better understanding of the Blue Cross/Blue Shield 375 percent requirement.

MR. BURRELL: Yes, yes.

COMMISSIONER BARLOW: Could you explain what happens --

MR. BURRELL: Yes.

COMMISSIONER BARLOW: -- at the various levels of the Blue Cross/Blue Shield?

And also, I guess I kind of understand there's the 375 level and the 200 level. Is there anything else as part of that?

MR. BURRELL: Yes, there is, yeah. Well, I think the best way to understand that is that -- and I think the starting point here is that the Blue Cross/Blue Shield association from which we get the name and the mark by license believe, I think, correctly that the public, when they see the Blue Cross and Blue Shield logos, believes that it is completely safe and is a Good Housekeeping seal of

approval. It means that the company is very solid.

And people, particularly small employers, but even large ones and certainly individual, buy on the basis of the belief in the solidity of the company. It's what the name and the mark have become synonymous with, among other things.

So the licensor, in this case the association, is very, very concerned, and I would say increasingly vigilant and tough about what reserve levels plans ought to have and how they ought to conduct themselves.

And so there are really two other levels. Obviously there's the minimum regulatory level of 200. No one would ever aspire to get anywhere near that. Then there's 375, which is not simply a reporting level. It is the beginning of intense monitoring by the association ultimately under threat that if you cannot operate as a solid licensee, you could have those license marks

removed.

And so it's not just simply monitoring. They demand plans. They begin to send in teams to work with the plan, to say, well, what is your corrective action.

There's a higher level, which is 500, which begins to make them sit up and take notice. We report to them. They monitor very carefully what it is our surplus levels are, this because a number of plans around the country have from time to time run into difficulty. They want to minimize that so that the name remains synonymous with the security that comes with Blue Cross and Blue Shield.

And so they are increasingly vigilant. I sit on the Blue Cross/Blue Shield board of directors. I sit on the committee that oversees plans when they get in trouble, and there's always somebody in trouble, and right now there are plans that are in trouble and not meeting the requirements, and I know

how difficult it is for those plans because the association is very tough on it.

So it's not simply here's a casual reporting level. It's treated with the utmost seriousness by the association. Our stock and trade in many ways is the Blue Cross and Blue Shield logo and name, and we wish ourselves to preserve its value.

COMMISSIONER BARLOW: What sources are available to increase the surplus of GHMSI should that be necessary?

MR. BURRELL: We have only one source and a second that derives from it. The only source for us is from the premiums that our subscribers pay, and as I said, we typically produce an operating margin of one percent or one to two. That is the only source.

And the other source that it's a derivative of that is income on the assets that are invested on behalf of the subscribers. So instead of paying dividends

to stockholders or paying it to anybody else, anything that we earn goes into our reserve. Our reserve is invested, and it is invested extremely conservatively.

All of the earnings of that go to the benefit of the subscribers, and so there's only two sources. One is from the subscribers, the difference between premiums and expense claims mostly, and the other is earnings on those assets.

Other organizations, particularly for profit organizations, may have other lines of business that produces profits for them. They may have technology companies or other for-profit companies that they own or control that can generate or other lines of business that can generate other sources of income. We don't.

So for us it's a one product kind of company with one source for gain.

MR. TOOLE: I have a couple follow-up questions on that. First of all, in

the Milliman report, there were three lines of business that were modeled that contributed to surplus.

MR. BURRELL: Right.

MR. TOOLE: So I perceive you to be diversified.

Second of all, in terms of access to capital --

MR. BURRELL: Can I respond to that for a minute?

MR. TOOLE: Sure.

MR. BURRELL: The three principal lines that we have are all health lines. Okay? I mean, it's just different forms of insurance risk for the same thing. They are the small and individual, small groups and individuals on which we take 100 percent risk, and by the way, that's where the bulk of this comes from, the reserve, to serve them, from them.

The second is administrative services only contracts with large employers

who themselves take the risk but hire us to do the servicing. That often has either minimal gain on it or it's operating at break even or sometimes even at a loss.

And then there's FEP, the federal employee program on which that's a risk premium, but they largely hold their own reserves, and the opportunity in FEP is largely on how well we service that contract. We can get an award to service that contract well. Administratively I'm talking about, and we have typically gotten those awards, including this year.

But in the scheme of the total picture, it is not material.

MR. TOOLE: But I'm concerned to hear that these large groups may be operating at a loss, which takes surplus from your other --

MR. BURRELL: It depends on the nature of the group. You know, our goal is not to run a loss on those, but group to group

it can vary.

MR. TOOLE: Okay. Talk to me about access. Well, first of all, the intercompany agreement between your --

MR. BURRELL: Yes.

MR. TOOLE: And I know that Mr. Chaney has some insight on that as well.

MR. BURRELL: Well, there is an intercompany agreement between CFMI, the Maryland company, and GHMSI and vice versa, and basically when the companies affiliated, they thought there would be, they sought to get benefits out of the affiliation, and one of the benefits was that each could back each other up.

So if one ran into trouble the other was there for them, and so the nature of that intercompany is essentially as backup if needed. It's a source, a source we haven't drawn on and don't want to draw on, but it is there as a backup.

Use of it raises all kinds of

interesting issues because if Maryland money is backing up D.C. money, Maryland subscribers have a material interest in that, and so one looks at that as a matter of last resort, and it has not been used, and we would hope it wouldn't be, but it's there for the protection of the larger whole.

MR. TOOLE: And also the question of surplus notes as a capital --

MR. BURRELL: That's a more technical question.

MR. CHANEY: Yeah, the typical access to capital is limited when you're trying to just add surplus, and obviously going and getting a bank loan doesn't do you any good because you had an asset, you had a liability, and then they all said there's no addition to surplus.

The one mechanism that does exist is surplus notes, and the largest example of that is when GHMSI got into financial difficulties and had to borrow $60 million

from other Blues plans. The price that comes with is extremely high.

The board turned over and a number of out of state people had to be placed on the board from other Blues plans that had provided the funds. Typically if you try to get it from a non-Blues source it comes at an extremely high funding level because people don't want to have the repayment of their note subject to Commissioner approval.

So I think that you would find that that's little used and for very good reason.

MR. TOOLE: And finally insurance is often used as a surplus tool.

MR. BURRELL: Yes. We are our own reinsurer, but Mark.

MR. CHANEY: Exactly. I think what you find is with organizations of our size, you know, if you would go to reinsure, there's someone wants to make 70 cents or so or 30 cents on every dollar and only spend 70

cents. Why pay that?

And if it were a catastrophic type of event, in today's world you have to make sure you're with a reinsurer that can really stand behind you.

And one comment on the intercompany agreement. Now that this is a potential source to GHMSI, it's a potential use , which most plans don't have. Again, it would come with all sorts of regulatory ties and issues, but if CFMI in theory ever needed to fund something, GHMSI is standing behind them.

MR. RECTOR: I'm sorry. This is Neil Rector, also with Rector & Associates.

One question on the intercompany. I guess it's really for Mr. Dobson. In the modeling, did you consider either the potential risk to GHMSI if Carefirst of Maryland dipped below the 375 or the potential safety net to GHMSI if GHMSI stepped below the 375? Did either of those aspects factor into

your modeling?

MR. DOBSON: The short answer is we were aware of it. We reviewed it. We considered it, but, no, it did not affect our modeling. We judged, and we had a lot of considerations at the time. I probably can't remember all of them right here because I haven't looked at it in a while, but I do remember thinking that there would be so many strings in either direction and likelihood that the plans might be both in trouble at the same time, and just we did our evaluation separately for GHMSI and for CFMI.

COMMISSIONER PURCELL: Can the company also rely on its parent in that same manner? Are there any agreements between --

MR. BURRELL: No.

COMMISSIONER PURCELL: There are not. Okay.

Skip.

MR. MYERS: Thank you.

Just a couple of questions. Back

on the reinsurance issue, in the testimony it talks about the justification for the high surplus. One of the issues is, you know, catastrophic loss.

Have you gone through the analysis of trying to price that out? It seems that, you know, commonly insurers use reinsurance or stop loss insurance economically to prevent their having to maintain, in effect, being their own reinsurance as you just said you were.

So have you done that analysis and can you share that?

MR. BURRELL: Let me give a general response and then ask if Mark and Bob Dobson would further develop it.

But when we say we are our own reinsurer, we have concluded that that's the most cost effective way for us to go. There's no profit margin in it for anyone else who might stand in the reinsurance role, which often there's large margins in there for them

to take that kind of risk.

And I think the second part of the general answer is when looking at the risk of catastrophic events, the modeling that Milliman does takes that into account and weighs that into the overall equation.

And I'd ask Bob maybe if he would speak more to that.

MR. DOBSON: Yes. That's definitely one of the factors in our probability distributions.

MR. BURRELL: I mean, I think I would make the distinction that there are certain types of risks that are more frequent and perhaps of less magnitude, and then there are less frequent but potentially when occurring very catastrophic.

And one of the things that makes the setting of a reserve difficult is how does one weigh all of that and model all of that and understand all of that and come out with a framework, a range that would reasonably

accommodate it, and that is why we decided to go to outside experts like Milliman, because there's a particular expertise and a particular way of modeling that kind of things that gives you a reliable range.

If you're a board member of a nonprofit and you're running the possible risk that you were inadequately reserved, you would want to know that something like a complicated model that had tested all the possibilities, and there could be millions of combinations of variables.

We've seen things happen that no one would have said two years ago. We have seen a financial crash no one anticipated. It had a big effect on our asset values, even though we are conservatively invested.

We have seen trends persist in health care costs that we wouldn't have expected. We issued products that we thought would discourage excess use that didn't do it to the degree that we thought. We've had all

kinds of things happen that we couldn't have anticipated.

Now we add on top of that the possibility of a flu epidemic. What is the possibility that the combination of infrequent large things and many other things that happen frequently, what's the possible combinations that one would have to protect against of all of them?

What's the possibility that customers in a hard economic environment don't pay their bills on time? We can't collect the revenue.

What's the possibility that providers will accelerate their billings to us because they themselves want money faster?

What's the possible combination of all of that? And that's what happens when you put the reserve together and you put a range around that because no one on earth could ever predict what the possibilities were precisely going to be at any given point in time.

What we were convinced and I think our board was convinced about was that Milliman had a very, very carefully developed, sophisticated way of doing that, and they themselves put a range around it, and that's where our optimal range comes from, and then we had them look at it again, and then we had Lewin look at that, and that's the way you get comfortable.

And then you observe what the actual experience is that emerges from it and tests the real world against what it is you thought it was going to be. That's the way it was done.

MR. MYERS: Understood, and I appreciate that explanation. The question though was why not use reinsurance in that equation, let's say, for a high severity risk like terrorism with, you know, very, very low opportunity of occurrence.

MR. BURRELL: Because the price of doing it is higher than the way we're doing

it, and I think --

MR. CHANEY: Well, and probably even more relevant in today's times is that even though the industry sometimes has difficulty working together, right after 9/11, it came together, both the not for profit Blues and the for-profits, and they set up a committee to establish a reinsurance pool for just that. It could not be done to the satisfaction of enough participants to stay in that pool.

The main thing that we would want to reinsure against, in addition to that catastrophic event is multi-year cycle losses, and for those who think the underwriting cycle may be dead, and it's always gains, 50 percent of the Blues' plans in the first six months of 2009 had underwriting losses. GHMSI is one of them.

So what we are very much concerned about could be facing us today, going into a down cycle, government changes ahead of us,

not knowing what the cost of that might be, and still having the possibilities of the flu epidemic and other catastrophic events.

So reinsurance is something that we've all looked at, but it's very difficult because no one can reinsure against a multi-year loss cycle. The catastrophic events, it's not worth the price because no one is going to take enough exposure to keep this type of company solvent if it had a truly catastrophic event happen.

MR. MYERS: Okay. Thank you.

I wanted to ask another question about the class of subscribers. In your testimony you talked about that the charter required that the exempt function, the charitable function is to benefit your subscribers, and then you responded to a question by saying that that would be the current subscribers.

There are, of course prior subscribers who would have dropped out of the

plan or died or whatever it would be who would have contributed to the surplus of the company and, therefore, by just focusing your efforts on current subscribers, you get the benefit of the activity of the prior subscribers.

I'm using this to set up the question as to would you consider it within your exempt function to expand the class of subscribers to new subscribers who would benefit. Let's say there's a determination that there is some excess surplus so that that new class of subscribers could have their premium underwritten.

That it seems to me would be consistent with your exempt function, but what are your thoughts?

MR. BURRELL: Subscriber in the sense of a party that's actually paying a premium?

MR. MYERS: Yes.

MR. BURRELL: You're describing nothing but a discount or a subsidy.

MR. MYERS: That's right.

MR. BURRELL: And we, like any company, you can't price yourself below cost for very long. You can do it temporarily, but you can't do it on a sustained basis.

Part of our obligation is, as I say, to be there, to be solid, and to have continuity, and we operate, as it is, with one percent last year, .2 of a percent margin, and there are certain product lines on which we tend to lose, if we're going to lose anywhere, and those tend to be individuals and small groups.

And so if there's a tilt anywhere, it's to favor those who are most in need of the coverage and are struggling most to keep the coverage and make it affordable, and it's always a tension. Every month new data emerges to tell you where you actually are, and so we're constantly vigilantly looking at it.

But to develop below realistic or

market pricing on a sustained basis is not viable.

MR. MYERS: I see. I'm just trying to get at, I think, the theme. One of themes of your presentation was that you are constrained by your charter to act and provide benefits for your subscribers.

MR. BURRELL: Right.

MR. MYERS: If it were to come to pass, let's assume that there is a determination that there is some excess surplus and it would toss back to you to say, you know, how you're going ot use this excess surplus, it would be within your exempt function, would it not, to use that for the benefit of subscribers, whether they be old, current or new subscribers?

MR. BURRELL: Well, I think it would certainly be within our thought that it would be for current subscribers, and in all likelihood what we would wind up looking at is a way to return any excess in one form or

another to current subscribers.

And that has its own consequences. It creates certain changes in the market, has certain downstream effect os artificially depressing price for some period of time for some component of our subscriber base, and the consequence of that is hard to understand fully in the marketplace.

And then when it's over, what tends to happen is that rates tend to pop up very dramatically in order to come back to a break even situation.

There's nothing in the collective experience of the company that would suggest that artificially low prices for some period of time followed by precipitously large premium increases all of a sudden is a wise way to operate the business in the interest of the public or of the subscribers.

So it's a very careful road of moderation that we try to follow, and for all of those reasons, there's no desire to hold

excess and there's no intent to hold excess. We want to be only in an optimal range, and by holding a steady course with very skinny margins as a not for profit, paying no one, no shareholder, no one, just for the benefit of the subscribers, we think it can have what its intent, what its charter says, which is to actually serve for the benefit of subscribers.

And if we do that well for 3.4 million people, we actually have helped this community tremendously. That's our view.

MR. MYERS: Thank you.

COMMISSIONER BARLOW: Okay. I have a few financial questions. So these may be more appropriate for Mr. Chaney.

But can you explain the increase in the non-admitted assets in the 2008 financial statement?

MR. CHANEY: Certainly. Let me start off by saying that the 2007 statutory surplus is accurate. The 2008 statutory surplus is accurate. The RBC calculations

associated with both of them are accurate, unlike some of the filings that were made related to this hearing.

In fact, that's not just management's representation. Typically when one looks at our financial situation, it's required to send in along with the NAIC statutory financial filings audited financial statements. Those audited financial statements actually have two footnotes describing this very issue. Those are made available to the public, I believe, by the DISB for anyone who requests them. If not, anyone who calls the company can always have them made available.

And lastly, it's not only my opinion or the company's opinion, ENY's opinion. It's also your all's opinion. The DISB just recently completed their examination; no adjustments to statutory surplus. No significant findings on how we reported in the NAIC statutory filing.

What happened is that as we always do, we talked to our independent auditors about more current presentations of various items in our financial statements.

We pay 20 percent alternative minimal tax rate for the federal income tax. Everyone else pretty much pays 35 percent. We used to treat our deferred tax asset on a net basis, offsetting deferred tax assets and liabilities. All those are is a difference between tax accounting and statutory accounting.

In 2008, it was decided a more comprehensive presentation would be to gross up the asset side and offset that gross-up by increasing the non-admitted asset. No impact on statutory surplus, no impact on RBC, certified by two different sets of auditors including your own.

COMMISSIONER BARLOW: Okay, and then there was another big item in the non-admitted assets, which I believe was a

pension contribution.

MR. CHANEY: Yes. As we're all aware, 2008 was not good to the capital markets. Our pension asset allocation is very typical of a company of our size, approximately 60 percent equities, 40 percent fixed incomes. Whenever you have the sorts of hits to market values that took place on both of those, statutory pension accounting requires certain adjustments to be made that flow through into your statutory surplus.

Very technical accounting treatments, debits and credits. Again, two sets of auditors, including your own, have agreed with our approach and presentation.

COMMISSIONER BARLOW: Okay, and again, when I read the testimony, I just, to be clear, I don't think we gave prior approval for those things. We just did not object to them in reviewing the financial statements.

MR. CHANEY: I wasn't suggesting that.

COMMISSIONER BARLOW: right.

MR. CHANEY: We're talking about independent auditors. You all review it retrospectively because we never ask for your prior approval. You always want us to have your findings based upon audits.

COMMISSIONER BARLOW: Okay. And could you explain? For like the previous three years up to 2007, your authorized control level RBC was roughly 70 million, and then in 2007 and 2008 it jumped up to roughly 80 million. Can you discuss if there was a reason for what gives an appearance of a spike up in the ACL?

MR. CHANEY: I think the simple answer is the NAIC approved RBC calculation has five different risks. They are by formula taken right out of the statutory filings. A number of different factors impact that.

I couldn't cite to you right now the particular drivers between the five different risks which had more impact, but the

biggest risks are your premium increases because it impacts underwriting gain and downstream affiliate ownership and the premium increases at that impacts the separate RBC, in this case computed for Carefirst/Blue Choice.

Those typically are the two biggest drivers to RBC increases. They both continue to have good premium increases and enrollment increases over the last two years.

To Chet's point of affordability, the Carefirst family of affiliates has had its best enrollment for 2007 and 2008 that it has seen in the past decades. I think that is the best demonstration of affordability, and that drives the RBC calculation.

COMMISSIONER BARLOW: Okay. Are there any limitations or constraints or is it available for GHMSI to pay dividends to Carefirst, Inc.?

MR. CHANEY: Not without the Commissioner's approval in both jurisdictions. Carefirst, Inc. is set up as a not for profit

holding company with no operations. It's capitalized to the tune of about $500,000. The agreement that's set up, the affiliation back in 1998 specifically required that Carefirst, Inc. stay as that type of company. So there's been no consideration and no provision for paying dividends upstream.

COMMISSIONER PURCELL: Are there any subsidiaries of GHMSI?

MR. CHANEY: The largest single subsidiaries are 40 percent ownership of the HMO jointly owned with Carefirst of Maryland. That's a significant piece of the total business of Carefirst.

The other subsidiaries include a TPA, a life insurance agency. We don't have a life insurance company. We sell on behalf of others, and a subsidiary related to the FEP operation center relationship with the association.

COMMISSIONER PURCELL: If there is a finding of unreasonably large surplus, how

would you want the department to consider the impact of that on the GHMSI subsidiaries or what would the impact of that be on the GHMSI subsidiaries?

MR. CHANEY: Well, I think ultimately how NAIC has established the whole risk-based capital formula, the combined statutory surpluses of all the subsidiaries to the extent that some have and some don't have any rolls up to the two affiliates, Carefirst of Maryland and GHMSI.

So I think as Chet has highlighted, our abilities to offer affordable services throughout will be directly impacted by any changes that are made to the financial strength of GHMSI and Carefirst of Maryland.

So I think it's a linkage that goes without saying because they are completely controlled by GHMSI in this case.

COMMISSIONER BARLOW: Could you explain, I guess, the purpose or the reason you have a line of credit, I think?

MR. CHANEY: We do, which we've never drawn upon. Sometimes it's better to establish such a line of credit when you have no need of it. You never know with the capital markets today when you might be put in a position that a cash need develops and you don't want to liquidate a portion of your portfolio because of the losses that you might have to take that would damage the subscribers and the health of the company, and it's available.

We've never drawn upon it. It also actually sits well when you respond to RFPs because they don't understand the nuances of a Blue plan. So just to say you have a debt facility with a commercial bank is one of the things they have to check off as they review our RFPs for some of our major accounts.

COMMISSIONER BARLOW: Okay. Could you tell us what the advantages and disadvantages of being a nonprofit health

insurance company as opposed to a for-profit?

MR. BURRELL: Let me start with that, please. I think there's an advantage to being a not-for-profit or nonprofit, and the essential maybe two or three advantages. One is we can actually operate at margins that are very small, and so when I say one or two percent, and that's what we've done for the last decade, in a for-profit world you couldn't do that.

The second thing is that in a for-profit world, particularly in insurance, health insurance, one of the ways -- and the President spoke to this last night -- that you can make profit is skim risk, not serve the whole community, not be really there for the community, just draw out better risk and make a margin on it.

The third thing I would say is that in a not-for-profit environment, you can take a somewhat longer term view of things. We're not in the business of having to report

quarterly profits to shareholders, and all the pressures that come from short-term decisions. We want to look at what our role is in the larger health system and make wise choices, moderate choices about how to play a constructive role without the worry that on a quarterly basis you don't look so good to shareholders because you had a dip in profits or something of that nature.

So it's the thin margins. It's the way you approach your mission, and it's the long-term nature of the view you can take that we think translates into value.

MR. CHANEY: And if I could, to echo Chet's point, it is very helpful to be doing what we're doing and using a three-year planning cycle even in the management of RBC because it is not something you can sit down at the beginning of the year and say, "Here's how we get to this number at the end of the year. It is dramatically impacted by the capital markets. It's dramatically impacted

by health care trends that you're projecting but you don't control.

