

GOVERNMENT
OF
THE DISTRICT OF COLUMBIA

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DEPARTMENT OF INSURANCE, SECURITIES,
AND BANKING

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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

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Adjourn

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

2 (10:01 a.m.)

3 COMMISSIONER PURCELL: Good

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

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

14 This hearing is being held
15 pursuant to D.C. Official Code, Section
16 31.3506, Subsections (e) and (f) of the
17 Hospital and Medical Services Corporation
18 Regulatory Act of 1996, or the HMSCR Act, as
19 amended by the Medical Insurance Empowerment
20 Amendment Act of 2008, or the MIEAA Act.

21 The Department convenes this
22 hearing to assist in making its determination

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

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

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

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

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

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

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

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

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

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

8 The purpose of today's hearing is
9 to shed light on this very important issue.

10 In order to make a final determination as to
11 whether GHMSI surplus which is attributable to
12 the District is excessive, and unreasonably
13 large, I will take into consideration the
14 entire record, which will include all
15 submissions and testimony. I will listen and
16 consider the views of interested parties and
17 members of the public. The information
18 received here today will be made a part of the
19 official record of this hearing.

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

1 revised notice was published in the District
2 of Columbia Register on July 31st, 2009 at 56
3 DCR 006000. Notice was delivered to Care
4 First on July 24th, 2009, and again on July
5 31st, 2009. The revised notice of public
6 hearing was also posted on the Department's
7 website.

8 On July 31st, 2009, as required by
9 the Department, GHMSI issued the GHMSI Report
10 incorporating the December 4th, 2008 Milliman
11 Report entitled, "Need for Statutory Surplus
12 and Development of Optimal Surplus Target
13 Range." Pursuant to the regulations governing
14 these proceedings, on August 31st, 2009, GHMSI
15 issued the GHMSI Pre-Hearing Report
16 incorporating as Exhibit A the August 28th,
17 2009 Milliman Report titled, "Evaluation of
18 GHMSI Surplus Attributable to D.C.", and
19 several attachments.

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

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

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

12 So, next I will try to explain the
13 general procedure for today's hearing. We'll
14 commence each witness or witness panel with a
15 swearing in of each witness. This will be
16 conducted by a Hearing Officer, or by me.

17 After each panel's presentation, the
18 Department Staff and experts may pose
19 questions to the witnesses. After all
20 testimony has been heard, and all the
21 Department's questions have been answered, we
22 will proceed to the next panel, or witness as

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

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

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

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

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

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

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

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

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

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

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

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

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

19 WHEREUPON ,
20 CHET BURRELL, MARK CHANEY, ROBERT DOBSON,
21 THOMAS CARLSON, DESMOND HOGAN
22 was called as a witness and, after having been

1 first duly sworn, was examined and testified
2 as follows:

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

13 Again, my name is Chet Burrell,
14 and I am the CEO of both Care First and our
15 affiliate in the District, Group Hospital and
16 Medical Services, Inc., GHMSI. Together the
17 companies serve 3.4 million members,
18 approximately one million of whom are members
19 of GHMSI. Of the GHMSI members, approximately
20 10 percent are residents of the District of
21 Columbia. Nearly half live in Maryland, with
22 the balance in Virginia, and out of area. In

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

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

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

1 the act.

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

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

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

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

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

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

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

1 hearing reports filed by Appleseed a week or
2 so ago.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 Appleseed turns this all on its

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

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

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

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

22 On this issue of affordability, a

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

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

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

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

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

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

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

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

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

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

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

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

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

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

13 To put things in perspective, if
14 \$100 million were taken out of the reserve,
15 this equates to about \$300 per member for all
16 individuals and small groups in the GHMSI
17 service area.

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

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

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

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

1 which GHMSI does business.

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

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

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

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

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

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

19 From our members' perspective,
20 this would mean adding approximately \$100 a
21 month to the average monthly family premium of
22 \$1,800, just for the difference between the 2

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

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

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

1 jurisdictions, and would cause GHMSI's
2 spending for these three purposes to exceed
3 \$23 million annually.

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

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

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

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

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

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

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

12 Just one other further perspective
13 on GHMSI's reserves. In its reports of July
14 31st and August 31st to the Commissioner, GHMSI
15 presented how it determines overall reserve
16 levels, and how it believes the requirement of
17 MIEAA to attribute a portion of the reserves
18 should be carried out. There is no need to
19 repeat those key points here. But we wish it
20 understood that we have carefully reviewed the
21 statements made regarding GHMSI's reserves by
22 Appleseed, ARM, and Mathematica, and find them

1 replete with error, mischaracterization, and
2 misunderstanding. Just a few examples are
3 offered now to point this out.

4 Milliman will speak to this further in its
5 testimony in a more complete listing in a
6 separate submission that will be made
7 following this hearing.

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

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

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

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

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

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

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

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

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

1 override the mandate in the charter.

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

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

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

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

1 now be carried out?

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

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

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

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

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

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

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

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

11 COMMISSIONER PURCELL: Thank you.

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

15 MR. DOBSON: Is that fine?

16 COMMISSIONER PURCELL: That's
17 fine.

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

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

5 Three of these studies are the
6 subject of my comments today, and I will refer
7 to these three as the 2005 Optimal Surplus
8 Study, the 2008 Optimal Surplus Study, and the
9