I certainly agree with the idea of not having to report quarterly earnings. We can focus more on running the business. One of the advantages we don't have that people think we have is we do pay federal income taxes to the tune of about $40 million a couple of years ago. We're right now at a 20 percent rate versus 35, but we'll lose that eventually, and we will be paying the same taxes as all of our competitors, income taxes, premium taxes, plus our giving to the community, which most of those do and nowhere at the terms we do it in.

COMMISSIONER BARLOW: Okay. Could you tell us in terms of determining an appropriate level of surplus how market share comes into play? I mean, do you have advantages in having the largest market share in this area?

MR. BURRELL: Well, I think the

reserve is in proportion to your market share, and one of the non-obvious effects of having a large market share is that typically there's really only one way to go, which is down. Every single other competitor looks with determination as to where they can find their foothold, and we see a market on the high end, large groups, that is extremely sophisticated, usually purchases only through consultants and consulting advice, and we see on the small end a broker-driven market that spreadsheets every option.

The President talked last night about exchanges, but I would say that we already have it in this market, which is virtually every small group that we're aware of comes to us through spreadsheeted approaches, which is to say here's the benefits you get, here's the network you get, and here's the price you pay for us compared to every other option on the market, and that's the typical process that is gone

through.

So if we were to look in any material way, not attractive because we didn't have the right network; we didn't have the right price, we weren't offering the right benefits. The market would detect it quickly, and we would start to lose enrollment, and so we are constantly vigilant about that.

If we were to have a material loss in enrollment, then reserves presumably would go down in absolutely dollars. Whether the reserve goes down in relative terms as measured by RBC is a different issue. Typically usually the smaller you are the higher the RBC because the smaller, the more likely you are subject to volatile changes, particularly if you're a one product company the way we are.

And so they are related, but those would be our observations in answer to your question.

COMMISSIONER PURCELL: How does

your company's reserve of surplus compare to your competitors, to your knowledge?

MR. BURRELL: Our competitors in this market are all large, for-profit, and in one case one large not-for-profit that do business on a national basis, and so you know, they are the names that everybody knows: Aetna, Signa Humana, United, and in the case of the nonprofit, Kaiser. They're all national players.

It's very hard for us to know fully what their RBCs are. They tend to have RBCs in a region, but they tend to put minimal in the region and roll it up to the parent, not fully disclosed to us. It's not possible to fully know.

And the important point I think about that is that they have the ability usually with multiple lines and multiple regions they serve to be somewhat more flexible on pricing. If they wanted to underprice for a while in a given market, they

could.

We're in one market, only here, with only one line, and so we do not deal with a series of, in any major way, local small plan competitors. We deal with the large national competitors, all of whom view the greater Washington-Baltimore market as a prime market. So they are here in force, and they compete intensely, and they do so with resources that are not limited simply to this region nor income streams that are limited to health care.

COMMISSIONER PURCELL: I want to touch on the issue of allocation for a moment. In your opinion, what's the appropriate method for allocating surplus in order to determine the amount of surplus that's attributable to the district?

MR. BURRELL: Well, we looked at this issue carefully, and first we would observe that there is no place anywhere in the country that we could find that allocated a

portion of a reserve based on a geographic distinction. There's no model for this.

It is not within an accepted regulatory framework. There's nothing in RBC calculations or in the NAIC rules and standards that deals with attribution based on geography. So it becomes a complex exercise.

But if you think of it this way, attribute, the dictionary meaning of "attribute" mean to be owned by, to be caused by. So if you took that as a starting point and you said, well, who caused the reserve, one of the things that we would observe goes back to the way GHMSI is positioned. Ninety percent of its enrollment is in Maryland, Virginia and out of area, 44 percent of it in Maryland alone.

So we actually did a claims run. We looked at where people live on the thought that where people live is where they get care, and where they get care influences their claims, what their claims look like and what

those claims cost. So we looked at that.

And we found out that there was some support to the idea that the claims pattern of GHMSI reflects where people live, and when you compare then what claims experience is with what premium is, it's the difference that built the reserve.

So our conclusion was that residency was the best way to determine who a reserve belongs to if you're forced to do it. We're not saying we would recommend it be done, but that's what the law requires.

So if you're forced to do it, do it on residency, and if you do it that way, and we had Milliman do this independent of us, what you come up with is what common sense would tell you, which is that ten percent of the enrollment of GHMSI is in the District, lives and resides in the District, probably therefore seeks care in the District, and lo and behold based on residency, about 11.6 percent of reserve is attributable to the

District by that methodology, and we'd be happy to explain that further, but that's the logic, and it starts with this notion of who does it belong to and who caused it.

COMMISSIONER BARLOW: And that's a snapshot of right now.

MR. BURRELL: It's a snapshot of -- actually it's meant to accumulate. Yeah, go ahead.

MR. DOBSON: The actual calculation of the 11.6 percent is not a snapshot. We actually started with a surplus as of 12/31/98, and we allocated based on results, underwriting results and other results over the ten-year period from the end of '98 through the end of 2008, and then we brought that initial surplus forward at the same percentage as the last ten years' experience. So it's a fairly complicated calculation, but recognizing time value money, the value of that surplus at the beginning, and the residency as subscribers over that

period of time, which is why it doesn't equate exactly to the ten percent, which may be a snapshot. I'm not exactly sure how the company determined that ten percent.

MR. BURRELL: But cumulative effect of how it was built over time.

MR. RECTOR: I've got a series of questions. I don't know if we want to start just with the attributable or I don't know what your plan is relative to a break.

COMMISSIONER PURCELL: We can continue on with the attributable issue.

MR. RECTOR: Okay. We had some questions, I think, just in, I think, the mechanics of what you did. I mean, I know you talked about looking at the residence of the certificate holders, and you've got at least four major blocks of business. You've got the individual business. You've got the non-FEP group business. You've got the FEP business, and you've got the ASO business.

Did you look to the residence of

the individuals in each of those?

So you did on the individual policies, at who the individual is. You looked at the certificate holders on the non-FAP group. You looked at the federal employees on the FEP business, and you looked at the employees on the administrative services?

MR. DOBSON: All based on residence, yes.

MR. RECTOR: Okay. And how did you -- did you then consider each person as one person based on the plan design, the premium benefit levels, those kinds of things?

So two different employees for two different plans, one of which may have had a contribution of $1,500 a month and the other one was $1,000 a month, did they get equal treatment or did you try to make weighting differences between the two?

I'm not suggesting one is better than the other. I'm just trying to find out

what you did.

MR. DOBSON: There were various data limitations over the period and various things we had to allocate by premium in different manners and members in different manners. So I'm not sure I can give a comprehensive answer to that question without actually looking at our work papers.

In general, the intent was to take the underwriting gains for a given year, allocate it by residency, which generally would have been a premium in proportion to membership. I think premium might have been the premium we had by jurisdiction, but members, we had to get special runs by residence because, of course, it was not tabulated that way for group business for, say, Schedule T of the annual statement.

So there were a lot of interim steps where we were allocating things. I probably sitting here can't give you a comprehensive answer, but I believe the short

answer to your question is that we would have done it in proportion to members and the premium for the members.

So, yes, we would not have been reflecting differences in plan probably in a very refined manner just because of limitations of the data.

MR. RECTOR: Okay. Did you look at underwriting results by product line differently? So you looked at the percentage that led to the individual, the percentage for the non-FEP group, and did that and built that up over time?

MR. DOBSON: Yes.

MR. RECTOR: Did you consider investment income or only underwriting results or how did investment income play into it?

MR. DOBSON: We considered all of it, but underwriting results drove things and then we allocated the investment income by various --

MR. RECTOR: With the same

percentages. Do you developed the percentages using underwriting results, but then you still factored the investment income into the ultimate.

MR. DOBSON: And the investment income got split between investment income on the existing surplus from previous years being brought forward and on the underwriting results for that given year.

MR. RECTOR: Okay. How did you allocate or to what extent did you allocate the residence of the subscribers for the subsidiaries, the direct and then the indirect subsidiaries?

MR. DOBSON: The Carefirst/Blue Choice, the largest subsidiary, we did in exactly the same manner as we did for GHMSI, the parent.

MR. RECTOR: And took -- I'm sorry.

MR. DOBSON: The predecessor, actually what's referred to as CCI, I believe,

we did the same thing for the period that that entity existed.

The other subsidiaries that were smaller, I believe we treated as separate investments.

MR. RECTOR: Okay. For an individual who is a subscriber of the Carefirst/Blue Choice, for that person did you count 40 percent of -- that's the way it worked up, so you did that?

MR. DOBSON: Yes. So to be clear on that, we would do exactly the same analysis like we did for GHMSI, and take 40 percent of the results and add it into the GHMSI.

MR. RECTOR: Okay. I understand the logic and read the materials of the logic as to why you believe the residence of the subscribers is the appropriate test. I know that MIA statute also sets out other factors that were required to at least consider, the first of which is the number of policies. Do we have any data as to the number of policies

by jurisdiction?

So if we looked to, for example, the number of individual policy holders, not necessarily -- I mean, for individuals it may be where they reside, but for the group there's going to be a policy holder that may be in Maryland or in the District, and the certificate holders could reside in North Carolina or Virginia or, you know, wherever.

MR. DOBSON: We weren't exactly sure how policy would be defined, and we did not look at that. I don't know if you guys --

MR. BURRELL: We have that data, but we did not -- because of what Bob just said.

MR. RECTOR: I'm having difficulty understanding why at least for some categories. I mean, for an individual policy I think it would be pretty clear what the policy is, I would think, and for the non-FEP group, I would think it would be pretty clear what the policy is. Is that -- am I missing

something?

Maybe I should just ask the question what makes it difficult to know what the policy is.

MR. DOBSON: I would just say we didn't do a lot of work trying to follow that line of reasoning because we weren't sure what the definition would be, and it's not just not a place we went in the analysis. We certainly could, but we did not.

MR. RECTOR: Okay. I think, based on discussions we've collectively had, I think it would be helpful in the materials that you submit at the end of September or, you know, whenever the next date is, to get us data on -- and we can describe what we mean by "policies," but for individuals it would be the insurance contract. For the non-FEP group, it would be the master group policy, not the certificates.

MR. DOBSON: No.

MR. RECTOR: For the FEP, I think

that's going to be the contract which you sign onto, and for the ASO it would be the administrative services agreement document, and we may or may not think that some of those latter portions work into the calculations. We don't know, but we're required to at least consider those factors according to the MIAC.

MR. HOGAN: Mr. Rector, could I ask you --

MR. RECTOR: Yes.

MR. HOGAN: -- where in the MIA you're pointing to? You're talking about Subsection F, about determining surplus to the corporation?

MR. RECTOR: No, I'm sorry. It's the reg.

COMMISSIONER PURCELL: It's actually in the regs.

MR. RECTOR: It's 4699.2.

MR. HOGAN: Okay. So it's not in the statement.

MR. RECTOR: It's in the reg. I'm

sorry. Yeah, 4699.2.

In that same reg, there's also a requirement that we look at and consider as a factor, as a factor, the number of health care providers under contract and, again, I'm presuming that isn't something we have data on here today, but do we have questions as to what data we might need?

MR. BURRELL: We have data on that that we could certainly provide.

MR. RECTOR: Okay. Another factor, the reg indicates that the department can consider other factors, too. One of the other factors that has come into play is there has been this discussion of, you know, what caused the surplus, what generated the surplus, who paid it. Obviously subscribers, individual subscribers through reimbursement to their employer, through deductions, pay a portion of premium, but in most group contexts employers also pay a portion of the premium.

Do we have any data that shows the

split between what an employer pays versus an employee?

MR. BURRELL: We have the data that I referenced earlier, but that's general data. What we don't gather is data employer by employer, what exactly the employer paid and what did the subscriber pay.

MR. RECTOR: Yeah, that doesn't surprise me. So when we're looking to say, you know, what person or entity generated the premium that then led to the surplus, we don't know whether it's 100 percent of the employer, wherever the employer may be located, or 100 percent of the employees regardless of where they may be located. We just don't know other than in a generic sense.

MR. BURRELL: We know in a general way.

MR. RECTOR: Yeah.

MR. BURRELL: And given our market share and the size of our subscriber base, it's probably not likely that we look a whole

lot different than the general trend.

MR. RECTOR: Perhaps you could then -- I know you indicated some of this in your testimony -- but if you could share again what those general -- perhaps over the last five to ten years and current since the data Mr. Dobson would have.

MR. BURRELL: Well, it's in my testimony.

MR. RECTOR: Yeah.

MR. BURRELL: And so if we find the right page here, let's see. The number of employers who offer coverage is going to 50 --

MR. RECTOR: Page?

MR. BURRELL: -- 60 percent, and the --

MR. RECTOR: Sir, the bottom of page 5?

MR. BURRELL: The bottom of page 5. Yeah, well, on page 6, the portion of premiums -- the decline has reached the point where the portion of premium paid by small and

medium employers is now at about the 50 percent mark.

MR. RECTOR: Okay. So if we're trying to think through, again, coming back to Mr. Dobson where he looked at data for like the last ten years, it's likely that 50 percent or more of the premium would have been paid by the employer as opposed to by the employee. Is that a fair statement?

MR. BURRELL: Probably so if the region looks like the general --

MR. RECTOR: Which, again, we don't know.

MR. BURRELL: yes.

MR. RECTOR: That's a good clarifying question. This data I'm assuming is for the non-FEP group.

MR. BURRELL: Yes.

MR. RECTOR: Do we -- and this shows my ignorance -- do we know what split there is in the FEP?

MR. BURRELL: We do.

MR. RECTOR: Okay. What's that?

MR. BURRELL: Seventy-two percent of FEP premiums are paid by the federal government, on average.

MR. RECTOR: On average. Okay. Mr. Burrell, in your testimony you talked about what attributable to means, ownership or causation. Again, we've been trying to sort through this difficult attribution process, which I think we all agree is a difficult thing to do.

For ownership, and again, we're looking at the non-FEP group business, I think my general understanding is that master group policy holders are frequently thought of as the owner of those contracts because they're the ones who technically pay the premium. They're the ones that have the only ability to enter into the contract, to amend the contract, to negotiate policy terms, to do all of those things; is that --

MR. BURRELL: No doubt that the

employer group typically is the arranger of and the part payer of the coverage.

MR. RECTOR: Okay, and on causation, again, there are two sides to what causes surplus. One is the premium coming in. The other, claims going out. It sounds like we've got good data on the claims going out. I think, Mr. Dobson, it sounds like your work was done based on claim runs so that we kind of know where claims were paid.

MR. DOBSON: -- base things on underwriting gains or loss we're taking claims into account, yeah.

MR. RECTOR: Okay. So the money going out the door, we have a pretty good idea where that money went out the door in Virginia or Maryland or D.C. or some other place; is that --

MR. DOBSON: Well, we didn't actually allocate in our analysis claims by jurisdiction. We allocate the member accounts and then the proportion of underwriting gained

and lost to that. So indirectly we're reflecting claims not really based on where the provider is located or where the service is rendered.

MR. RECTOR: Okay. So if a person lived in D.C. you would count them as a D.C. resident even if they were serviced by a doctor in Virginia or vice versa?

MR. DOBSON: Sure.

MR. RECTOR: Okay.

MR. BURRELL: But we did do a separate claim run to verify the thought that --

MR. RECTOR: That's fine.

MR. BURRELL: -- they tend to get care near where they live.

MR. RECTOR: Okay. It would be helpful, I think, if you include in your next submission some information about that, trying to show the correlation between where people live and where the claims are generated.

MR. BURRELL: Yes, yes.

MR. RECTOR: The flip side of that obviously is what caused them to even participate as a subscriber in the first place, and obviously on the non-FEP group the commonality is the fact that they are employed by the master group policy holder as opposed to where they live. I mean, we're assuming most of these people live in Virginia, D.C. or Maryland, but in theory someone could live in West Virginia or Pennsylvania.

MR. BURRELL: And in fact, they do. A number of them do.

MR. RECTOR: Okay. I guess the last question that I had on the attribution part is when we took a look at Schedule T of the annual statement where premiums are allocated by state, obviously it's a radically different distribution than either Mr. Dobson's or yours, where it shows that if you exclude the FEP business it's about 26 percent in the District. If you include the FEP business it's about 63 percent.

I wonder if you could just help explain to us the difference between the allocation you have here and how you get the ten percent or the 11.6.

MR. BURRELL: Well, I think the essence of the point is that if you take the situs of the group, like take FEP, it's a district contract, group contract. but like the rest of the enrollment of the company, most of the people, 90 percent of the people actually live in Virginia or Maryland.

The same thing is true with other groups. Most of the membership is actually residing in the other jurisdictions, and the claims experience that emerges for them is mostly related to where they live, and so the reason we thought residency was a better measure is it reflects that fact, and if one is to try to get to the most equitable split --

MR. RECTOR: Right.

MR. BURRELL: -- which is what the

law requires.

MR. RECTOR: Okay. So it's the claim side, again, the policy side. It sounds like more than 50 percent of the premium in the group context, whether FEP or non-FEP, is going to arise based on where --

MR. BURRELL: The group is.

MR. RECTOR: -- the group is.

MR. BURRELL: But the group's members are more typically in the pattern of 9010.

MR. RECTOR: Yeah. I think we understand that distinction that you're making. I appreciate that.

Commissioner, that's all I have on the attributable.

COMMISSIONER PURCELL: Okay. Thank you.

I think we're going to take a break, and we'll resume with this panel after the break, a 20 minute break. So if everyone could reconvene at 1:30.

Thank you.

(Whereupon, the foregoing matter went off the record at 1:14 p.m. and went back on the record at 1:35 p.m.)

COMMISSIONER PURCELL: Okay. We're going to reconvene.

I just want to mention again if there's anyone in the room who wasn't here for my initial opening and is a witness and would like to testify, please fill out a card and pass it to the transcriber so that we can make sure to have you on our list.

And so at 1:33 I will reconvene this hearing. Neil, I'll turn it over to you.

MR. RECTOR: Thank you, Commissioner.

One of the other areas I think we've really had some difficulty reconciling the reports and the statute or regulation, depending on which it is at the relevant moment, is the what I call the standard. I

mean the Milliman report and the reports from Carefirst have gone through a series of calculations to come up with a, quote, optimal surplus target range, unquote, and of course, that phrase isn't in the statute or the regulation, and we're trying to measure something that may be the same; it may be different. We're trying to get some idea of how you view the numbers you've calculated relative to the statute.

Obviously, one of the factors that's in the statute is financial soundness because you've got the obligation to make a contribution to the maximum extent consistent with financial soundness, soundness and efficiency.

You've come up with your optimal range of 750 to 1050 RBC. Is that in your mind, is that the same range as the range of financial soundness so that if you fall below 750 you're financially unsound or is financial soundness a different number, a different

method, a different calculation?

I'm just trying to get some sense on how those two things reconcile.

MR. BURRELL: Well --

MR. RECTOR: It's kind of for the panel. I'm not sure who's the appropriate one.

MR. BURRELL: Go ahead.

MR. DOBSON: Optimal surplus studies were not done in view of this specific statute at all. So I would defer that to the company, but our definition of optimal surplus range is defined in the report, and I kind of mentioned it today, and it's based on the considerations for the company and its board and not directly related to the statute.

Our work on the attribution, of course, was in relation to a statute, but our surplus was not.

MR. BURRELL: Yeah, I think in some ways I would echo that, that without regard to the statute first, the fundamental

question the company would have to ask or the board would have to ask is what range ought we as a company to be in, and from the standpoint of what would a healthy company -- how would a healthy company want to position itself, optimum is the answer to that. Be within a certain range. It's neither too high nor too low.

At times you may be at different points in the range or you may even be below the range. We have never been above it, but you strive to be in a certain place. That's on the company as a whole.

I think an important point is that regardless of how attribution is done, it's a piece of a whole, and the smaller the piece, then the higher typically the range.

So if optimum of 750 to 1050 is on the company as a whole, what's optimum on the piece that happens to be attributable to the District? How much higher would that have to be is a fundamental question.

We didn't posit an answer on that, but we did offer the thought that it has to be higher, and it depends on the final methodology that is chosen as to how you develop an attribution.

But if you took our situation, the one that we proposed, it comes out with an 11.6 percent of the total GHMSI reserve. That's a very small piece. It is proportionate generally to the membership where they reside.

We did not ask Milliman -- we could, but we did not ask Milliman to advise us on what RBC range ought to apply to 11.6 percent of the total reserve.

MR. RECTOR: Have you asked Milliman or have you conducted any internal studies on what you consider to be a range that equals financial soundness of the company as a whole?

MR. BURRELL: Well, i think you would say in all honesty there are different

definitions of financial soundness, right?

MR. RECTOR: Right. Could be.

MR. BURRELL: Is it sound to be above a regulatory level? Yes.

Is it sound to be above the Blue Cross level? Yes.

Is it sound to be in what you ought to be in is a optimum range? Of course.

So there's a subjectivity to that judgment of what is soundness. Our point was somewhat different, which was that the alternate uses of a reserve, particularly in light of the command in the charter to benefit the subscribers, had to be taken into account.

If subscribers are struggling to afford, how do you use your resources to help them afford their coverage? And so we were trying to bring that to light, but in the end soundness is judgmental.

Our board chose that on the aggregate, that the company ought to be just from a sound business operation standpoint in

an optimum range, within an optimum range, and therefore, they sought the best possible advice as to what that optimum range ought to be, and we have been consistently, as we said, in the bottom third of it or the bottom half of it. We would consider that to be financially sound.

The more you drive lower, the more you go down towards control levels, these are things not to be sought after, but to be avoided. They are not optimum, and so we looked at it and I think in that context.

And then if you try to struggle through all of the complexities of how do you do attribution, whatever it is you come out with as a conclusion, it's going to be a subpart of, a piece of a larger hole. So if the optimum on the whole is 750 to 1050, it's going to have to be higher on the part.

MR. RECTOR: Yeah, I'm sorry. I may not be asking the question well. I'm trying to figure out, again, on the whole with

the company if there is a range that you believe or if there is a number or a methodology you believe as to what constitutes financial soundness of the whole.

MR. BURRELL: I think the simple answer to that is the range we have.

MR. RECTOR: So if the company, if GHMSI were to fall to 700 percent RBC, you would consider GHMSI to be financially unsound?

MR. BURRELL: Again, it's not optimum, and soundness is such a judgmental thing. The purpose of the policy of the board was basically to say what range ought we be in and if we slip below it to gradually bring ourselves back as moderately as possible to be within it, and if we're too high, to bring ourselves back down so that we are within it again.

And so that's what I think it's the statute that used the term "soundness," "financial soundness." We were looking at it

from the standpoint of how would you sensibly run a business with these characteristics.

MR. RECTOR: yeah, I understand the difference in approach, which is, I think why we're trying to figure out how the information Milliman has is relevant to the task that we have, which is a different task.

MR. HOGAN: Could I speak to that, too?

MR. RECTOR: Please.

MR. HOGAN: I think that the beginning point, we are mixing two different issues here. There is a two-step analysis under the statute that you're required to go through. One is, and I think that this was lost in the Appleseed, and Covington analysis mixes these issues. The first decision you have to make or that the Commissioner has to make is whether we have an unreasonably large surplus.

And the regs define that as two parts: one, whether we're above the NAIC Blue

Cross level and then the amount of surplus needed by the corporation to meet its expected and unanticipated contingencies.

I think that what Milliman has done here and what the company has done is looked at the first element of that, and the report goes to whether our surplus is unreasonably large. I think the conclusion has to be in reading the analysis that it isn't 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 until you make a determination that the surplus is unreasonably large.

And so I think if we look at it through the prism of that as a two-step process that the Milliman report goes to the first part of that issue. It is unreasonably large? No, it isn't is the answer based on where Milliman was, what they recommended, and

where the actual surplus is.

The second part of it, if you get to that, if there's a finding of unreasonable largeness of the surplus, then you get to the issue of what Mr. Burrell spent a significant amount of time talking about: rate moderation, contributions to the community, long-term investments to benefit our subscribers.

So I think it's really critical to keep those two things separate when we're analyzing the approach to the decision that the Commissioner has to make.

MR. RECTOR: Okay.

COMMISSIONER PURCELL: Is it possible though and has the company considered operating outside of that optimum range? We're not talking down at RBC levels, but we're talking at a range that is not in the optimum range that Milliman has come up with and that the company has subscribed to, but perhaps just short of that or somewhere in

between the two that is still a sound position to be in financially.

MR. BURRELL: i think the board has taken the vie that the place to be is within the range, and if we were to fall below the range, to try over time to get back to the range and to follow the best expert advice they were given.

So, no. If you were going to do, I think, what you described you would lower the range.

COMMISSIONER PURCELL: So the board is not willing to operate outside of that optimum range is basically what you're saying. That's the range that has been professionally suggested to you, and that's the range you subscribe to and you're not willing at this point --

MR. BURRELL: Not a matter of policy to operate outside the range. As a matter of choice.

That would be basically the board

saying we have obtained the best advice we could get. We have had it multiply confirmed, and we won't follow it, and I think from the standpoint of the fiduciary responsibility of the board, they don't want to be in that position.

COMMISSIONER PURCELL: But where in that decision do you weigh your community obligation?

MR. BURRELL: It's part of it. It's part of it because as I said before, the giving that the company provides every year that is growing is part of that.

COMMISSIONER PURCELL: So you've struck that balance you believe.

MR. BURRELL: Yes.

COMMISSIONER PURCELL: Appropriately.

MR. BURRELL: Yes, I believe so.

MR. RECTOR: Mr. Hogan, I just want to repeat back what I think I heard to make sure I understand it, that when you look

to the statute -- and, again, I'm looking at 31-3506(e)(2), which is the after the hearing portion -- "after the hearing is the Commissioner determines that the surplus is unreasonably large and inconsistent with the corporation's obligation."

I think I'm hearing you say that the Milliman test of optimal surplus target range is the functional equivalent of the words "unreasonably large" in the statute.

MR. HOGAN: Well, I believe that the Milliman report goes to the issue of whether the reserves of the company are unreasonably large or not, and they've come to the opinion that our range should be between 750 and 1050 RBC. In applying the facts that are in the world that we know, the RBC in 2008 was at 845. I think that answers the question of whether we have an unreasonably large reserve or not.

MR. BURRELL: Well, stated alternatively, can you have an unreasonably

large reserve when you are within the bottom half of an optimal range that was professionally advised based on all your facts?

MR. RECTOR: That was actually going to be my next question. And the answer in your judgment?

MR. BURRELL: I would say no. Now, it's possible, and Milliman's second analysis of the company's reserves set a slightly lower range than the first one did. The first one was 800 to 1100. The second one was 750 to 1050. It is theoretically possible that in the real world, I guess, as well, that if the characteristics of risk for the company changed materially, that you would readjust the range based on those characteristics and facts.

And that's why the company does this every three years. So you could envision a situation where the risk characteristics were different, up or down, and we would

expect that the professional advice would be to answer the question, what's the optimal range given the risk characteristics and other things that need to be considered. What's the optimum range we ought to be in, given the then current understanding of the facts?

And so we would expect that the range would possibly be modified over time, but based on sound actuarial advice. That's why we had them come back and do it again, and we will have them come back and have them do it yet again at least every three years if not more frequently, given the scrutiny that this issue seems to evoke.

MR. RECTOR: So we've got testimony from Milliman which goes toward, in your judgment, toward whether the surplus is unreasonably large. I think I'm hearing you say we don't really have testimony on what level constitutes financial soundness for the company because in your judgment we didn't need to get there because we haven't made

the --

MR. BURRELL: Can the surplus be unreasonably large that is found to be in the middle or lower end of an optimal range.

MR. RECTOR: Yeah, I'm sorry. I'm dealing with the second half or second part of the standard. Is there any testimony as to what constitutes the level of financial soundness or unsoundness of this?

MR. BURRELL: No, but I'd just make one other point here. The optimal range, to state the obvious again, that Milliman came to was on the whole. We think it is conceptually, mechanically and every other way impossible to conclude that a part would be lower than the whole, the range on the part would be lower than the whole. It is somewhere higher.

And so the test in the law is on only the portion that is attributable to the District after you get finished with the conclusion about whether the whole is

unreasonable.

MR. HOGAN: And if I could supplement that answer, the statute says a corporate -- this is the definition of the community health reinvestment. "A corporation shall engage in community health reinvestment to the maximum . . . and consistent with financial soundness and efficiency."

I think there's been a significant amount of testimony today by Mr. Burrell and others talkinga bout exactly what our community health reinvestment is, the board decision of how they set it, particular numbers, $46 million, for instance for this year, about what the reinvestment in the community would be in light of the current financial circumstances of the company.

There's been significant testimony about the board committee and the staff that comes to the board committee to analyze that, and I think it's fair to characterize all of that testimony to say that those decisions are

driven by what can we give to the community consistent with our charter and in light of the current financial situation of the company and our board's commitment to being a participant in this community and assisting the community and are subscribers to the extent that it can.

So to answer your question, I do think we deal with both elements of the inquiry that the Commissioner has to undertake here.

MR. RECTOR: Okay. I have two very specific questions and I know there are a couple of questions on the community investment and then we've got some actuarial things.

Well, actually three. The first is, I mean, Mr. Burrell, you've talked extensively about the thin margins, the one to two percent, the .2 percent. I just want to make sure I understand. We're talking there about underwriting margins, not including

investment income or does that include investment?

MR. BURRELL: It does not.

MR. RECTOR: Okay. The second is on page 3 of your testimony where we're talking about the charter and you go back to the language. It's the second full paragraph. It's only one sentence. GHMSI "shall not be conducted for profit, but shall be conducted for the benefit of the" -- there's an ellipsis. Do we -- I don't know if you have to read it into the record, but I'd just like to make sure we get a copy of what was omitted.

MR. BURRELL: We can tell you what that is.

MR. RECTOR: Okay. What is it? I don't know if it's long or short.

MR. BURRELL: It's short.

MR. RECTOR: Okay.

MR. BURRELL: I think.

MR. HOGAN: You are talking about

this?

MR. BURRELL: "Shall not be conducted for profit."

MR. RECTOR: "But shall be conducted for the benefit of the" and there were some words.

MR. BURRELL: "Aforesaid."

MR. RECTOR: "Of the aforesaid"? Okay.

MR. BURRELL: That's the only word that's taken out.

MR. RECTOR: Okay.

(Laughter.)

MR. RECTOR: I'm confident the department has a copy of the charter, but could you make sure we get a copy for the record?

MR. BURRELL: Certainly.

MR. RECTOR: And I guess the last question that I've got is for Mr. Dobson. On page 3 of your testimony, you talk about the criteria that you used in developing your

models, the first one being that you provide a "very high likelihood" that you're going to exceed the 375, and then second, that you're going to have "virtual certainty" that you're going to stay over the 200 percent.

MR. DOBSON: Right.

MR. RECTOR: And I know you believe both criteria are important, and I know that your charge from the company was with respect to both criteria, but if the only criterion had been the second one, the 200 percent of RBC, do you know what your range would have been?

MR. DOBSON: Not as I sit here I don't, no.

MR. RECTOR: I don't know whether that's something we know or can figure out or if we would like to have them.

MR. DOBSON: I do recall that the upper bound, the 1050 is driven by the 375, but I don't know exactly what the range would be just driven by that second criteria.

MR. RECTOR: Do you know if the lower bound would be altered or was the lower bound determined solely by --

MR. DOBSON: The lower bound would not be altered.

MR. RECTOR: So it would be 750 to some number that -- your belief is that if you only had the second criterion that the range would be 750 to some number probably less than 1050, but 750 to some --

MR. DOBSON: That's my recollection, not that I would agree with that, but --

MR. RECTOR: I understand that.

MR. DOBSON: -- if that were the only criteria, yes.

MR. RECTOR: Okay. Jim, I just want to make sure we either get from them information where we know that or that if we don't think we have that, then that they at least provide that information with respect to their -- yeah, if you can go ahead and --

MR. DOBSON: We may even have it in some of the documentation that you have, but we can talk about it.

MR. RECTOR: Okay. I think that's all the questions I have, Commissioner.

COMMISSIONER PURCELL: Jim -- oh, sorry.

MS. SCHROEDER: I'm sorry. I just had a few quick questions on the community health reinvestment expenditures issue. The definition in the statute of those expenditures are those that promote and safeguard the public health or that benefit current or future subscribers, including premium rate reductions.

Some of the documents that were on I know the District's Website included your community care initiatives reports. Would you say that all of those kinds of charitable givings you would include within that definition?

MR. BURRELL: Yes.

MS. SCHROEDER: Okay. There's also a number of places where there's different references to numbers contributed either by the Carefirst organization or by GHMSI specifically. I think you mentioned today in your testimony, I think, a $14 million figure, and then also a $46 million range in the region.

MR. BURRELL: Which is the company as a whole.

MS. SCHROEDER: Right.

MR. BURRELL: CFI.

MS. SCHROEDER: I'm having trouble finding though in what we have the specific numbers of those total expenditures both for 2008 and thus far or projected in 2008.

MR. BURRELL: There is detail on that, and we can certainly supply that ot you.

MS. SCHROEDER: That would be wonderful. Okay.

MR. RECTOR: I think the reason Sarah asked that first question is because as

we started looking through the numbers here, we saw things at least on their surface that didn't necessarily look like they met the promote the public health thing.

I mean, for example there's, you know, the sponsorship was to the House of Representatives' Christmas party or the Howard University Office of the President.

MR. BURRELL: Right, right. There are a lot of things that we do as a corporate good citizen that you could say are not going to be things that promote the public health. The vast majority of what we do -- and we can break it down -- we think does.

Those categories that you just mentioned are tiny, little pieces of our total community spending, but we can break it down, and that's the whole essence of the triangle that I mentioned earlier. The tip of that triangle are for things like what you described. They're the smallest, most inconsequential piece of our whole community

relations efforts.

Where the big dollars are are in subsidies, catalytic giving, that kind of programmatic initiatives that we do think have a direct bearing on public health.

MR. RECTOR: Okay. I guess our question or our request would be when you submit materials in a couple of weeks if you could just scrutinize these lists to just see what -- and you don't have to worry down to the penny. Again, it's the big dollars we're concerned about, but just make sure that in your view that your belief is that the numbers that you're submitting are numbers that you believe meet that statutory or regulatory test.

MR. BURRELL: We can do that.

MS. SCHROEDER: And one quick question. On this report when there's a reference to NCA, what --

MR. BURRELL: National Capital Area, which is often used as synonymous with

GHMSI.

MS. SCHROEDER: But not necessarily in this report. That might include contributions by other corporate entities?

MR. BURRELL: no.

MS. SCHROEDER: It will just be GHMSI. Okay, great. thank you.

COMMISSIONER PURCELL: Jim.

MR. TOOLE: Good afternoon. I've got some broad questions, and then some more specific questions about the model and also following up with some questions for Mr. Carlson.

Okay. Could you describe the pricing margins over the last few years and kind of how you come at a range and byproduct, how they varied?

MR. CHANEY: Certainly. Our long-term model was to target margins that we thought were actuarially sound, taking into consideration the risk of a particular segment

and the need to maintain our surplus at certain levels. So those levels are approximately for the individual products in the four to five percent range, for the small group in the three to four percent, and for the risk business, let's say, 51 plus, more in the two to three percent range.

We have, because of the economy, because of the competitive marketplace and because of trying to maintain an affordable position, not included margins at that level in recent years. I think somebody asked earlier what happened since 2005, since the last hearing.

One of the things if you look at some of the charts that we provided in our filings, you can see that our margins have come down significantly, that our underwriting margins had been much closer to one to two percent than they were previously, which was generally over two percent, and our bottom line margins have been in the one to three

percent range.

So we're basically taking each of those products and considering the dynamics in the marketplace and coming off that longer term profile, and on average I would say each of those margins has been reduced by a point or two.

MR. TOOLE: So when you price you don't expect to come out with an underwriting margin of zero. You do expect, if everything goes as planned and risk volatility, you would expect to earn money.

MR. CHANEY: For all of our Carefirst companies, we've targeted for 2009 one-half of one percent underwriting margin for 2009. In our longer term planning we hope to be able to grow that back closer to one, one and a half percent subject to where the surplus is, the market, the economy and health care trends because the affordability balance of this is always premier, right at the top of our list in making this decision.

MR. TOOLE: At the end of each year and end of each quarter you have to set IB&R reserves. Can you describe your philosophy? Are you trying to hit that exactly or do you have a margin in that reserve, or what has your experience been in the last few years

MR. CHANEY: In recent years it has been somewhat different than it was for, let's say, going back three to five. Typically we've tried to put best estimate plus some margin for deviations of approximately eight to ten percent dependent upon the particular product line and the volatility that we've seen in that.

Up until the 2007-2008 time frames, we were pretty good in our estimates. that has since changed, and we proved the point that you need those margins in some years because we had, as many others in our insurance, as the trend started spiking up in late 2007, going into 2008, some run-on claims

that we didn't expect.

MR. TOOLE: But if you set a reserve with margin and you don't need it, where do those margins go?

MR. CHANEY: As long as one keeps the same level of margin year over year, it balances out, and therefore, the run rate of a particular year really reflects the premiums and costs of that year, subject to enrollment growth that might require some additional margin on top of your best estimate.

MR. TOOLE: You mentioned the underwriting cycle, and if you could for those of us in the room who maybe might not understand it, if you could explain that to people, including myself.

MR. DOBSON: Well, historically, for many years the health insurance industry had a three year up and three year down cycle that was well documented by both commercial carriers and notably the Blues. That has definitely changed over recent history.

There's no doubt about the change in the cycle.

So I would characterize the work that we do now as looking at adverse loss cycles that could occur as opposed to thinking it's going to be any sort of regular recurring, you know, three years up or three years down.

But we still strongly believe in the possibility of an adverse loss cycle that could, as we model it, take into account two or two and a half rating cycles and thus be experienced financially over a three or a four-year financial period.

MR. TOOLE: So after an adverse loss cycle, what would you expect?

MR. DOBSON: After the adverse loss cycle, you would normally expect some sort of recovery going forward from there.

MR. TOOLE: Okay. In your 375 percent Blue Cross/Blue Shield scenario, I guess we assume that GHMSI is a going concern.

You're still solvent, right?

MR. DOBSON: Well, test just as a gift to the 375. We really don't go beyond that.

MR. TOOLE: Okay. So they're a solvent, going concern.

MR. DOBSON: Right.

MR. TOOLE: Okay.

MR. DOBSON: Right.

MR. TOOLE: So how are the up cycle gains in the future taken into account in your model?

MR. DOBSON: Well, the expectation would be that if they survive that, they then build back hopefully to the optimal range. The modeling is just looking at the adverse cycle and the probability of what happens to get them down to that adverse position.

MR. TOOLE: And during the down cycle, how do you handle the tax implications?

MR. DOBSON: The tax implications during the down cycle are that we assume that

any loss carry-forwards or deferred tax assets will not be recoverable because they're currently in a loss cycle, and beyond that I guess I'm not positive of the intricacies of the model.

MR. TOOLE: So in the future when there are gains, those losses, they would be of value.

MR. DOBSON: Certainly, depending on timing and the tax laws and things like that.

MR. TOOLE: Okay. This is more of a -- I don't know -- speculative question. The 2008 RBC calculations include approximately nine percent for the non-FEP, two percent for FEP premium, and one percent for ASC premium. That's in that underwriting portion, H1, of the RBC calculation. Do you think those ratios properly reflect the risk attributes of those lines of business?

MR. DOBSON: I'm not sure I follow the question. You're talking about the actual

NAIC prescribed --

MR. TOOLE: That's correct.

MR. DOBSON: -- calculations.

MR. TOOLE: Yes.

MR. DOBSON: And the intent of that is to reflect the mix of business of the company in establishing minimum regulatory surplus levels.

MR. TOOLE: And in that calculation --

MR. DOBSON: The two and the one are proper reflection of the relative risk between the two.

MR. RECTOR: Yeah, for this company I is really the question. It's does the NAIC model percentages in your view accurately show the risk. I think that's your question.

MR. TOOLE: Yes.

MR. RECTOR: He's not asking for general judgments on the NAIC model, but does the NAIC model in its numbers and its relative

risk positions and relative risk charges, does that seem to match up to the risks that you've seen in this companY?

MR. DOBSON: We don't believe that the NAIC prescribed RBC calculation can reflect the risk totally accurately. It's a rough tool to be used by regulators, and we understand the purpose and the intent of it. That's why we don't just say there's a prescribed percentage of RBC that every company ought to hold, and that's why we do our own analysis of the particular risk characteristic.

So I'm not sure that the particular question, although I think I understand it, is relevant to our analysis because we don't really do that. We look at what the surplus needs to be and then just for convenience we measure that as a percentage of RBC.

MR. TOOLE: Can you briefly describe the history of your model and how it

evolved?

MR. DOBSON: It goes back. I mean, the initial surplus work that the firm has done goes back preceding that technical advisory committee that I mentioned chairing in the late '70s or early '80s. So I think our work probably started in the early '70s.

At that point, of course, there was essentially no computing capabilities. We tended to do more of a scenario approach, which was not as statistically based, much the currently out of vogue method of, you know, stacking probabilities on top of each other without really doing the convolutions or combined simulations.

That evolved over the years and, in fact, that that technical advisory committee presented two possible alternatives of how to do it, one being computer based model, and so things were just evolving during that period.

In the early '80s, I was involved

in a study for the Illinois Blue Cross plan where the Insurance Department of Illinois requested that I be hired to do that because of my chairmanship of the technical advisory committee, and that's when we joked about it the other,day, but we actually developed a model that shut down the company's computers over New Year's Day weekend because the computing power even using their mainframe just still wasn't there to do the sorts of things we do now.

then I left the firm for a while in the '80s --

MR. TOOLE: I'm sorry.

MR. DOBSON: -- probably when most of the current method evolved. So I think the current modeling probably developed through the '80s and '90s. I wasn't directly involved in a lot of that until these recent Carefirst assignments.

And even there with the high mark work that the Milliman Philadelphia office

did, I wasn't personally involved in that. There were certain criticisms made by the Commissioner that we did reflect in later versions of the model. So we continue to refine is what I'm getting at. We continue to make changes as people look at it and give us suggestions or as we find things that don't really meet the client's needs or the regulator's needs.

MR. TOOLE: Can you describe how you modeled the three what I would call lines of business and how the income streams for each were handled?

MR. DOBSON: Well, that's all based on the company's pro forma financial projection. So we established the three different risk cells, one being the non-FEP risk, FEP by itself, and then the ASC risk, and we're using the company's financial projections and looking at that, but we make a simpler model to be used for our purposes that reproduces that in their instance and

then that we can put our probability distributions in the adverse loss cycles into that kind of model.

MR. TOOLE: Briefly describe the different risks. I know that you have the seven risks, which I affectionately call the seven sisters, and you have the FEP and the ACS. Can you describe how the FEP was modeled in the pro forma and the ASC and how that's different than these others?

MR. DOBSON: Well, in terms of our assumptions, the FEP is treated totally differently because we don't have the -- we don't apply the rating risk, which is the big driver. This is that number one risk, the rating risk, which is partially medical trend, but it can be other factors in the rating formula, any sort of mistake that the company makes or any sort of fact that the assumed results don't occur gets reflected in that first one. That does not apply to FEP. That does not apply to ASC.

MR. TOOLE: So let me stop there because if there's no rating risk, it feels to me that the RBC calculation might put too much weight on FEP in their analysis, thereby driving up RBC ratios to levels which may not be necessary for the singular company GHMSI, which has the bulk of the FEP risk.

MR. DOBSON: I see where you're going with that. I don't think that would affect our results. It might affect the percentage.

For example, if you change the NAIC prescribed formula and made that .1 percent instead of one percent, it will have a much lower RBC. The recommended ranges would then be much higher ranges.

MR. TOOLE: Okay.

MR. RECTOR: I'm sorry. Just to follow up on that, so if they had done that, the companies reported RBC you're saying might be lower, but the Milliman recommended ranges even would stay the same or would even be

higher. Is that the point?

MR. DOBSON: We develop it as a chance of getting to the various levels.

MR. RECTOR: But I think if the NAIC changed so that they went from line one percent to ..1, what it would change from the NAICs would be the authorized control level RBC. That would go down.

MR. DOBSON: Yes, but --

MR. RECTOR: So I think the multiple would actually be a higher multiple.

MR. RECTOR: -- change in itself, too.

MR. RECTOR: Is that --

MR. DOBSON: Yes, I would have to look at that. That could have some impact. I'm not sure about that now that you mention it.

MR. RECTOR: You haven't thought of that. That's --

MR. DOBSON: I see a different aspect of it I wasn't think though.

MR. TOOLE: Okay. That's why I'm here.

You have really a rich history in your model, but can you talk about some limitations that you see in the approach both from the standpoint of your company's specific assumptions and maybe in model design? What are your strengths and your weaknesses?

MR. DOBSON: The strengths?

MR. TOOLE: Yeah. I think we've heard the strengths. It's the standard, but what maybe does it not capture?

MR. DOBSON: Well, not model is perfect.

MR. TOOLE: Right.

MR. DOBSON: There's always simplifying assumptions, of course. I'm sure there could be a lot of things one could look at and think, well, gee, we could do this a little bit better or that a little bit better.

The biggest thing I can think of offhand that we might want to refine going

forward is the reflection of size. We have introduced reflection of size now, but it's still not very sensitive to size. So that might be something that we look at changing in future iterations.

MR. TOOLE: How does your model -- well, as it stands, it's my understanding that the model is independent of management actions. So can you describe specific interventions that management could take to mitigate losses or discretionary during a down cycle?

MR. DOBSON: I'm not sure I would have described it as independent of management interventions, but I can see you describing it that way because in the loss cycle we assume that that loss cycle is going to occur, and it may be in spite of management's intentions and various interventions that management might do.

The other thing that counters that a little bit is if management is not actually

getting the margins that we assume, we do assume that those margins are being built in the rates. So to the extent that those aren't into it going in, you know, maybe there's a lack of conservatism to that element. So that may counter that just a little bit.

Again, it's impossible for a model to exactly replicate what would happen in reality.

MR. TOOLE: Then I guess I'd throw out to management then if we're in a down or an adverse cycle, what sorts of investments in infrastructure can be delayed.

MR. BURRELL: Well, you're talking about administrative things?

MR. TOOLE: Well, I know that you're in your long-term plan. You have quite a bit of plan investments in infrastructure, and they do contribute to the down cycle. So I guess --

MR. BURRELL: Well, it has a very, very minor --

MR. TOOLE: I mean, management has to matter. So what steps can you take during an adverse loss cycle to mitigate that?

MR. BURRELL: Let me just put it in perspective. Our admin as a percentage of our revenue last year was 10.8 percent. It might vary a fraction of a percent year to year as we go forward. It's not a very big difference year to year, will never have by itself a huge impact on the cycle.

Things that relate more to the cost of care, what care actually costs and what trends are actually in the market, I mean, we are always looking at ways to improve the way we contract with providers, provide incentives for high quality, cost effective care, ability to measure it, see it, reward it.

But in terms of the actual administrative expense, it's a small piece of the total equation, and even minor foreseeable changes in that don't have much impact on the

whole.

MR. TOOLE: Sixty million dollars.

MR. BURRELL: Well, and billions.

MR. TOOLE: I recognize that, but that's the difference between --

MR. BURRELL: -- over a period of years it's capitalized. It's not all in one period.

MR. TOOLE: And your long-term plan and in this year there were specific expenditures for $60 million.

MR. BURRELL: It's counteracting forces. By making the investment we become more efficient. The net off that we're trying to get if you just look at just the administrative dollar is to cut the administrative dollar, not add to it. So the investment is almost always in that context.

MR. TOOLE: Okay. One of the drivers of the range was the amount of growth that was assumed in a down cycle. Can growth be managed?

MR. BURRELL: Do you mean enrollment growth or premium growth?

MR. TOOLE: Correct.

MR. BURRELL: Well, it goes to the heart of our mission. We put ourselves out there for the community, to attract subscribers because we offer products that they perceive having value. We don't say to people, "We attracted you and we'll turn you away in order for us to limit our growth." That is antithetical to our mission.

So we take the growth we get, and we seek to manage that, the costs of that growth, by constantly becoming more efficient, which comes to the investment question.

With regard to the yields in our revenue, we have consistently in recent years produced less revenue than our rating formulas would indicate because employer groups buy down their benefits. They reduce their benefits.

So just as an example, to pick a

simple example, if a group had a ten percent rate increase and didn't want to pay a ten percent rate increase, they would increase their deductible or introduce other limits in their benefit plan design to cut that increase down.

And the biggest thing that has happened, as I mentioned in my testimony, in recently years, and it has been very fast, I think unprecedented, is the movement towards high deductible health plans. As I mentioned three years ago there was virtually none of it, and today more than half the market in Maryland in the small group market has a high deductible health plan, and that's what's happening now by degrees in the District, same pattern, just a slight stagger later.

So what happens is the premium is quoted. The groups reduce the scope of their benefit, and they don't have the rate increase that they would have had otherwise, but they're also offering to their members less

benefits, and that has had an effect on the growth of the company's revenue for sure, and that has been the biggest single factor is that buy-down process, and that is not in any way unique to us. That's basically going on all over the country.

And it's a response, the first wave of response, if you will, to the high, unaffordable price of health care coverage.

MR. TOOLE: thank you.

How many companies have you advised with regard to their surplus levels do you think, Milliman, using this model?

MR. DOBSON: We've tallied that up at one point. I don't know if I recall the exact number. I think it would be somewhere between ten and 20.

MR. TOOLE: And are all of them in a public hearing situation or some of them just --

MR. DOBSON: No, some of those are non-public.

MR. TOOLE: Okay.

MR. DOBSON: And did you put a time frame on that?

MR. TOOLE: No, I really didn't.

MR. DOBSON: Okay. Because I was speaking over a number of years.

MR. TOOLE: Yeah. Have you been in a situation where you've had to talk to a company where their surplus was too little, below the range?

MR. DOBSON: Oh, that they had--

MR. TOOLE: That you advised, below their advised range.

MR. DOBSON: I'm sorry. That their surplus was below the --

MR. TOOLE: Outside of the range.

MR. DOBSON: Outside of the range? Not that I've personally been involved in. I'm certain that's happened. I've certainly been in situations where companies had too little surplus.

MR. TOOLE: True. Have you been

in situations where you have advised companies where there surplus is too high?

MR. DOBSON: I think there have been some situations, none that I can recall. I couldn't point you to a single one, but I certainly concede that that could have happened, yes.

MR. TOOLE: It would be wonderful to have that sort of information if it's available.

MR. DOBSON: Yeah, I can try to find out certainly.

MR. TOOLE: So what are some potential downsides to accompany having too much surplus in a market where they have a dominant position?

MR. DOBSON: Are you addressing that to me or to the company?

MR. TOOLE: I guess it's to the panel.

MR. BURRELL: Downside of too much?

MR. TOOLE: Are there any downsides to competitiveness for a company having too much surplus when they are the controlling force in the market?

MR. BURRELL: I don't know that there's any controlling force in a market.

MR. TOOLE: Well, let's call it a monopoly status where you've got 80 to 90 percent of the market.

MR. BURRELL: Okay. As I explained earlier, every group comes to us pass through extensive filters, if you will, consultants who advise, who tell them what their best value is, they don't listen to us entirely. We make our case. They decide with expert advice, without exception on the big end, and on the small end we are always virtually spreadsheet against the competition.

MR. TOOLE: Okay.

MR. BURRELL: Our value compared to every other competitor. No market is perfect, but to say that that is a control

situation, I think, is not the right way to look at it. One thing about holding a reserve that has been helpful and helpful to subscribers is that the earnings on the reserve itself are available so that you don't have to get those from the premiums themselves, and that has a moderating effect on premium.

We do have a substantial portion of our bottom line come from the earnings on our reserve, and we return that, in effect, in the form of lower premiums than we otherwise would have charged because we don't need to get it from premium because we're getting it from the earnings on the reserve itself, and so that helps the subscriber. It helps make it more affordable. The lower the reserve gets, the lower the earnings go and the less it helps.

MR. TOOLE: but there's no situation where you talked about large companies trying to enter the market and they

support lower rates coming in which are not supportable on the other side of the equation where you lower rates which are not supportable in order to prevent competition.

MR. BURRELL: Again, we are, in terms of our connection to this community, seeking to be the most stable continuous force here. We're not in the business of buying business.

I would put something in perspective. In the small group market, and I don't know that it is in the District off the top of my head, but I do know what it is in the region overall. We cover 41,000 small employer groups, and we cover another couple of thousand groups that are between 51 and 199, and you could say those are medium size groups, and we cover the jumbo groups that have tens of thousands of people in them.

And the consequence of that is that we also offer flexibility in benefit design. So for 41,000 small employer groups,

there are literally hundreds of benefit combinations that they could pick, and at any point in time, depending on the need of the group, the advice of the consultant or the broker, they're picking different combinations of those things. It's a very complex market.

What we try to do in the light of that complex market is to say all things considered, take all of that complexity, all of the changes in the benefits, 45 percent of our groups change benefits on renewal. So you take all of the complexity and the benefit designs, all of the churn in the market, all of the changes in the membership, all of the changes in the medical care trends, and you try to say as a company can we get that right within one percent.

And last year we had two-tenths of a percent, and this year we aspire to the lofty number of between half a percent and one percent. And the consequence of these millions of transactions that are going on is

such that it's hard to pin it down precisely, but that's as precise as human beings can do it, and we try to do that consistently over a period of time so that it's not just one year. It's multiple years.

COMMISSIONER BARLOW: A couple of times in your testimony and in answer to, I think, that last question, you seem to imply there's a relationship between the level of surplus that you have and the pricing of your products. Is there an explicit component of the pricing of your products that's related to the amount of surplus that you have or --

MR. BURRELL: No.

COMMISSIONER BARLOW: -- it's --

MR. BURRELL: No, I think it's the whole idea. If you take what we have said, we try to establish on the best professional advice we can get what an optimal range ought to be. We try to stay within that range, which is the net of all the things I just described.

COMMISSIONER BARLOW: And an optimal range of --

MR. BURRELL: The reserve.

COMMISSIONER BARLOW: Okay, but I'm trying to understand how that impacts pricing.

MR. BURRELL: Pricing policy is affected by that because if you're below that, you try to come back into it as moderately as you can, which means you put a little more margin in, and if you are in the range, you don't have to put so much in. If you were at the top of the range, you wouldn't put it in at all or you would put very little in so that you would come back down.

COMMISSIONER BARLOW: Okay. So the way that the level of your surplus impacts the pricing of your products is in the level of the margin that you include in the pricing.

MR. BURRELL: Yes.

COMMISSIONER BARLOW: Okay, and so there's not like a direct relation. You look

at your surplus and you --

MR. BURRELL: With all of the product designs that we have, in all of the group sizes that we have, with all of the individuals we have, it's the net effect of how all of that is interplaying against each other. It's a complex situation.

MR. TOOLE: Bob. Sorry. Mr. Dobson. We're going to go into some assumptions. I don't want to bore everybody in the room, but I want to get some stuff on the record. Recognizing that each assumption is different in those seven groups, can you explain the general process that you went through and company specific factors?

I know you had some stuff that's general for the Blue Cross/Blue Shield and then some stuff that's company specific. Talk about how you did that.

MR. DOBSON: The assumptions themselves are the series of distributions of the contingencies around those risks that we

shared with you and went through. Most of that is based on the experience of the consultants doing it and looking at and considering the individual characteristics of the company. I wouldn't say at least none of it I can think of offhand is based directly on Blue Cross as a whole, other than the fact that it affects our experience, I guess, because we've worked with lots of Blue Cross plans.

But the actual setting of each of those is based on considering the company we're working for at the time and what we see from the experience and various analyses we look at, you know, some of which I think we discussed with you when you were in our office.

I can't sit here now and tell you exactly what we looked at for each one of those unfortunately. I'd need the rest of the team with me to be able to do that justice.

MR. TOOLE: There's a lot of

detail. Can you quickly describe -- you've already mentioned it -- how prior industry and the GHMSI prior underwriting cycles impacted your future underwriting cycle loss distribution?

MR. DOBSON: Well, we don't actually set the loss distribution based on those past ones. We look at those after the fact as I described in my testimony. I would say that this was going through the assumptions related to the seven risks. We're considering what happened in prior times, in past adverse experiences. That's more subjective in terms of setting those assumptions about what might happen in the future.

For example, on the trend or rating factor miss, you know, we assign probabilities that are literally within two percent each way, you know, X percent probability that within two percent each way of expected, you know, Y percent that it will

be five percent deviation, and those are based on our collective experience of all the different operations we've seen over the years and what we know about the company's pricing.

MR. TOOLE: Could you explain how the margin that we just discussed is used in your model, the pricing margins?

MR. DOBSON: Yes. The margins go in, the assumed margins, and that does have an impact because that directly goes into that calculation of the trend. For example, if we assume the company is going to be three percent off on the trend, but we know they build a three percent margin in, then that financial impact of that is zero. So we directly take that into account, and that's why if the company increases or decreases that margin it directly affects our results.

MR. RECTOR: Can I ask a quick follow-up on that? In the adverse cycles, did you take the margins down to zero or --

MR. DOBSON: No.

MR. RECTOR: -- I mean, the adverse cycles I guess you'd increase the margin, pricing margin.

MR. DOBSON: If you think about margin perhaps the way Mr. Burrell is looking at it of what they achieve, of course, that can go to zero; that can go negative.

MR. RECTOR: Right.

MR. DOBSON: But the intended pricing margin we give credit for. So if we say the company is off by five points in the rating factors, well, we know they've built in a three percent margin. Then we say the underwriting loss is going to be two percent.

MR. RECTOR: Yeah, I flipped it. In the model as you're going through the adverse cycles, and I'm coming back maybe to Jim's earlier questions on management intervention. In the model as you start going in the adverse cycle, did you increase the intended pricing margin?

MR. DOBSON: No, we don't. We use

the same one. One of the things I mentioned in the testimony was we look at the adverse loss cycle that are over two or two and a half rating cycles, and then we use a three or a four-year financial period, and awe assume that there's going to be three years of positive margin in the three-year cycle, four years of positive margin in the four-year cycle.

So the four-year actually gives less severe bottom line results because we've got four years of margin coming in.

MR. RECTOR: Margin.

MR. DOBSON: Right.

MR. RECTOR: What's the standard margin that you use throughout in the model, if you recall?

MR. DOBSON: Is that considered proprietary to the company?

MR. RECTOR: Well --

MR. BURRELL: I mean the actual margin we achieve is --

MR. RECTOR: No, I'm talking about in the model.

MR. BURRELL: In the model I don't.

MR. RECTOR: You don't? Okay. That's --

MR. DOBSON: Yeah, I think that's considered proprietary to the company, and I would be hesitant to answer that without their permission, but that has been shared with Jim, yeah.

MR. TOOLE: So I'd like to change over to Mr. Carlson, get you involved. You mentioned in your statement what you based your opinion on, and I marked up something that based on our understanding of their model and consideration of their assumptions. What sort of access to their assumptions did you have that you were able to review?

MR. CARLSON: We had the report that was publicly available, and we also have similar models that we run ourselves. So

based on their report, we interpreted, you know, what we would have put into our similar models based on the publicly available report.

MR. TOOLE: In the publicly available report, there was no information on any of the seven risk assumptions.

MR. CARLSON: Right.

MR. TOOLE: So you gave an opinion without even looking at their risk assumptions?

MR. CARLSON: We gave an opinion based on what we felt were a reasonable range of what we would expect for these types of assumptions, and then we tested these ranges, the high end and the low end, and we did not run a Monte Carlo simulation as referenced in the paper, but we were doing tests on the high and low end.

So we were sort of testing the extremes to see if we thought that our results would have been in line with their results.

MR. TOOLE: So you took a somewhat

different approach in that you didn't really have any assumptions, and you didn't run any simulations. I'm having a hard time understanding what your report -- how it --

MR. CARLSON: Well, you're correct. We took a very different approach.

MR. TOOLE: Okay.

MR. CARLSON: And that is true. And our approach was, you know, coming in at a very high level and examining what we -- based on, you know, previous models that we've run for previous Blues plans and some of the basic, publicly available information on GHMSI if we felt that the results that were coming out of Milliman's model were in line with results we've seen in other Blues plans and, you know, modified for assumptions that may be applicable to GHMSI or assumptions that would be sort of on the, like I mentioned, on the testing the edges of what would be a reasonable assumption.

MR. TOOLE: So about how many

companies has your firm been involved in in doing this sort of analysis?

MR. CARLSON: In the last ten years it's been about five companies.

MR. TOOLE: Okay. Have any of those companies been found to be outside on the excess?

MR. CARLSON: Yes.

MR. TOOLE: Okay.

MR. CARLSON: Yes.

MR. TOOLE: That also would be of great interest to us.

MR. CARLSON: Okay, and you know, a lot of this is proprietary.

MR. TOOLE: I know.

MR. CARLSON: Or not in the public forum. So we can look into what -- we can describe this in more detail.

COMMISSIONER PURCELL: I have one question for Mr. Carlson. On page five of your testimony you state at the bottom of the third paragraph, second full paragraph, there

are a number of additional risk factors and individual market considerations that should be considered when comparing surplus needs.

Can you detail or just summarize what some of those are in distinguishing Pennsylvania's example from the current GHMSI issue?

MR. CARLSON: Sure. Well, I think the one issue that really stands out at GHMSI is the FEP contracts. GHMSI has the largest FEP contract of the Blues plans, and the Pennsylvania plans, you know, are certainly much smaller in their federal business.

COMMISSIONER PURCELL: Okay. I just was curious as to what those were since you made the example.

Were there any other questions?

MR. RECTOR: I had one quick question for Mr. Burrell. If the company -- I think you said you were on the Blue Cross board and on the early monitoring board. If a company, if a Blue Cross plan breaches the

375 percent threshold, is that public?

I mean obviously their RBC, somebody could look at the financial statements, but is there some sort of announcement or anything that's --

MR. BURRELL: Not from the association, but all of the company's reports are obviously public as they have been filed.

MR. RECTOR: Okay, and I know you talked about there being a 500 percent trigger. Is there any trigger between the 200 and the 375 or is it -- so it's 200, 375, 500, are the three triggers?

MR. BURRELL: I think that's the way to think of it, yeah.

MR. RECTOR: Thanks.

COMMISSIONER PURCELL: Okay, great. I think with that we will dismiss this panel. Mr. Hogan, Mr. Burrell, Mr. Chaney, Mr. Dobson, and Mr. Carlson, thank you.

We're going to deviate slightly from the witness list because of a scheduling

issue, and, Mr. Smith, thank you for pausing for one moment. We're going to hear from the Maryland Insurance Commissioner, Mr. Ralph Tyler.

MS. JOHNSON: Mr. Tyler, would you raise your right hand, please?

Do you swear or affirm to tell the truth, the whole truth, and nothing but the truth, so help you?

Thank you.

COMMISSIONER PURCELL: Good afternoon, Ralph.

MR. TYLER: Good afternoon, Commissioner, and my thanks first for being allowed to be here today to participate in this important hearing and, secondly and not insignificantly, I appreciate your taking me out of turn, and I promise not to abuse that privilege, and I will be brief because I know there are others from whom you wish to hear.

My name is Ralph Tyler, and I'm the Insurance Commissioner for the State of

Maryland, a position I've held since September of 2007. I've submitted written testimony, which I would propose to summarize and not to read in the interest of time.

The first and perhaps most important thing that I would like to say is that we in Maryland are keenly aware and appreciative of the importance of the hearing in the matters you are considering. These are matters in which we have a deeply shared common interest because as you well know and certainly confirm by the earlier testimony, one of the unique features of the company you're looking at, GHMSI, is that it operates in three jurisdictions, including significantly and importantly in Maryland.

We also share your interest in insuring that the company meets its public purpose obligations. We take those obligations seriously in Maryland as you do here.

We take no position on the

question of whether GHMSI has excessive surplus. It's not because we're not interested in that question. We are very interested in that question. We take no position on it for the reason that we are ourselves in the midst of an examination of that question. We've hired a consulting firm, the Invotex firm that is working on that question, and we expect to have a report from them within approximately 45 days of now.

And what I wanted to specifically say is we want to work with you and cooperate with you throughout this. We certainly want to make that report available to you. Obviously the schedule you're on and the one we are on don't match up perfectly, and whatever might be done to accommodate that, and whether you might consider issuing an interim report so that you'd have the benefit of the Invotex work, I mean, of course, I leave that up to you.

But what I want to stress is that

we do want to cooperate and we are also looking at these questions.

Now, there was a lot of discussion from the earlier panel about the question of attribution, and that, of course, is important, and it's important to Maryland as it is to you. The statute calls upon the Commissioner here to review the portion of the surplus of the corporation that is attributable to the District, and I believe that the questions that were asked by Mr. Rector as well as others, we would associate ourselves with that; that that is a difficult question with considerably greater complexity than the papers acknowledge, and we, too are interested in that question, and that is one of the questions upon which we expect to be getting advice from the Invotex firm, and I think that that is a difficult question, and that it's important, again to all of us and to our shared interest.

The final point I would like to

discuss is this, and that is the question of the remedy, if you will, if the surplus is determined to be excessive. Again, and for present purposes I assume that such a determination is made, albeit we don't take a position on that because we are waiting advice on that question.

And the District statute, and I say this with no chauvinistic sense. It happens to be true. The District statute here was modeled on an existing Maryland law. Again, I'm proud of Maryland, but it's a small point, but it happens to be true. The Maryland statute upon which the District statute is modeled is Section 14-117(e) of the insurance article of the Maryland code.

And the Maryland statute like the District statute calls upon if in the event that there's a determination that the surplus is excessive and calls upon the corporation to develop a plan, and then as to the plan, the language in the District statute is as

follows. It says, "A plan submitted pursuant to Paragraph 1 of this subsection may consist entirely of expenditures for the benefit of current subscribers of the corporation."

The Maryland statute is not permissive in that regard. The District statute says the corporation plan may consist entirely. The Maryland statute, by contrast, is mandatory. It says the distribution ordered under Paragraph 2 of this subsection may be made only to subscribers who are covered by the corporation's nonprofit health plan.

But my point would be this, that in the event that there is a determination that there is an excessive surplus, I think this remedial provision is a very thoughtful and correct one, that any excess exists because subscribers paid, experience showed, excessive rates, and so the appropriate plan for distribution of any excess would be for rate reductions or some other way to return it

to the subscribers, and that that importantly answers concerns that the regulatory system and the integrity of decision making would be distorted by thinking that a finding of excess would be a source of revenue for general use.

The corporation would have it within its rights, again, under the plain language of the statute to come forward with a plan consisting entirely of expenditures for the benefit of current subscribers, and we would suggest that that would be an appropriate plan and, indeed, the only appropriate plan.

With that, I will stop and I would be happy to answer any questions. And, again, I thank you for allowing me to be here.

COMMISSIONER PURCELL: Thank you for your testimony.

And it's inspired that you speak of that because my question to you was going to be your thoughts on that distinction in the Maryland law, that restriction of distribution

which we don't have as clearly written in ours.

I will say I'm not patently averse to your suggestions in terms of working together, collaborating. I've expressed to you that's something I'm willing and able to do. I will definitely take into consideration the suggestions you made about possibly doing interim order. Of course I'm limited and restricted to the duties that I've been assigned, but I will certainly keep you informed as I hope I have been doing.

MR. TYLER: You surely have.

COMMISSIONER PURCELL: I don't have any specific questions for you. I think that we will talk a lot over the next few weeks hopefully. I am interested in seeing the suggestions that come in your report from Invotex. I'm in the information gathering stage right now, and so I think to the extent you're willing to make that part of the record, we are on board and would appreciate

that.

MR. TYLER: Certainly.

COMMISSIONER PURCELL: Any questions from the panel?

(No response.)

COMMISSIONER PURCELL: No. Thank you, Mr. Tyler, very much.

MR. TYLER: Again, thanks to all of you. Thank you very much.

COMMISSIONER PURCELL: Thank you.

At this time we will proceed by calling Mr. Walter Smith, Executive Director for D.C. Appleseed Center for Law and Justice and his witness panel.

Good afternoon. After we've sworn you in, if you could just introduce yourself and let me know in what order you'll be providing your testimony.

Thank you.

MS. JOHNSON: Would you all raise you right hands to be sworn in, please? Do you swear or affirm to tell the truth, the

whole truth, and nothing but the truth so help you?

WITNESSES: I do.

MS. JOHNSON: Thank you.

MR. SMITH: Good afternoon. I'm Walter Smith, the Director of D.C. Appleseed. I have with me here Deborah Challet at my far left from Mathematica. This is Mr. Cory Zass from ARM. This is Mr. Mark Shaw, also from ARM, and this is Kurt Calia from Covington & Burling.

As you know, we have filed both a prehearing report and are submitting testimony today, and it's the collective effort of all of these folks at the table, but because we only have 20 minutes what we're going to try to do, Madam Commissioner, is I'm going to speak for just a few minutes about some overall points that we want to make, and I'm going to try to make them in furtherance of the conversation you've already been having rather than trying to read what is the

prepared testimony.

And then I want you to hear from our actuarial experts who we engaged to try to assist you in this process.

And I should say at the beginning the reason why we engaged actuarial experts was because when we read the submission from Carefirst, as we interpreted it, the whole of their case comes down to Milliman range. Everything they're asking you to do comes down to them asking you to accept the Milliman range, and that thought was confirmed further by what I heard here today because they believe, I think that the range that Milliman has urged them to adopt equates to financial soundness, drives their position that they're meeting the maximum feasible, and has driven where they set the community reinvestment.

I think in an exchange with you, Madam Commissioner, Mr. Burrell said they know how much to spend on community reinvestment once they know how much is available given

their surplus range.

The reason why we think it is so critical to scrutinize the Milliman range, since that's their whole defense, is that it is in the interest of the public that they get that range right and that you get that range right because if you don't, the twin requirements of the statute can't be served, that is, financial soundness, on the one hand, and maximum feasible, on the other. If you don't get the range right, you're not going to serve the public's dual interest in those two somewhat competing policies because if you don't give them enough for financial soundness, you threaten their solvency, of course, but if they don't meet maximum feasible, here's what happens, and especially if they've been following the surplus range to set maximum feasible.

It means, as they candidly admit in their documents, they are overcharging subscribers because the source of the surplus

is revenues that came from the subscribers, and as they say, if they've got a surplus, they've overcharged them and they should refund it.

And the longer they're in a surplus range that may be inappropriate, the longer they're overcharging. Now, here's why it's important though for an additional reason.

Another exchange that Mr. Burrell had with you, and he invoked the President from last night, I'd like to do the same thing. We live in an economy right now where a lot of people are having difficulty getting access to affordable health care, and as premiums go up, it's harder for them to get that health care. One of the tremendous things that this company could do if it has excess surplus is, in fact, make it easier for the people Mr. Burrell is solicitous about to get access to affordable health care. Because if he continues to have low community

reinvestment, and if he continues to have a surplus range that is too high, he is to that extent not using the company's ability to assist people to get access to affordable health care.

Some people are under insured. Some people are uninsured, but the net at the end of the day is this public asset, our D.C. Attorney General has told us, this company is an asset of the public, and it could be used, if there's excess surplus here, to help the public get access to more affordable health care.

And in our view, that is why it is so important that you get this right, and it is why, since we saw their whole position is based on Milliman, we engaged actuarial experts.

Now, let me say -- let me see how much have I used up. I'm going to take three or four more minutes.

When we submitted the report from

our actuarial experts, I apologize to you and to Carefirst and to Milliman and to Lewin. If they read any disrespect toward their professional judgments, none was intended. We realize though, and I can say this as a non-actuarial expert, these are difficult and complex judgments being made where professionals can reasonably disagree, and the smallest shift in an assumption produces movements of millions of dollars, millions of dollars that if they made an unsound assumption would have been available to bring to more people affordable health care.

So that's why we wanted you to have the benefit of our actuarial experts thinking about, and the primary purpose of what they did was to show how three or four assumptions that seemed to us to drive the Milliman report produced differences of hundreds of millions of dollars with regard to a permissible range.

Let me say one thing about Lewin.

I have great respect for Lewin. At the beginning of this project we tried to see if we could hire them. We couldn't afford them, but there's a very important sentence in the Lewin report. I'm sure you caught it, but I just want to bring it to your attention.

I do not believe the Lewin report should be read as a second opinion validating the particular ranges that have been produced by Milliman. If you read pages 45 and 47 of the Lewin report, they are very careful to say, and the Lewis Group are very careful people, that they cannot endorse the specific ranges that were produced by Milliman.

They endorse the methodology, if used correctly. So would we. They endorse the proposition that you would have ranges. So would we. But I do not believe it is so that Lewin endorses the particular ranges.

I want to say one last thing. At the beginning of Mr. Burrell's comments there was quite, I would say, complimentary attack

on D.C. Appleseed. Let me tell you that we're not so powerful that we have produced the statute in front of you. In our view what has produced the statute in front of you is a long string of decisions by the Insurance Commissioner in this jurisdiction, the Insurance Commissioner in Maryland, the legislature in Maryland, the legislature in the District of Columbia, the Attorney General in Maryland, the Attorney General in the District of Columbia, all of them questioning whether or not this publicly owned asset is being managed in the public interest. That is why we've been engaged in this process, and I believe that's why the legislation you have in front of you was passed.

The council finally said they needed to have a system of accountability for this company, and that is what you are about here.

I am going to make one more point. Much was said at the beginning in Carefirst's

presentation that D.C. Appleseed and other have in mind taking money from subscribers to give it to non-subscribers so that we can set up a dual between them. Nothing could be further from the truth.

As you know, the statute, if you find excess surplus, authorizes the company to develop the plan, and as was point out by Mr. Tyler, in fact, to spend all of the excess surplus found for subscribers.

The truth of the matter though is, as the D.C. Attorney General has made clear and as Commissioner Burrell made clear, they have the discretion to spend money on other than for subscribers, and they have been doing it for years, in our view to their credit.

So there's a contradiction in what they're saying. They label money that they would spend on other than subscribers of confiscation, but on the other hand, I think they recognize that spending money on other than directly for subscribers advances their

public service mission, but at the end of the day it will be their choice. They will develop the plan for your review. So neither we nor anyone else is going to force them to spend money on other than subscribers, although the statute does authorize it, and as the work we have done throughout this long issue that we've been working on, we believe that the federal charter likewise contemplates that money can be spent on past subscribers, current subscribers, and for the benefit of future subscribers.

But that is not nearly as important, as I said at the beginning, as the range. If you proceed to review their work based on the Milliman range, then that drives everything the company has asked you to do, and that is why we have engaged the folks that we have, and I want you to speak to them next.

Thank you very much.

COMMISSIONER PURCELL: Thank you.

MR. ZASS: Good afternoon. My

name is Corwin Zass.

First I'd like to make a quick comment. I know we're given a limitation on time. So my written testimony will be obviously a little different than what I'm going to verbally talk about here.

I'm a principal and consulting actuary of Actuarial Risk Management. I'm an associate of the Society of Actuaries, a member of the American Academy of Actuaries, and a Fellow of the Conference of Consulting Actuaries.

I'd also like to welcome my astute colleague Mark Shaw who joins me in being available to help explain our conclusions. Mark is a Fellow of the society, a charter enterprise risk analyst with the Society of Actuaries, a member of the academy as well.

Both I and Mr. Shaw are actuaries in good standing with the American Academy of Actuaries, and we conducted this assessment in a professional and ethical manner, and we

followed actuarial standards of practice in providing our August 31st, 2009 report, and honor any code of professional conduct in which we conduct this expert testimony.

To echo Walter's comments, I agree a difference of opinion does not imply unprofessionalism.

Actuarial Risk Management is a global actuarial risk provider and independent member of the BDO Seidman Alliance Program. We provide BDO, the fifth largest global accounting firm, with audit and non-audit support across very similar practice areas as Milliman.

ARM's business model relies on a deep resource pool which currently consists of approximately 50 well tenured and technically savvy, qualified actuaries, risk managers, and benefit specialists. Many of the ARM experts available to us have previously held practice leader positions with accounting firms, other large national and international consulting

firms, as well as chief actuary roles in insurance arenas.

I must admit that Mr. Burrell's adds to some of the confusion with his interchange on labeling reserves and surplus. This is not a discussion, in my opinion, on reserve adequacy. It's a question or a comment on the excess or the deemed excess of surplus, not reserves.

In this engagement we assessed and reported our findings in an objective manner. Before I make any comments specific on Milliman, I'd like to make a couple of general comments on a model review and assessment that we conduct.

Specifically, a good model can be very useful in managing future unknowns only if -- and I stress "only if" -- a model's methods are sound and the assumptions reasonably combine the past knowns with common sense and educated expectations and, finally, have model approaches and results conveyed in

a very transparent manner.

Models have been the backbone of the actuarial professional for many centuries and will continue well into the future. I instill in every ARM engagement that we must enter a project with healthy skepticism. This cautious approach engages ARM to identify situations in the models that are simply wrong where others might take for granted as not being possibly wrong. Our approach to models in general includes the asking of questions like this:

How well does the model predict the future?

Another question, how many variables or assumptions are used in a model?

This gives a model reviewer some sense of complexities using the model. Over the years I've witnessed some very simple models that were very useful, but on the other hand, I've seen some complex models simply missing the mark.

This leads to the next question. Yet another inquiry would be are those models and the assumptions used correctly? Again, to reiterate, transparent models, when properly constructed by experts, with the understandable and defendable assumptions, are very important in the management of the future unknowns.

Now I'll give you some insight into the models, the modeling, the modelers. I will, albeit briefly, discuss our findings of our assessment of GHMSI's surplus position.

Before I do this, I must stress that ARM requested a comprehensive list of items we needed to thoroughly assess GHMSI's surplus. However, we received little other than the GHMSI's public financial statements along with any information we garnered from simple searches.

Using these sources, we conducted our assessment. As previously discussed, transparency is key. We deemed the lack of

transparency in the model as a black box characteristic. That's why we used that throughout our report.

We identified four key Milliman assumptions which we believe distorted the Milliman model and, thus, the results which overstated the needs of GHMSI's surplus. As described in our submission, the following points were submitted in written testimony and summarized our findings.

I will now take a few minutes first to comment on Carefirst testimony. On page 1 and 2 of Mr. Dobson's testimony, he discussed the information relevant to the model. However, this was information available to Milliman internally only.

We also note that Mr. Carlson of Lewin said on page 3 of his report, akin to what Mr. Toole had raised, that there was really no review of the assumptions themselves, nor was there any performance of extensive modeling. We do note that.

We wanted to comment on some black box aspects, or what we've deemed as non-transparent assumptions in the Milliman report. These are just simply examples and submitted in the written testimony.

On page 46, they discuss the range of possible values for each risk in contingent categories, but there is really no explanation on the breakdowns or what those were.

Page 46 to 49, the complete range of Monte Carlo results before application of pro forma modeling, again, there's no real information here other than providing some insight.

The assumptions in the pro forma on page 53 to 54 discuss the modeling relative to the FAP. Again, there is no real information on the pro formas, which as we have found out was really the basis of GHMSI's own internal models.

Speaking further on Mr. Dobson's submission, which it specifically does mention

on page 3, we find out for the first time that Milliman did use GHMSI's internal models for the pro forma model. We asked did Milliman validate those models.

Secondly, on page 5, we see no evidence that Milliman offset the potential underwriting losses. Again, we have transparency concerns. For us to be able to ascertain that that was offset, we'd actually like to see it.

On top of page 6, the comment with respect to considering the growth of First Care Blue Choice, we certainly see this as being an irrelevant statement and bears no meaning to what this assessment was and the surplus of GHMSI.

Also on number five, Milliman has not disclosed before that they tested this eight percent growth rate. They said that they would not change the lower end of the range. What did change would be our kind of comment there.

Furthermore, Mr. Dobson under further testimony stated that Milliman takes the company's pro forma models and converts it to a simple model. We talk about complexity of the models, and then we hear a comment about simple models. I'm not sure which one it is.

Speaking of another comment, there was a statement in reference to earnings. I do note that GHMSI did lose about $6 million in underwriting loss for year to date 2009, but ended up showing a bottom line income of $16 million positive.

But I also note that the surplus dropped $2 million, and primarily driven by a change of $20 million in the not admitted assets. Again, we have made comments in the past about the non-admitted assets in our submission.

We'd also like to point out on Carefirst's filings, it's their consolidated financial statements and other financial

information for 2008 with the report of the independent auditors. On page 37 they quote, "Management has determined based on the company's long-term history of operating earnings and its expectation for the future that income of the company will more likely than not be sufficient."

This simply implies positive earnings into the future.

In closing, given the fact that we have not had access to much other than public information, financial statements and so forth that we could garner from the Carefirst Website and from the DISB Website as well, we are confident that adjusting the four assumptions that we have submitted will produce a more realistic range of 400 to 525 percent RBC.

We do have a desire to look under the hood of Milliman's model, but in the interim, we have assessed the methods and assumptions in a very independent fashion with

a healthy dose of skepticism.

Thank you very much.

COMMISSIONER PURCELL: I'm going to give everyone an opportunity just to make a brief statement even in light of the time since we're here.

MR. SMITH: All right. Well, thank you very much.

COMMISSIONER PURCELL: Who's next?

MS. CHELLET: Thank you very much, Commissioner.

I don't have a prepared statement for today, but I would like to make a few points.

Number one, I think the importance of this hearing is obvious, and I agree with Mr. Smith that the range of the surplus is critical. I think there is ample reason to be doubtful about the high level of this surplus range that Milliman has produced, and that relates largely to the ranges of its clear competitors in the D.C. area and other

companies that are similarly situated with similar ACL levels and the ranges in which they operate.

It has always struck me, and I speak as an economist, not as an actuary, but it always has struck me that somebody has to be right; that if this company is so much more heavily reserved than other companies, then other companies must be under reserved because they face similar risks.

And I say that simply as an empirical observation.

The other thing that I'd like to point to is with respect to the research that I and Mathematica have done with respect to community needs. A number of years ago, and this was a report that was commissioned by D.C. Appleseed, we went to community leaders in Maryland, the District and Virginia and asked them about the role of a dominant insurer, like GHMSI, and what an insurer like this could do that would benefit not only

their subscribers, but also the general public and the community at large.

And my written statement lists some of those items that I think are certainly within the role of a community leader like GHMSI and certainly would be of value to its subscribers and the community that the company serves more broadly.

Thank you.

COMMISSIONER PURCELL: Thank you.

MR. SHAW: Thank you for the opportunity to speak, Commissioner.

Again, my name is Mark Shaw, and I will just comment briefly on the attachment to Walter Smith's testimony that goes into our review, ARM's review, of potential attribution of surplus if there is a finding that there is excess surplus.

Again, not having the benefit of some of the information that perhaps Milliman looked at in addition to what is available publicly, we based our report and looked at

it, a couple of different approaches based on publicly available data, and most of it coming directly from the statutory annual statement that GHMSI is required to file with the District on a regular basis.

We believe that the way insurance is regulated, that is, the District of Columbia regulates insurance contracts entered into the District as opposed to the insurance owned by persons that reside in the District is the way to look at things, and it is also the way that GHMSI's annual statements I would point out summarizes the way that premiums are allocated by jurisdiction.

So as we looked at the way that the annual statement addresses the premiums that GHMSI reports on an annual basis by jurisdiction, I will just describe to you what's on pages 5 and 6 of the attachment, basically take you through the ARM methodology looking at it not only by residence approach, but by looking at the data that's reported in

the annual statements of GHMSI from 1999 to 2008, the same time period, I would point out, that Milliman looked at by looking at different data.

I would point out, first of all, that 23 percent of the current surplus of GHMSI existed at the beginning of this period and 77 percent of the surplus emerged during this period as it grew from what it was at 12/31/98, but we took the data from the annual statements as follows.

We took from the five-year historical page, data page, in the annual filing the total surplus, the change in surplus, net underwriting gain, net investment income.

We took from Schedule T total premium income, District non-FEP premium, and District FEP premium, and from the analysis of operations by line of business exhibit of the statement, we took net underwriting gain for FEP and net underwriting gain for all other

lines of business as our key input.

From that data we calculated the D.C. total profit for a given year as the sum of the net underwriting gain for FEP and with a percentage of the net underwriting gain for all other lines of business, that percentage of use being the proportion of non-FEP premium in D.C. versus all non-FEP premium in all jurisdictions.

We also calculated the D.C. net investment income for a given year as GHMSI's total net investment income for the year multiplied by the proportion of all GHMSI premiums in D.C. for the year to the total of all GHMSI premium in all jurisdictions for that year, and then we calculated the D.C. percentage of the surplus change for a given year as a sum of D.C. total profit and D.C. net investment income for a given year divided by the sum of total profit and total net investment income for the year.

Following these steps, we

calculate that the percentage of surplus attributable for D.C. for the years 1999 through 2008 is 56.7 percent, and as reported by GHMSI, D.C. premium was 78.8 percent of all premium for GHMSI during this time period, and even 31.7 percent of all non-FEP premium during this time period.

We point out again that this calculation, the 56.7 percent, is almost 77 percent of the surplus that has emerged since 12/31/98. If the prior surplus arose more akin to the way that the premiums were in 1999 and 2000, that is, approximately 70 percent of it from the District, then we would calculate in total that approximately 60 percent of the total surplus in the District, total surplus of GHMSI, is attributable to the district.

Then, as a second approach to determining the appropriate amount of attribution to the District, we looked at an exhibit that has appeared in the annual statements of GHMSI since 2002. We would have

looked at it before that if it had existed, but it didn't, and it's called the exhibits of premiums, enrollment, and utilization, and what this exhibit lists is the total member months of insurance by jurisdiction, and there are separate pages for Maryland, Virginia, and D.C., and we looked at that and looked at what it was over the time period, and 63.4 percent of the member months during the time period from 1999 to 2008 were for D.C. member months.

So our conclusion in looking at these two approaches is that roughly 60 percent, since they're fairly consistent, that roughly 60 percent of the surplus that is currently held by GHMSI is attributable to the District.

COMMISSIONER PURCELL: Thank you.

MR. CALIA: Good afternoon, Commissioner Purcell. I appreciate the opportunity to speak.

I am Kurt Calia of Covington & Burling, and like Ms. Chellet, I didn't

actually have any prepared remarks.

But I did want to speak briefly to the issue of the legal obligation that has arisen here because there has been some discussion about that in the context of the charter, in the context of the act that's at issue here today and otherwise. So I wanted to very quickly see if I could address some of the statements that were made with the earlier panel.

It was charged that the theories that D.C. Appleseed has espoused with regard to the legal obligation in characterizing GHMSI as a charitable and benevolent institution and saying that their assets belong to the public and saying that the assets or that GHMSI exists to serve the public is a D.C. Appleseed theory, that's not correct. Mr. Burrell got that wrong.

That language flows directly from opinions from the D.C. Attorney General and is entirely consistent with observations that

have been made by prior Insurance Commissioners.

But what I'd like to do in looking at that legal obligation is actually start with the charter, and I know that, I guess, a copy of the charter is going to be provided to this group.

Section 8 of the GHMSI charter declares it to be a charitable and benevolent institution. In his remarks Mr. Burrell said that was for the purpose of establishing the company as a tax exempt organization.

We disagree with that reading of the charter and, indeed, Congress has plenary power over taxation and has created tax exempt status for organizations without also taking the step of declaring them to be charitable and benevolent organizations.

We don't think that's a correct reading of the charter. Indeed, in Section 8 of the charter itself, there are some margin notes, and there is pretty clear case law that

says the margin notes in a congressional charter make clear Congress' intent, and in the margin notes in Section 8 it says, "Purposes declared."

So Congress intended to declare this company as a charitable and benevolent institution. Well, what does that mean? And I think the charter actually sheds some light on that, in addition to some other things that I'll talk about.

So Section 3, which was the subject in some earlier discussion refers to the corporation being conducted for the benefit of certificate holders.

In addition to the fact that there's case law, that means that the obligation applies not to just current certificate holders, but prospective policy holders or certificate holders, and indeed, we cite some of that authority in the 2004, December 2004, D.C. Appleseed report in Section 2, page 17, and I believe that's part

of this record, but if not, we will certainly provide it.

But also the precise language of Section 3 of the charter itself supports this view that the obligation doesn't exist only with regard to current subscribers. So Section 3 refers to, as I stated, the obligations of the corporation extending to certificate holders.

Actually the language is "aforesaid certificate holders." So in order to understand who the aforesaid certificate holders are, you actually have to look to Section 2 of the charter, and that refers to groups or persons including those with whom GHMSI is empowered to enter into contract into the future.

In other words, it's prospective. Specifically Section 2(c) of the charter states that GHMSI is authorized to "cooperate, consolidate, or contract with individuals or groups or organizations interested in

promoting and safeguarding the public health," in other words, prospective certificate holders as well as actual.

There is further case law which we cite in the December 2004 report, Section 2 on page 24, a Supreme Court case, the Jones case and the Geisinger Health Plan case, and I commend those to you.

Now, beyond the charter there are, as has been discussed, some legal opinions from the Attorney General and from the Insurance Commissioner that bear on this issue about the scope of the obligation, and I wanted to make sure that we had clarity in the record as to some of the statements that have been made.

In March 2005, then Attorney General for the District was looking into this issue about the legal obligation, and in an opinion published on March 4th of that year stated that D.C. Appleseed is correct in concluding that GHMSI, which was chartered by

Congress as a charitable and benevolent institution, has an obligation to pursue a public health mission, and that this obligation is not inconsistent with its obligation to operate for the benefit of its subscribers.

At page 2, the Attorney General went on to state, "GHMSI cannot simply fulfill its mission simply by allocating its percentage of specified premium to charitable activities. GHMSI is to devote its entire operation to serving directly or indirectly the purposes for which it was chartered."

He then goes on to write on page 4, "It is true that under both District and common law GHMSI's assets belong to the public, and unlike a for-profit company, GHMSI exists to serve the public."

There was also a hearing --

COMMISSIONER PURCELL: If I may, Mr. Calia, I apologize, but I'd like to enter the question and answering period just in

light of the time.

MR. CALIA: That's fine.

COMMISSIONER PURCELL: And perhaps we'll touch on some of the issues that you were going to summarize.

Speaking on allocation, what in your opinion -- and this is to the panel -- is the appropriate method for allocating surplus to the extent it is determined to be unreasonably large?

What is the appropriate method for allocating the amount that's attributable to the District?

MR. CALIA: Sure, and I can speak to that. Let me first and foremost preface my comments about the allocation or attribution method, however you want to characterize it, by saying at the outset that we agree with the comments that Commissioner Tyler made, and I think, Commissioner Purcell, that you made earlier, that I think under the circumstances it really does make sense for the

jurisdictions that would be affected by the evaluation of any excess surplus to coordinate their efforts in looking at this issue. It is a complicated one.

Having said that, as we look at the attribution method, there are really two aspects to it. The first is that there has to be initially obviously a determination that the surplus is, indeed, excessive. That is independent really of figuring out what the attribution is. The attribution goes to what the remedy is and how the remedy associated with the spending down of any excess surplus is to be implemented.

It's our view that the attribution method should be based on where the contracts are written, where the insurance contracts are written, and there are really three reasons for this.

First, in defining the remedy, the act itself states that in the event that there is excess surplus and GHMSI does not dedicate

to community health reinvestment in a fair and equitable manner in a manner to address that excess surplus, that the Commissioner "shall deny for 12 months all premium rate increases for subscriber policies written in the District."

So I think within the act itself there is support for the notion that it's really the jurisdiction where the policies are written that help define the remedy that's at issue.

Secondly, I think there was some discussion about Schedule T. I'm not sure that there was clarity in terms of how it has been used. The fact of the matter is that GHMSI, in fact, allocates revenue based on where contracts are written, where the policies are written. Attached to their annual report, they have this Schedule T, which breaks out by jurisdiction the percentages and the amounts of policies based on where they're written, not based on where

the ultimate insured reside, but where the policies themselves are written.

What this means, we believe is for group plans, it's the location of the principal place of where the employer is, and for individual plans it would be the residence, which presumably for individual plans is information that's readily ascertainable.

The third reason why we think the touchstone here is really where the contract is written, is based on what we've observed in our neighboring jurisdiction, Maryland. So there was a discussion earlier about how in Maryland there is a premium tax imposed. That premium tax is on revenues that are reasonably attributable to business conducted within the state. That's the language of the statute.

Now, there is an exemption, which was also referred to earlier, equal to the amount that is spent in a manner that serves the public interest, and I believe it was said

that it was capped at two percent.

Well, in late 2008, the Maryland Insurance Commissioner was evaluating that very issue about whether GHMSI has complied with the Maryland law related to premium tax, and in so doing, the Commissioner relied on Schedule T in making the determination about what falls within the scope of a business within the state.

Thus, certainly at least implicitly, if not explicitly, the Maryland Insurance Commissioner had embraced this notion of Schedule T and the fact that it's where the contract is written for purposes of attribution at least in the context of evaluating this exemption to the premium tax.

COMMISSIONER PURCELL: Thank you.

Mr. Smith, I just want to keep going.

MR. CALIA: Surely.

COMMISSIONER PURCELL: Mr. Calia, we'll get back to that.

The whole issue of surplus and Carefirst's statement that their duty extends to their subscribers, and so if a determination was made that this reinvestment plan needed to be formulated and approved, that I think what I heard was that they would concede that it would extend to the subscribers only, present subscribers only.

What are your thoughts on that? Do you feel that the reinvestment obligation extends past present subscribers only?

MR. SMITH: Well, under the statute they are permitted to develop a plan that would spend the surplus only on the subscribers. So, I mean, that's within the prerogative of the company, I believe --

COMMISSIONER PURCELL: Okay.

MR. SMITH: -- under the statute.

COMMISSIONER PURCELL: Right.

MR. SMITH: I would add that I think they under the statute again have the prerogative to extend it beyond just current

subscribers.

COMMISSIONER PURCELL: And are you rooting that in the charter interpretation that we just heard or in the community mission, benevolent status generally, or --

MR. SMITH: I believe the statute is controlling here. I mean, different people may have differed as to whether or not they thought it was good to authorize a spend down plan that was limited only to current subscribers, but that is what the statute says, and I think I heard Mr. Burrell say this morning that if they were to develop a plan, they indeed would limit it to current subscribers.

COMMISSIONER PURCELL: In your report you suggested a range, a surplus range.

MR. SMITH: I did.

COMMISSIONER PURCELL: Could you explain the rationale in determining a broad range for reasonable surplus but then requiring GHMSI to exist just at the bottom of

that range?

MR. SMITH: Yes, I'd be happy to do that. There was a lot of conversation earlier about how one applies the maximum feasible standard, and we have argued in part that one way to apply the maximum feasible standard is first to develop reasonable ranges for the surplus, which I assume you may do. I don't know how you'll proceed. That's what Milliman did, and in adjusting Milliman's work, that's what we did.

But we believe once you've developed a reasonable range of surplus on the assumption that any number within the range would be sufficient to insure financial soundness -- and I think that's what Mr. Burrell said was the case -- therefore, the only say you can meet the maximum feasible standard is to pick a number toward the lower end of the surplus range that you've developed.

COMMISSIONER PURCELL: Okay.

COMMISSIONER BARLOW: So but I think as was mentioned earlier the first step in the process would be to determine if the surplus was unreasonably large.

MR. SMITH: Right.

COMMISSIONER BARLOW: So if the surplus fell within the range, do you think it would fail that first test and would still be forced to be moved down to the low end of that range?

MR. SMITH: I get your question. My answer is yes. Our view is that the only way to insure compliance with the statute with regard to the maximum feasible requirement is if you go the route of picking ranges first. I think that the company needs to be toward the lower end of the range in order to meet the maximum feasible.

COMMISSIONER BARLOW: But again, that, I believe, is the second part. The first part is determining if the surplus is unreasonably large. So if we determine a

reasonable range of surplus and the company falls within that range, it sounds like you are arguing that if they fall in the high end of that range, it's unreasonably large even though it falls within the reasonable range.

MR. SMITH: I think there are two ways to look at that, but I think you get the same result either way. You can say first we'll see whether it's unreasonably large. It has to be within the range. If you do that without looking also at the same time to the maximum feasible.

I think the unreasonably large range has to be computed in light of the maximum feasible, but if you do it as a two-step process, you could first compute what you think the reasonable range is and then apply the maximum feasible as a second requirement, and if you do it that way, I think you'd have to conclude that in order to meet maximum feasible, they need to be toward the lower end of whatever range you develop.

COMMISSIONER BARLOW: Okay. I guess I could try asking that question again, but I don't guess I'd get a different answer, but you --

MR. SMITH: I'm sorry. I do want to be responsive.

COMMISSIONER BARLOW: Well, I know. All right. You've suggested that a way to do this would be to determine a range of surplus.

MR. SMITH: Yes.

COMMISSIONER BARLOW: -- that's appropriate.

MR. SMITH: Right.

COMMISSIONER BARLOW: If the company falls within that range, then you still want to say if they're at the high end of that range, you still want to say that their surplus is unreasonably large.

MR. SMITH: Either that or it has to in addition meet the maximum feasible.

COMMISSIONER BARLOW: But if it's

not unreasonably large, then the second criteria ceases to exist as an issue.

COMMISSIONER PURCELL: What would need to happen is the range would be established, and then we would evaluate and discover that they are, in fact, over that range. Then we have a finding.

MR. SMITH: Ah, if they're above the range. Is that the hypothetical?

COMMISSIONER BARLOW: No. If they're within the range, if they are within the range, if they're within the range of surplus that we have determined.

MR. SMITH: Yes.

COMMISSIONER BARLOW: So my understanding of that range would be that that's a reasonable range of surplus for the company to have.

MR. SMITH: At least before you apply the maximum feasible.

COMMISSIONER BARLOW: But if my understanding of the laws are -- I'm not

lawyer -- but if we do not determine they have unreasonably large surplus, then the second part doesn't come into play.

MR. SMITH: Oh, I see. Now I understand. Then I have an alternative answer.

(Laughter.)

MR. SMITH: I think, as I said before, in determining the appropriate range, that range needs to be determined in light of the maximum feasible requirement.

Let me give you an example of what I'm talking about. The Pennsylvania Insurance Commissioner noted that at some point there's a tradeoff as you try to further limit marginal risk by increasing surplus when you could make alternative uses of the surplus and not increase it.

I believe as you develop the range that you think is a reasonable range, the assumptions you make in determining that range need to be informed by the maximum feasible

requirement. I think you need to give life to that requirement of the statute.

One of the reasons why we think some of the assumptions in the Milliman work should be deemed unreasonable is they seem to have taken no account whatever of the maximum feasible requirement. There is a tradeoff here. There is a balancing going on.

That's why I didn't mean to be unresponsive, but you can do this in one step or two. You can first compute a reasonable range irrespective of maximum feasible, and then if I had my way, you'll pick the lower end of the range in Step 2, or you'll develop the reasonable range as informed by the maximum feasible. You may get to the same place on either approach.

I hope I'm making better sense now.

COMMISSIONER BARLOW: I don't believe you would get to the same place on both of those things.

MR. SMITH: Okay. Maybe you wouldn't.

COMMISSIONER PURCELL: If it was determined that the company had an unreasonably large surplus and a portion is attributable to the D.C., it's determined, and it's detailed in a reinvestment plan, and it's given back or however that proceeds, if it happens, and then the company finds itself in financial trouble, how can the company rebuild its surplus without harming District residents, District subscribers, in your opinion? What would happen and how would we proceed once that happened?

MR. SMITH: You're envisioning a situation where you got it wrong or later there was a development that so --

COMMISSIONER PURCELL: Theoretically, yes.

MR. SMITH: -- the company?

COMMISSIONER PURCELL: Yes, yes.

MR. SMITH: What would you do

then?

COMMISSIONER PURCELL: I'm saying what are your thoughts on how to proceed at that point in light of the position we now find ourselves in, the determination to be made. It's made. Something is drastically wrong.

MR. SMITH: I'm assuming that the company would take steps on its own to remedy the situation and would take it before it got to the point that you're talking about. I mean, certainly what Milliman has in mind is that you'll have a lot of advanced notice that you may have a decline in service. They have tried to develop a formula that I believe is so unduly conservative that the risk of ever going down to 200 and 375 is very, very remote, but it might happen. That's your hypothetical.

COMMISSIONER PURCELL: Right.

MR. SMITH: I suppose the company would take steps, and you would be working

with the company as it took steps.

I mean, can I add one other thing though?

COMMISSIONER PURCELL: Sure.

MR. SMITH: I believe it is a hypothetical that is extremely remote, but if you permit them to develop their surplus range based on really remote contingencies. It is certain that in the meanwhile it will continue to charge premium rates at the level that they are, and it is certain they will have no funds available to give back to the community to address what they have acknowledge here today is a very difficult situation for a lot of people in the National Capital Area.

COMMISSIONER PURCELL: I guess what I'm trying to solicit or get at is the balance that Mr. Burrell discussed. What in your opinion -- is there room for that balance? What is your opinion on where that balance sits right now? Has it been struck at the right --

MR. SMITH: Oh, our view is it won't surprise you to learn, is that they're woefully out of balance right now, that they're required to balance two things: financial soundness and maximum feasibility. I don't believe they've ever taken maximum feasibility into account at all. Not a single witness this morning in their presentations to you described to you how it is either they or the board weighed these two very important, sometimes competing policies.

They simply -- and I mean no disrespect to Milliman -- they simply used an analysis that Milliman put in place without ever looking at the statute at all, without taking any account of maximum feasibility, in fact, use an analysis they used in 2005 essentially before the Commissioner. So I don't believe the balance has been fairly struck at all. I don't believe this company has come close to trying to see that there is a balance to be struck and that the council of

the District of Columbia believes that maximum feasible is important. I don't think they've acknowledged that yet.

They said we picked a surplus range, and so long as we're within that surplus range we're done.

I don't hear any balance being struck in that analysis at all.

COMMISSIONER PURCELL: What are some examples of additional activities that you think they should be engaging in?

MR. SMITH: They're listed in the statute, but there are a lot of them. Mr. Burrell fairly described them. There are a lot of people in the National Capital Area who are having more and more difficulty paying for insurance, and he told you that they're losing people trying to get insurance.

It's a very difficult time out there for a lot of people, and as you know, the council is trying to work with the company to further expand the open enrollment program

to let more people have an opportunity to get coverage.

And I have to tell you every time Mr. Burrell talks about how much money they will lose by meeting their primary mission. It reminds me that they haven't struck the balance yet. If what you're supposed to be primarily about is delivering insurance to people, particularly those who have difficulty getting insurance, then that ought to be the thing at the top of his list.

Right now for this company it is a complete afterthought. So long as they get their surplus range, if that allows for any money for investment in the community, they will do it. If it doesn't, they're done.

COMMISSIONER PURCELL: And in your opinion is there a difference between maximum feasible and maximum feasible consistent with financial soundness and efficiency? Because you use them interchangeably in your report.

MR. SMITH: I mean, I think they

have to be taken together. Don't misunderstand me. I acknowledge to you that those are two things to be balanced, but they're both important. They are both important.

We are Carefirst subscribers, we at D.C. Appleseed. Okay? I care about both parts of what the council has put into the law. I want this company to be able to meet claims, but I also want this company to be what I believe the federal charter envisioned them to be: someone with a public service mission, and I think they're not doing it.

COMMISSIONER PURCELL: Well, how does financial efficiency and capital adequacy then fit into your analysis, your rationale? I mean, are they to operate at that slim margin right above RBC or perhaps even --

MR. SMITH: Well, no.

COMMISSIONER PURCELL: -- a few hundred percent above RBC?

MR. SMITH: No, not necessarily.

COMMISSIONER PURCELL: Are they to be every year --

MR. SMITH: I think there are a lot of different ways that this could have been analyzed, but what we did at least for purposes of this hearing, because we didn't have a lot of time, was to take the Milliman approach, and Milliman offered that approach to Commissioner Mirel, as you know, in 2005. They offered it to the Pennsylvania Insurance Commissioner, who did a lot of additional analysis of her own, but I think the idea of coming up with a reasonable surplus range that's based on a number of reasonable assumptions about what might happen in the future to give you reasonable assurance that you'll be able to make claims, I think that's a sensible way to go about it.

I do not think it's sensible, as the Pennsylvania Insurance Commissioner to go about this in planning for every conceivable contingency no matter how remote. She

rejected that, and Milliman's work was based on that proposition, and even though you heard earlier that the Pennsylvania Insurance Commissioner didn't reject the Milliman work, I urge you to look at that opinion and see if that is not so.

And by the way, may I add also that Commissioner Mirel also effectively rejected the Milliman work when it was presented to him. He said in the opinion -- you didn't hear this quoted before, and this is back when their surplus was around 500 million -- he determined in 2005 that they ought to be spending that surplus down. He said there as no doubt that there was plenty of room for them to be investing more in the community than they were doing so.

Since then they have decreased the amount they're investing in the community and increased their surplus.

COMMISSIONER BARLOW: In your report on page 1, you indicated that a surplus

in the range of 325 to 427,000, million would put GHMSI in line with competitors and other comparably situated nonprofits. I'm not sure I understand comparably situated nonprofits. Are you talking about other insurance companies or non-insurance company nonprofits?

MS. CHELLET: We were talking about other insurance company nonprofits. That would include the comparable companies that I listed in my written testimony. It would include Kaiser Foundation Health Plan in the District.

COMMISSIONER BARLOW: Okay. Now, I mean, referring to the companies that you -- I mean, you identified, I think, kind of two groups of companies. You -- I think it was you who identified two groups of companies, one set of competitors where in the D.C. metropolitan area, where you said that compared to these GHMSI has a high surplus. I think United Health Care may have been higher, but the rest of them were lower.

But if put GHMSI down at the range that you proposed in the report, GHMSI would be at the bottom of those companies. I mean, so could you explain if near the top is no good, why is near the bottom better?

MR. SMITH: Go ahead.

MS. CHELLET: Well, I think my answer will be and Walter will no doubt elaborate on this, that GHMSI has a unique mission. It has a difference in its charter, and a difference, I think that is very material relative to especially his for-profit competitors.

I also want to say that in the 2005 report that I also conducted for D.C. Appleseed, I went and interviewed a number of nonprofits. It included Harvard Pilgrim Health Plan, Kaiser Foundation Health Plan, High Mark Blue Cross/Blue Shield, and especially with respect to entities like Harvard Pilgrim and Kaiser Foundation Health Plan.

The language of their mission was very different than what you heard today. The language about how they approached their mission was that it was a preeminent concern for them, that it was a balanced concern, and so the discussion we had today reminded me of those conversations, and I think Walter Smith's comment that the company hasn't made the balance also harkens to that. The language is different, the sense of the balance of the mission is different, and that's why I think GHMSI should be held to a very high standard in terms of how it serves its mission.

MR. SMITH: Just to add a couple of points, one is that only GHMSI, to my knowledge, has this maximum feasible requirement right in the statute, and I think it needs to be given teeth, and if that means as you balance the need for protecting against marginal additional risk, which may or may not occur, but today having the opportunity to

invest in the community, I think this statute directs that the balance be towards investing in the community, and I think that's important.

The other point that I would make though is that, as both of our actuarial experts have said, what they did was because of the lack of access to the kind of data that they would want it to have, they simply took Milliman's methodology and made four corrections that they thought needed to be made, and the range that produced is what came out of that mathematical computation, is what we've produced here.

We didn't do it to try to line up the RBC range with other companies. We simply took Milliman, made the corrections, and wanted to show to you for purposes of your work how big a difference you get based on what assumptions you make when you use this methodology.

COMMISSIONER BARLOW: Okay. So if

I understand what you're saying then, it sounds like when determining where you believe GHMSI's surplus should be, you are focusing more on the maximum feasible than the unreasonably large.

MS. CHELLET: No, I think that's not true. I think this is the issue of the balance. Do you make the most conservative assumptions possible for this company or do you make -- in which case there is almost no surplus that's too large, and these very conservative assumptions lead them to surplus levels that are much higher than most of the companies in the National Capital Area and also some comparable companies outside that have similar ACL levels outside of the National Capital Area.

So do you retain these very conservative assumptions or do you balance those assumptions against the maximum feasible standard?

So I think there is no one on this

panel who would say this company should be in a vulnerable position, and I think the statute doesn't envision that, but it does as we've stated envision a balance.

MR. RECTOR: Philip, I think I'm sure during the rebuttal time tomorrow, which will probably be we'll hear some feedback on it, but I think what I'm hearing the difference as they're articulating the standards, I think Mr. Hogan was saying you first look to see whether it's unreasonably large. If the answer is no, that stops your inquiry. If the answer is yes, then you look to see, you know, whether they've done the maximum feasible consistent with financial soundness.

I think D.C. Appleseed is saying there are two things operating. So it's a two-step process, as Mr. Hogan said, but it's a sequential thing. You do the first step and then after the first step you decide whether to take the second step.

I think I'm hearing D.C. Appleseed say there are two steps you're supposed to be taking and two analyses you're supposed to be taking simultaneously, and that either they inform each other so that as you're trying to determine what is reasonable, you try to figure out. You have a simultaneous obligation to do what's the most you can so long as you're financially unsound or somehow you have to deal with the two as side-by-side steps. So I think that's the difference in philosophy. I think that's what I understand the difference in philosophy to be.

COMMISSIONER BARLOW: Okay. In -- again, I believe this is your report, Exhibit C -- you took issue. Maybe that's too strong a word, but you raised concerns about the non-admitted assets of GHMSI and thought it might be proper to add them back into surplus.

MS. CHELLET: I think that the salient point is it might be. I don't have a position that it would be, but in looking at

the reduction in surplus that occurred in 2008 one has to ask where did the money go, and that is the most obvious place that the money went.

So then I went to look at other companies to see what they were holding in non-admitted assets, and it's very small, if anything, holding a non-admitted asset.

So my conclusion was that, number one, I think that that should be looked at, and number two, it appears that GHMSI is using accounting conventions at least that are very different from its competitors.

COMMISSIONER BARLOW: Well, I mean, as I understood it from what GHMSI explained earlier, the bigger of the two big changes in non-admitted assets was the deferred tax asset, and that was a change that impacted both the assets and the liabilities. So the net impact on surplus was zero for that. So --

MS. CHELLET: I would have to

confirm that. I'm not saying that they're misstating it, but I did not look to see the liabilities drop by the same amount.

COMMISSIONER BARLOW: And also, again, it does not seem unreasonable that one might make a contribution to a defined benefit pension plan in light of what happened in the financial markets in 2008.

MS. CHELLET: That certainly is reasonable, but I will tell you that their competitors did not.

COMMISSIONER BARLOW: Okay.

MS. CHELLET: Not in the same way, not with the same effect on their financial statement.

MR. TOOLE: I'm sorry. You introduced yourself as an economist?

MS. CHELLET: Yes.

MR. TOOLE: Are you a CPA as well?

MS. CHELLET: No, I am not.

MR. TOOLE: Okay.

MR. ZASS: I'd like to comment

there. If I look at the June 30th, 2009 GHMSI's NAIC filings, the $186 million change in the non-admitted assets flows directly to the bottom line of the surplus. So I really was taken back by the comment that there was no impact on the financial statements by such change in non-admitted assets between one period and the next.

Thank you.

COMMISSIONER BARLOW: Okay. I have just a couple of questions for Mr. Zass.

Now, have you done this kind of analysis in other similar situations?

MR. ZASS: Have I conducted similar assessments of companies' capital requirements? Yes, I have.

COMMISSIONER BARLOW: Really? I mean, have you done it for a third party in a setting like this or something else?

MR. ZASS: Certainly not in a hearing. I can confirm that has not happened in the past.

COMMISSIONER BARLOW: And not as a third party to the --

MR. ZASS: Me personally or the firm? The firm that I'm associated with has in the past done this kind of review.

COMMISSIONER BARLOW: Okay, and do you tend to get access to company models when you are acting as a third party in this kind of analysis?

MR. ZASS: I'm not sure if that can be completely stated as 100 percent. Yes, we do not get what I would deem as proprietary information. In some cases you may be deemed depending if it was more of an M&A type of arrangement, as Mr. Toole would probably acknowledge, but from the standpoint of a third party independently coming in and looking at someone else's financials and the surplus and so forth of the organization, no, you have to use what you've been given.

COMMISSIONER BARLOW: Right, and so would it be safe to say that, I mean, some

of the concerns you raised about the Milliman model being a black box is not necessarily a -- I mean, there shouldn't be a negative implication to that. It's just that you don't have access to the same information that they have?

MR. ZASS: Well, I think what I would want to comment on that is that any time you look at a third party or another actuary's work product that there are certain levels of communication standards and the level of transparency and assumptions that are going into the actual model and the results of those models that are used for that firm or that entity's conclusions.

So such that in my opinion when there is vagueness in and around model assumptions, it gives you apprehension on the bottom line results.

COMMISSIONER BARLOW: But apprehension is just you don't know, not you have information that there's something wrong.

It's you just don't know.

MR. ZASS: Well, based on the information that was in the report, we can definitely state that there are some assumptions that were used that we would question, and we've made that clear.

Is there a smoking gun in the Milliman black box? You know, I have no idea. Again, based on our assessment, we can simply only go on the information we're provided. The vagueness of the report for us to reach our conclusions.

COMMISSIONER BARLOW: Okay, and, I mean, it's certainly an appropriate thing to question. I'm just trying to make sure that there's not an implication or anything like that that because you did not see their model that there is something inherently wrong in their model. It's just you have questions about their model that if you had more access to their model you might be able to answer, but you raised concerns or issues that you

think we ought to look into with the model.

MR. ZASS: Well, I think any time you provide further insight to someone in and about the report or a model and the results thereof should be enough ammunition, so to speak, for the deciding party, which in this case is you, to make your own determination whether the things that we brought up are, indeed, valid or not.

In essence, the things that we brought up in this report we believe those four items materially impacted the surplus range to the tune of what discussed in the report itself, in the submission.

COMMISSIONER BARLOW: Okay.

MR. ZASS: Had we have looked under the hood, would we have thought that the smoking gun would have refuted their range? We don't think that if you would have looked under the hood and looked at the assumptions themselves, it is our opinion that we believe that the range may even be lower.

COMMISSIONER BARLOW: Okay, and I mean, we have taken seriously the issues that you raised, and we are looking at them with respect to the Milliman model.

MR. SMITH: Can I just add one thought on this line of inquiry, please? No one meant to suggest wrongdoing by Milliman with regard to things we hadn't seen and couldn't work out. We were simply identifying the ways in which the thing wasn't as transparent as one would have liked if one was trying to replicate their work.

But I'll say this. I think the Insurance Commissioner ought to be as interested as possible in making what Milliman did as transparent as possible, which is why we said in our pleadings we are eager to take them up on their invitation to meet with us and to walk us through what they did so we can have a better understanding of what it is they did.

I mean, I took them at their word.

They meant that genuinely. They didn't want it put it all up for all to see, but we're doing our best to be a little bit of a surrogate for the public here. We're not perfect, but that is what we're trying to do, and we would like to see more of what Milliman did if you can help arrange that.

COMMISSIONER PURCELL: Have you asked and been refused this information?

MR. SMITH: No, we did that in our pleading because we didn't know they were open to that till we saw their pleading.

COMMISSIONER PURCELL: Right.

MR. SMITH: But if that's something you can facilitate and you think is proper, I know that these two gentlemen would be eager to look further under the black box.

MR. SHAW: May I add to Mr. Zass' response, as the co-author of the report?

As actuaries, we often look at confidential assumptions and do it in the context of confidentiality agreements. That's

a very common process, whether it's an M&A work, whether it is being hired by a client simply that doesn't want their particular assumption shared with anybody else.

And so to suggest that the assumptions that have been used in the model, you know, can't be exposed to other peer reviewers with the expertise needed to make an intelligent review, I think, is out of step with how actuarial practice actually happens.

Secondly, I think what I would say as someone experienced in these matters is that the model description that they have put in their actuary report that is creating a Monte Carlo method and then doing some pro forma reports is a very generic type of description, and you will notice that we didn't criticize that in our report.

What really makes a difference is the assumptions that go into that type of model. That's where all the action is, and as some of the questions that were asked earlier

to Mr. Dobson were, for example, the fact that the model does not appear based on his response to be dynamic such that if there's a loss period that it assumes that the amount of surplus margin in the pricing goes up, which is the normal response, would be of concern to us.

Those are the types of issues that we'd like to look at in the report to be able to form a more full opinion as to the appropriateness of their results.

COMMISSIONER PURCELL: Well, I will go on records as saying I'm happy to assist in having this done to the extent GHMSI is willing and you are able. It could even occur at our offices if necessary, although I'm sure there may be some travel involved, and if it could happen before the end of the record so you could do some sort of analysis and submit that, that would be great as well.

MR. SMITH: Thank you very much.

COMMISSIONER PURCELL: Is there

any further? Yes, Neil.

MR. RECTOR: I have just a couple of questions. Mr. Shaw, you went through pretty quickly today the -- if I have the term and make sure I have the right report -- the one that deals with the attribution.

MR. SHAW: Yes.

MR. RECTOR: I just have a couple of questions. We've not looked at this. I think this is new material. I don't think we had this before; is that right?

MR. SHAW: You did not.

MR. SMITH: It was filed today. This was part of our testimony today.

MR. RECTOR: Okay. On Approach 1 that you have, when you're determining the percentages, are the percentages based on the location of the master group policy holder for the group business?

MR. SHAW: I believe that's the case. We used Schedule T information, which is how the company reported it to the

insurance department, and that is typically done based on the location of the contract.

MR. RECTOR: Okay. So your Approach 1, the numbers that you have are based off of Schedule T in terms of determining the percentages?

MR. SHAW: Yes.

MR. RECTOR: Okay. For Approach 2, the numbers are on the D.C. and the other member months. Haven't really looked back at that schedule in a while. Do you know if that's also based on the location of the group policy holder for -- do you know how the member months are determined or calculated?

MR. SHAW: I believe it is also consistent with Schedule T and that it's based off of the location of the group if it's a group contract or the location of the individual if it's an individual contract.

MR. RECTOR: Okay. I had a couple of questions for Ms. Chellet; is that?

MS. CHELLET: Yes.

MR. RECTOR: You had, and I think Philip referred to these before; I think it's pages 5 and also 8 of your report. On page 5 you talk about some other Blue Cross plans and their RBC levels, and on page 8, I think you go to competitors.

One of the things Mr. Burrell talked about in his testimony was comparing GHMSI's surplus to the surplus of the companies that were the four Blue Cross plans in Pennsylvania. Have you done any analysis?

I mean, he matched up one and said he thought GHMSI's closest brother-sister was, I think, the Capital Blue Cross/Blue Shield Plan. Have you done any analysis to say whether you agree with that, disagree with that or --

MS. CHELLET: I was actually very surprised at that because I would place GHMSI somewhere between Highmark and Independence, Blue Cross/Blue Shield, Highmark serving the Pittsburgh area and Independence serving the

Philadelphia area, as much more likely equivalent firms.

My understanding of Capital Blue Cross, and I'll have to go back and look at it, is that it serves a largely rural central Pennsylvania area. So I just would not see that as a company that would have similar risks to a company like GHMSI which serves a large metropolitan area.

MR. RECTOR: Okay. I think it could be helpful for us if -- I think you are also submitting materials in September and I think you have another chance to. If there's something that you could put together with thoughts one way or the other regarding those companies, and again, I'm sure that GHMSI will do that as well.

I guess the last question I have is for the lawyer from Covington & Burling. You know, you heard a lot of discussion this morning about or this afternoon about the standard and what the standard is and we've

had a lot of discussion here, including whether it's a two step, one step, and all that stuff.

But I'm interested if you have anything more to add without just repeating what someone has already said as to what D.C. Appleseed thinks is according to not what the standard should be, you know, because everyone can have their own public policy judgments, but to what the standard actually is under the MIA statute.

MR. CALIA: Yeah, I guess the only thing I would add to what's been said is that the maximum feasible extent part of the standard is unique, and I think there has to be just as a point of statutory construction some life given to that part of the statute. I think it's clear that the council had something in mind when that became part of the statute. I think it has to be given full force and effect by purposes of this evaluation of surplus.

I think the concept as I heard it expressed from the folks from GHMSI was they made their own determination of what they thought was the optimal surplus range, and as I understood what they said earlier, it was without regard to that legal standard.

I think that legal standard has to be the overriding principle that drivers the analysis here. Otherwise it's surplus in the statute and it has no meaning.

MR. RECTOR: Well, where I would challenge you or at least challenge the question is when you look at the statute, I mean, it says the Commissioner determines that the surplus is unreasonably large and inconsistent. I mean the statutory words make it look like it has to be both unreasonably large and inconsistent, which I think comes back then to Philip's question of if you've got something within the range it could be that the Commissioner completely has a different range or whatever.

But if you have a range, if you're within the range, somehow to meet the statute you have to say, I think that it is both unreasonably large as well as inconsistent, and I'm trying to figure out how you read that.

MR. CALIA: Yeah, the structure of the statute actually refers to the maximum feasible extent consistent with financial soundness and efficiency. It really is before you get to the unreasonably large aspects. So as I read it, it's the overarching principle that really drives the whole analysis here.

In view of that standard, when one is evaluating what the appropriate surplus range, if it is clear that in the face of that standard it is unreasonably large, then this statute sets forth steps that must be taken in order to address that, in order to provide essentially remedial measures for that.

I'm hoping I've answered your question.

COMMISSIONER BARLOW: I think maybe what we should do is ask anybody who's willing to provide us their legal analysis. I think I'm going to guess people understand the question, and so if people would provide us their legal analysis on that during the period.

MR. RECTOR: I agree. That would be very helpful.

MR. CALIA: We would be very happy to do that.

MR. SMITH: We'll look further at this.

COMMISSIONER PURCELL: Thank you, Mr. Smith.

Mr. Calia and Mr. ARM -- Mr. Shaw, rather --

(Laugher.)

COMMISSIONER PURCELL: -- Mr. Smith, Mr. Zass and Ms. Chellet, thank you very much. Thank you.

MR. SMITH: Thank you very much.

COMMISSIONER PURCELL: Okay. We're going to keep plugging away. Next on the list, Ms. Sondra Roberto from Consumers Union.

Thank you for your patience. Good afternoon.

MS. ROBERTO: Good afternoon. My name is Sondra Roberto and --

COMMISSIONER PURCELL: One moment. I just want to swear you in first.

MS. ROBERTO: Sorry.

MS. JOHNSON: Do you swear or affirm to tell the truth, the whole truth and nothing but the truth so help you?

MS. ROBERTO: I swear.

MS. JOHNSON: thank you.

MS. ROBERTO: Okay. My name is Sondra Roberto, and I'm a staff attorney with Consumers Union in San Francisco.

I thank you for giving me the opportunity to speak to you today about GHMSI surplus. I've come a long way to be here, and

it is because the question of whether a particular health plan is holding too much surplus is an important issue for health care consumers.

I may deviate from my written comments given everything that has gone on already, but I would first like to start with some background and a discussion of why these proceedings are so important to our nation's goal of making health care coverage affordable for everyone.

CU views these surplus proceedings as part of a widespread and ongoing effort by regulators, advocates, and consumers to hold nonprofit health care corporations accountable to their missions.

For example, for more than a decade CU and other groups have worked to protect and redirect the charitable assets of nonprofit insurers when they converted to for-profit corporations to insure that these assets continue to benefit communities and

help meet their health care needs.

This work is based on established legal principles that hold that the assets generated by a nonprofit corporation must further the nonprofit's charitable mission and purpose.

The same principles apply to the surplus of a nonprofit plan. The plan's surplus is an asset which must be used primarily to fulfill the plan's mission as a charitable and benevolent institution. Maintaining adequate surplus is no doubt important for the solvency of the plan and fulfillment of its charitable mission, but we have seen that for some nonprofit plans, surplus has become excessive, to the point where it no longer serves the best interest of the plan's policy holders and the community in which the plan operates.

CU supports your effort to determine whether GHMSI has reached that point. At a time when all of America is

debating how we can hold health plans accountable, how we can extend coverage to those in need and how we can make health care more affordable, your proceedings here are an extremely valuable contribution.

We welcome the attention that D.C. is giving to the issue of excessive surplus, and I think the value of this hearing is already self-evident.

On this subject I note that GHMSI has used considerable space in its prehearing reports and its testimony today expressing regret that D.C. has undertaken this effort. For example, the company stated that it is important to note -- and this is a quote -- "It is important to note that the usual posture of regulators in the health insurance field has been to focus on the solvency and financial strength of insurers."

It has also stated, "In essence, the most important question for the regulator from the standpoint of protecting the

consumers who purchase insurance coverage is whether come what may the company has the solid financial footing necessary to meet its obligations to pay claims."

GHMSI also believes that "the notion that an insurer can offer its subscribers too much in the way of financial protection is at odds with historical concepts of insurance regulation."

We agree that a regulatory focus on health plan financial stability is critical and must continue, but it need not be to the exclusion of other consumer protections. Our state insurance departments should exercise their authority to the fullest extent possible to increase the numbers of consumers getting access to care and to make sure people are getting their money's worth from their health insurance.

We believe that more states should and will begin to focus on excessive surplus as premiums continue to escalate and community

health care needs go unmet. Other states will look to D.C. as a precedent setting jurisdiction to evaluate how you have approached this problem. By adhering to values of transparency, fairness, and thoroughness, you will provide guidance for similar proceedings to come.

We also disagree with GHMSI's suggestion that an insurer can never have too much surplus. Much of this has been touched on, but if I may, for one, surplus that is two, three, four, or more times greater than the authorized control level for risk based capital can indicate that the insurer is not meeting its obligations as a charitable institution. That's why scrutiny is important.

Excess funds held in surplus can and should be redirected toward more affordable premiums for existing and prospective policy holders, subscribers, and for charitable giving to programs that help

the uninsured or under insured.

In addition, rapid growth in surplus such as we have seen in the past decade among many plans means that policy holders and employers may be paying too much in premiums. When surplus reaches a comfortable level where insolvency is a very remote possibility, subscribers should not have to pay contributions to surplus.

Regulatory review of surplus is important for these reasons. Moreover, surplus review along with rate review is necessary to make health insurance markets function as efficiently as possible. Studies have shown that most local health insurance markets across the nation are concentrated with one or two health plans holding a majority of market share.

In D.C., as we've already discussed, GHMSI is the dominant player. In theory nonprofit plans with sufficient surplus should be able to price aggressively. This

drives fiercer competition with for-profits and leads to more competitive pricing for all purchasers, but dominant insurers with market power have little incentive to price aggressively. Regulatory surplus and rat review benefit everyone by helping to address the problem of concentrated markets.

We also disagree with GHMSI's argument that that any distribution of excess surplus to public programs would mean that existing GHMSI subscribers can be made to shoulder not only their own costs, but those of others who are not subscribers.

In reality, GHMSI subscribers are already shouldering that burden. The federal government estimates that right now hospitals and doctors in the District of Columbia lose more than $141 million in uncompensated care, which they often pass along to insured families in the form of a hidden tax on premiums, and again, this was discussed by the President last night.

Remarkably, Milliman itself conducted a recent study which found that in 2008 families across the nation paid an average of more than $1,000 in higher premiums to cover more than $42 billion in uncompensated care.

Therefore, any community health reinvestments that directly provide charitable care or subsidize low cost insurance for those who need it will benefit GHMSI's existing policy holders or subscribers by helping to alleviate the hidden tax.

Of course, for-profit health plans also must be regulated and held accountable if we are to make health care available and affordable for everyone. But here in D.C. where GHMSI has the highest market share, it is best positioned to play the leader in providing community health reinvestments. These reinvestments can and should include rate relief or cost sharing relief for existing subscribers, low cost coverage for

prospective subscribers, and public health programs that benefit the community at large.

The notion that the plan's community health reinvestment requirement benefits nonsubscribers to the detriment of subscribers is false. The plan, along with the Commissioner, can work to identify the most important community needs and develop the right mix of programs or products to address those needs.

Now I'd like to turn to some specifics about GHMSI's adopted optimal surplus range of 750 percent to 1,050 percent of risk-based capital authorized control level. As stated in my pre-hearing letter, CU urges you to reject this range for several reasons. I don't intend to go into all of those reasons here, but I will point out some glaring shortcomings.

In the first instance I want to agree with the prior testimony that we found the Milliman report to be what they call the

black box, and one of our goals here today was to urge you to seek more information from Milliman about what assumptions and probabilities that they used.

We gave the report to an expert in health plan management, and he told us he could not test or evaluate Milliman's analysis because Milliman did not disclose its underlying assumptions.

So what we want to say is that we hope you would not accept that range as optimal without learning the assumptions and probabilities used to achieve the outcome.

Our expert also questioned among other aspects of the report why Milliman used growth rates of 12 percent to 14 percent when GHMSI's growth rate has averaged about eight percent with only one year above 12 percent. The higher growth rates lead to the need for more surplus.

Further, when questioned about excessive surplus, nonprofit health plans,

including GHMSI, repeatedly argue that they need larger stores of capital for improvements, new products or the ability to respond to market changes. They suggest that it is easier for their for-profit competitors to raise money because they can sell stock.

However, neither GHMSI or any other nonprofit that we know of has put forth evidence showing that for-profit health plans regularly sell stock to raise capital. In fact, in a surplus proceeding in Pennsylvania which we've discussed, the Insurance Commissioner cast doubt on this argument when she pointed out that it misleadingly implies that selling stock is a cheaper source of funding than other forms of borrowing.

In addition to the questions raised by our expert, Milliman's range is simply too high. It would allow GHMSI to maintain surplus up to five times higher than RBC ACL. We don't see how GHMSI can maintain surplus at these high levels and comply with

D.C.'s requirement that it engage in community reinvestment to the maximum feasible extent consistent with financial soundness and efficiency.

On that note I want to deviate and just address one of the issues that you had brought up, and that was the question of how can we rebuild surplus if something does happen and it falls below the recommended range. I just wanted to point out that in Pennsylvania the Commissioner there sort of looked at it as having two ranges. One she identified as an efficient range, and one she identified as a sufficient range.

The efficient range which started at -- she said she really wouldn't identify a lower level, but if we assume that it's 200 percent where there would be regulatory intervention, then she said between that range and 500 percent is an efficient range where there is no risk of insolvency.

And then she said the sufficient

range at 550 to 750, and she said that if you fall below that range and you're in the efficient range, you're still not in danger of insolvency, but what you can do is start rebuilding your surplus.

So the idea is that you set a range where if you go below it you can gradually rebuild so there is no dramatic premium increases in order to rebuild the range, and I think that's a good approach, is having sort of a cushion and then a range.

And I also wanted to reiterate that the Commissioner rejected Milliman's recommended optimal range in that case.

So if Milliman's range is too high, what is an appropriate surplus range for GHMSI? And is GHMSI's surplus unreasonably large right now?

To conclude my testimony, I would like to urge the Commissioner to take the following steps to answer these questions.

First, seek more information from

GHMSI. As noted, we don't know how Milliman reached its optimal range or why it used certain assumptions.

Also, more information is needed about GHMSI's other risk protection mechanisms. For example, the Blue Cross/Blue Shield Association requires all of its licensees to participate in a guaranty fund using alternate mechanisms such as a subscriber protection account or in the absence of either of these conditions, maintain surplus at 800 percent of ACL. They require this as an additional protection for subscribers.

We would like to know how GHMSI has satisfied this requirement. Is that component of surplus or is there an additional subscriber protection account out there that would be used in the event of solvency?

We urge the Commissioner to require GHMSI to annually report all activities that meet the definition of

community health reinvestments and how much money was used for each activity. This report should be clear, comprehensive and made public. Consumers need to be able to see exactly how GHMSI is meeting the statutory requirements.

We understand that the Commissioner has hired independent actuaries to determine an appropriate surplus range, and we applaud you for that. We hope that that surplus range will take into account the requirement that GHMSI contribute to community health reinvestment to the maximum extent feasible.

After determining a sufficient surplus range, the Commissioner should limit contributions to surplus while GHMSI is operating within the range.

We also urge you to use your authority under D.C.'s prior approval statute to consider surplus when reviewing rate increase requests for individuals and small

groups. Rhode Island, for example, has rejected requested increases based on the amount of surplus held by that state's Blue plan.

Rate approval should not be a rubber stamp. Going forward we urge the Commissioner to carefully consider in light of GHMSI's surplus its need for increases or the need for other measures imposing hardship on its existing and prospective subscribers, such as tightening underwriting requirements for pregnant women and newborns as it did in July 2008, and that was at a time when it held over $780 million in surplus.

I'll conclude with a final comment regarding the determination of surplus that is attributable to the District. We believe that using a residency standard as GHMSI believes you should would lead to an unfair result. After all D.C. employers paid for large portions of the premiums that funded GHMSI's surplus.

The Commissioner should work with all jurisdictions involved to create a more appropriate standard for this determination, taking into account several factors, including revenue and subscribers in each jurisdiction, the contracting entities, the providers, and the needs of the relevant communities.

Thank you for having me here today and for engaging in this important process.

COMMISSIONER PURCELL: Thank you. Thank you for coming and thank you for coming across the country. I think it's important to hear the voice of consumers, and I thank you for representing them here today.

I did have one question for you. The balance that we've been speaking of all day, the notion that there is a prudent balance to be reached between financial stability and additional community reinvestment, particularly in this situation.

What are your thoughts on this from a consumer's standpoint? Is the consumer

care that businesses are required to strike this balance and maintain this balance ultimately they say for their own benefit?

Do you have an opinion on that?

MS. ROBERTO: Yes, and I think I hinted to this in my testimony. I think that consumers are very concerned about the affordability and the increases that they've seen, and to the extent that community health reinvestments benefit everyone in the community by making health care more affordable, it becomes more affordable for people who are already insured. We don't seem to realize the impact that the uninsured have on what we're paying right now, the cost that they add to the system.

And so that these community health reinvestments are beneficial to everyone.

COMMISSIONER PURCELL: Okay. Thank you.

And one final question. In your experience are there any similarly situated

nonprofit health insurers that perhaps are doing a better job of striking that balance?

I know GHMSI is very specific in the region that it operates and other factors, but generally speaking.

MS. ROBERTO: Yes, I'm aware of other nonprofits that are doing a great deal more for community benefits, and there are others who are not and who are in similar positions as far as holding what we would view as too much surplus.

COMMISSIONER PURCELL: If you would be willing to provide a list or even a short summary of both of those, those who are doing it right, in your opinion, and those who are not, I would be interested in seeing that.

MS. ROBERTO: Absolutely.

COMMISSIONER PURCELL: Thank you. Thank you for coming.

Oh, I apologize. Hold tight.

Jim.

MR. TOOLE: At the top of page 8

of your prepared response you appear to have skipped a paragraph, and I was just wondering if there's a reason behind that or I was briefly narcoleptic or --

MS. ROBERTO: No, I skipped it because I felt we had gone over it a bit, but I can read it to you if you'd like.

MR. TOOLE: Well, it says more than I think --

MS. ROBERTO: Well, I wanted to agree that -- the top of Paragraph 8 you're talking about -- I wanted to agree that bringing Lewin here today and having them do another report really doesn't add much to the debate or to the conversation. Lewin simply said that, quote, that their review does not allow us to comment as to whether we would have produced the same range of surplus requirements as shown in the Milliman report.

And I also wanted to note that in reference to the Pennsylvania Commissioner's decision Lewin decided that she had "set

reasonable bounds on the Pennsylvania Blue plan's accumulation of surplus that were unlikely to disrupt the Pennsylvania insurance market.

So I'm not sure by having this other huge player in this field come in really added much to support Milliman's recommendations.

Anything else?

COMMISSIONER PURCELL: Thank you.

MS. ROBERTO: Thank you.

COMMISSIONER PURCELL: Next we will call Cheryl Fish-Parcham from Families USA.

Ms. Parcham, you're allotted 20 minutes. Our timekeeper has stepped out. Oh, here he is. You may begin.

MS. FISH-PARCHAM: Thank you.

And I --

COMMISSIONER PURCELL: Oh, one moment. I apologize. Swear you in.

MS. JOHNSON: Would you raise your

right hand, please?

Do you swear or affirm to tell the truth, the whole truth and nothing but the truth so help you?

MS. FISH-PARCHAM: I do.

MS. JOHNSON: Thank you.

MS. FISH-PARCHAM: Thank you.

I've submitted my prehearing statement, and I don't have an additional written statement, but I'd like to summarize some of the concerns in light of the testimony that we heard today.

I'm Cheryl Fish-Parcham, and I'm the Deputy Director of Health Policy at Families USA. We are a national, nonprofit health care advocacy organization. We work on both national and state issues, and in D.C. we have worked both on behalf of Medicaid consumers and on behalf of uninsurable consumers. So it's in light of those concerns that I'm speaking today.

First, I am hoping that my

testimony will inform both you and the company on what might be appropriate community reinvestment if you find that there be excess surplus, and I am not an actuary or an economist, but just in reading the Carefirst reports even if you take their assumptions, they have defined a range that is an optimal level. It's not minimum level for financial solvency. It is an optimal level, and it seems to me that the statute is requiring that they spend the maximum feasible consistent with remaining financially stable.

So even if you were to take their assumptions, I don't understand why they would above the minimum optimal level, and so that seems to me already requires some spending on behalf of the community, and I defer to Appleseed and others about whether that range should be lower.

But I want to talk about some of the subscriber needs that Carefirst mentions, making premiums affordable to subscribers is

among their primary missions, and I want to talk about ways that they could better target assistance to consumers.

And first, in my testimony, the last page is a chart that I hope is accurate. It was our best understanding of the rate filings that are on the Website, and I want to point out some of the rate increases that appear to have occurred that seem inconsistent with keeping premiums affordable.

The first is in conversion policies. As I understand it, conversion policies are the policies that must be sold to people when their former group policies, their former employers go bankrupt, stop offering plans, and they must be offered instead in the District a conversion policy to an individual policy and maintain some coverage for them.

And it looks to me from the filings that those policies increased 14 percent in January '08 or 24 percent in April '09. I'm not quite sure what the two

different conversion policies are that are listed here, but in either case, those are very big increases to consumers who have just lost their source of employer based coverage at a time that the economy is tanking.

So that would be one way that Carefirst could really help consumers, is by lowering those premiums.

Small business premiums according to page 7 of the last filing that's on the Website have a different rate of offer than of renewal that they are charging 414 per month to new subscribers, but 572 a month to businesses that are renewing their premiums. So relooking at those policies are ways that consumers could make or Carefirst could make policies more affordable to businesses.

But now I want to turn to open enrollment, which is an issue that I've been tracking for a few years, and this is the policy that is supposed to make coverage available and affordable to individuals who

have preexisting conditions and cannot otherwise get policies in the market, and those policies increased. In one instance one consumer wrote us about an increase from $478 a month to $591 this July.

Another consumer wrote to us about a 41 percent increase in their couple coverage. They're now paying over $18,000 a year in premiums.

There have been hearings over the past year about what is an appropriate enrollment obligation, and Carefirst says that it anticipates spending $5 million for that product now. This is above what the premiums earn for that product.

Yet their statements show that whatever the premiums are that are attributable to that product in the individual market lying all together, they are earning and underwriting gain. So it appears that they're not dipping into their surplus to subsidize premiums substantially. They are

instead using the conglomerate of how they array their individual premiums, still earn a profit for them.

The discussion over the past year or so has been should other insurers share this risk, and sure, we're all for other insurers sharing this risk, and should Carefirst be permitted to just spend $5 million on this product or should they instead put $5 million into some other public-private partnership that was going to serve people, but my fundamental question is why is it just $5 million. Why isn't there money to increase the commitment to help uninsurable residents get coverage?

Another part of this product has been the debate, has been how many people should be served. So an appropriate use of surplus would be to expand the number of people that are served under this product.

And another big concern has been benefit caps. These are the sickest D.C.

residents who cannot get coverage elsewhere. They're denied coverage by definition, yet they face a $1,500 annual cap in their prescription drug coverage.

We heard testimony this fall from a consumer who testified in the city council hearings about losing his job where he had full drug coverage and now he had a disease for which there are no generic equivalents. His annual drug bills are $20,000 of which Carefirst was paying 1,500. And this is a true unmet need of a current subscriber.

Just to mention quickly the one assumption that I do know something about in terms of risk, Carefirst lists one of the variables in the coming year as being national health reform, and I really question whether they should be building reserves to deal with national health reform.

As you know, national health reform may help actually people who have preexisting conditions to get coverage and

maintain coverage, but that is, in the bills that we've seen so far, several years down the line and there will be many measures taken nationally to offset any potential losses to insurers from that measure.

There is risk adjustment that is built in. There is a larger insurance pool created, perhaps an individual mandate, subsidies, and for an insurer to be building surplus now in anticipation of health reform just does not seem appropriate to us.

And finally I'd like to comment briefly on this distinction that's been talked about between current subscribers and community benefit. I think it's really an artificial distinction. We heard testimony from Consumers Union that we agree with about the cost of uncompensated care to subscribers, but moreover in the District there's really very little distinction because the people who might be served by public programs are the same people who are not getting open

enrollment now because the premiums are too high.

So as you make premiums -- you can make premiums more reasonable or you can give to public programs. You're still trying to accommodate the same universe of people who are uninsured and uninsurable.

And as this is played out with Healthy D.C. and the Alliance and other programs that the city has thought about constructing, a big question has been sort of what benefits will premiums support, and we have concerns still about whether the sickest residents will well be served by products that are being created.

So one possible look at a community giving obligation for Carefirst in the future is to provide funding for catastrophic benefits that are not covered by their insurance plans, be they public or private, to help fill in some of these gaps, the gaps in prescription drug coverage that

Carefirst now has, the gap in mental health coverage that the D.C. Alliance leaves, and many other gaps that are yet to be determined.

So thank you.

COMMISSIONER PURCELL: Thank you, Ms. Fish-Parcham.

I don't have any questions for you. Your testimony is very thorough. We'll certainly consider it. It's included in the record as you know, in addition to the one that was submitted before, and perhaps Carefirst will respond to some of your concerns in their rebuttal statement tomorrow.

Thank you.

MS. FISH-PARCHAM: Thank you.

COMMISSIONER PURCELL: Okay. Continuing on, we have to be out of this room by 5:00 p.m. So we have about 15 minutes. So we could take another panel of three if the next three on the witness list would like to come up all at one time. We're going to stick very strictly to our three minute time period

and hopefully have some time for a few questions.

So JoAnn Lamphere, David Wilmot and Ms. Barbara Lang. Good afternoon.

MS. JOHNSON: Please raise your right hands to be sworn in, please.

Do you swear or affirm to tell the truth, the whole truth, and nothing but the truth, so help you?

WITNESSES: I do.

COMMISSIONER PURCELL: And, Ms. Lamphere, you may proceed.

MS. LAMPHERE: Commissioner Purcell, distinguished panel members, good afternoon.

I know we're standing between you and dinner. So I'll make my remarks short.

My name is JoAnn Lamphere, and I serve as Director of AARP's State Government Relations Health and Long-term Care Team. I'm honored to testify in behalf of AARP's 91,000 members in the District of Columbia who are

concerned about excess reserve funds held by Carefirst's D.C. affiliate GHMSI and its inadequate community health reinvestment.

AARP appreciates your leadership and the opportunity to participate in this hearing. AARP believes that it's important for the District of Columbia to insure that Carefirst is fulfilling its public mission to provide quality, affordable, and accessible products and services to its customers and the community.

We believe such reasonable standards can be accomplished by Carefirst in a viable and invigorated way.

It appears the amount of reserves that Carefirst GHMSI holds in its possession is unreasonably large based on information that's publicly available. If you determine that this surplus is excessive, we commend that a portion of these excess funds be used first to invest in proven health initiatives to improve the overall health of the

District's population; also provide affordable health coverage choices for the District's so-called uninsurable adults; and third, constrain rising health premiums for current policy holders who are struggling under rate increases.

Resources are needed more than ever to assist struggling residents in the District. As I listened to the sophisticated testimony of Carefirst this morning, I was struck by the effort of the company that it has made to defend both its level of reserves and community investments. I can only imagine the millions of dollars that have been spent securing expert consultation to advance this perspective and how much health care coverage these millions of dollars could have supported.

I dream of a different kind of not for profit insurance company serving the District of Columbia and neighboring states that does not view the idea of community

reinvestment in opposition to the idea of benefit for subscribers. It seems Carefirst is hampered by its 20th Century perspective that is unable to envision how to meet 21st Century community health commitments. Meeting a not-for-profit community benefit obligation means more than charitable contributions and giving to worthy causes.

Indeed, many health insurance companies across the United States have figured out how to commit passionately to filling in the cracks and service needs of a broken health care system, to invest in prevention and care management especially for at risk populations, and third, to adopt communities, actually adopt communities and work in partnership to make them healthy.

These innovations have been found to benefit these communities and the company's bottom lines.

Most of us in the room value the innovation that the private sector can

deliver. It is proper that this innovation and creativity be harnessed by government on occasion for the social good. While this hearing by necessity has focused on financial accounting details, we should not lose sight of the overall community objectives that the NEA legislation sought to achieve.

COMMISSIONER PURCELL: Ms. Lamphere, could you please sum up?

MS. LAMPHERE: Okay.

COMMISSIONER PURCELL: Thank you.

MS. LAMPHERE: We believe Carefirst should be required to devote more resources to the health and coverage needs of the Washington area community to the maximum extent possible. Serious multiple chronic conditions are harming the District, and through a greater investment of evidence-based community programs by Carefirst improved assurances of health care and coverage can be provided to members of our local community.

And we are happy -- we would be

delighted to work with you to further that vision.

COMMISSIONER PURCELL: Thank you. Thank you.

Ms. Lang.

MS. LANG: Thank you.

Good afternoon, Commissioner Purcell and members of the department. I am Barbara Lang, and I am pleased to be president and CEO of the District of Columbia Chamber of Commerce.

I'd like to thank you for allowing me to testify on the determination of the Group Hospitalization and Medical Services, Inc. surplus.

I'm coming at this from an entirely different perspective. I'm not going to talk about charters or actuarial tables or legal opinions. I am speaking purely in support of a robust business community in the District of Columbia.

The Chamber of Commerce would like

to urge that you leave the decision about the appropriateness of GHMSI's reserves where it rightfully belongs, with its board of directors. Our concerns are similar to those expressed at a hearing in 2005 when we testified before Council Member Graham on this same very issue.

And I will say that I've testified several times on this very same issue. In expressing our concerns, the Chamber recognizes that the Medical Insurance Empowerment Amendment Act of 2008 was narrowly drafted such that it would apply to only one corporate entity operating in D.C. The corporate entity identified in the law that Carefirst-Blue Cross/Blue Shield through its Washington area affiliate GHMSI is an important member of this business community in D.C., so much so that we plan to honor them at the Chamber's annual gala this October in front of 1,200-plus guests. So we think very highly of this business in D.C.

Not only are they an exemplary member of this business community for its sound management and strong financial position, but it is also one of the largest financial givers in the city. It's our opinion that this company lives up to its mission.

In fact, by all rights District officials should be commending Carefirst and GHMSI for their exemplary contributions to the community instead of continuing to drag it through burdensome regulatory and over sight reviews, legislative mandates and lawsuits.

The lion's share of Carefirst's members are individuals and small employers, almost 5,000 businesses in total, nearly 70 percent of which have fewer than nine employees. The reserves that are the subject of this review were built by those premiums, paid by those individuals and businesses and those reserves are maintained for their protection.

Any attempt to redirect some share of those reserves for other purposes would impair the company's ability to moderate future premiums and insure that it will always be there for its members no matter what.

For small employers, the decision to provide health insurance is both a necessity and a sacrifice. We believe that any determined excess reserves should be returned to the employers, employees, and individuals who helped to create it.

GHMSI's board is charged with the following major duties, and I see my time is up. So it's in the written testimony.

But let me just say in closing because I know we are out of time, is this is a very slippery slope. While this legislation is geared to Carefirst and their nonprofit status, if we go down this pathway, we are going to -- what other for-profit company are we now going to go after? And that impairs the ability to attract businesses and to

retain them in the District of Columbia.

Many times when I testify on the Hill looking for more money I say being the nation's Capitol is an honor and a privilege, albeit a very expensive one. One of the things that I do when we compare to surrounding jurisdictions, it is almost 30 percent more to do business in this District of Columbia than in Maryland and Virginia. So why would anybody want to be here?

And so today I had a phone call from CNN wanting me to do an interview on why I want to bring business in D.C. and why it's so great to be in the District. I am considering not doing that interview because it's very difficult to extol the virtues.

So I implore all of you not to burden this company. We need them and their 1,500 people that they employ just in the District of Columbia.

And so I thank you for the opportunity to be here today.

COMMISSIONER PURCELL: Thank you.

MS. LANG: The other part of my testimony is written.

COMMISSIONER PURCELL: And it will be entered into the record.

MS. LANG: Thank you very much.

COMMISSIONER PURCELL: Thank you, Ms. Lang.

Mr. Wilmot.

MR. WILMOT: Good afternoon.

COMMISSIONER PURCELL: Good afternoon.

MR. WILMOT: Commissioner Purcell, can you hear me? Thank you.

I'm Dave Wilmot. I'm the Executive Director of the District of Columbia Association of Health Maintenance Organizations.

Our association consists of seven managed care organizations, and at the time that I took over, there were 19 such organizations operating in the District of

Columbia, many of whom are no longer here today, and it's directly related to the conversations that will happen with respect to their reserves.

They can't hear me?

COMMISSIONER PURCELL: Sorry. Yes, just put the mic right in front of -- oh, is it engaged? Push the green.

MR. WILMOT: Can you hear me now?

COMMISSIONER PURCELL: There you go. thank you.

MR. WILMOT: Okay. Directly related to the conversation that we're having today.

You have my testimony. So what I'd like to do is I'd like to turn to the highlights. The association member plans believe that it's important to maintain a strong and competitive health insurance industry in the District of Columbia. It's something that I believe that you agree with.

At one time, the DCHMO Association

had as many as 19 member plans. As you're aware, several of those companies had to cease operations because they did not have adequate reserves.

Carefirst affiliate, Group Hospitalization and Medical Services, Inc. is one of the largest insurers in the city, and it is essential that the company remain financially strong. We recognize that you are mandated to conduct a review of the company's reserves and to make a determination on whether those reserves are excessive.

Specifically the Commissioners are required to assess the reserves that are attributable to the District. Typically companies establish reserves based on their entire business obligation. A number of our member plans are concerned that a policy with the stated objective to divide reserves based on an individual's jurisdictions could weaken the entire company as well as have an adverse effect on other member plans as well.

In the health industry, the risk-based capital standards set by the National Association of Insurance Commissioners establishes a minimum threshold to measure the financial solvency. It is in no way the standard that should measure excess.

If a company is operating at that level, it should send off an alarm bell and result in an intervention by the Insurance Commissioner.

Health insurers and other companies establish reserves to make sure that they can effectively meet both expected and unexpected business obligations. Establishing an appropriate level of reserves is going to be different for each company. The DCHMO Association believes that it is the role of the company's board of directors and its management to make that determination.

We urge you to give careful consideration to the important decisions you have to make. As the Insurance Commissioner,

you have an obligation to protect insurance consumers and to make sure insurance companies provide quality service in accordance with the law.

In order for an insurance company to meet the obligation to its customers, the company has to be effectively managed and financially strong. That is where Carefirst is now.

We hope that the first decision you make in your role as Commissioner sets the right balance.

Thank you for giving us the opportunity to testify on this issue, and I remain available for any questions that you might have.

COMMISSIONER PURCELL: Thank you.

Thank you, Mr. Wilmot, and thank you all for your testimony today.

I do not have any questions for you. You all have very compelling and very clear testimony. It will be entered into the

record and considered fully.

I want to thank you all for coming today, all of the witnesses. Please note again that the record will remain open until September 25th, and I have one additional request, an that is that you send an E-mail or forward it to the attention of Leslie Johnson, but also to my Executive Assistant Carmelita Snowden either by mail or E-mail, and just to insure that we have it.

And with that I will adjourn this hearing. This hearing will resume tomorrow morning at 10:00 a.m. in this room, and thank you all again. Have a good evening.

(Whereupon, at 5:01 p.m., the hearing was recessed, to reconvene at 10:00 a.m., Friday, September 11, 2009.)

**E**

**H**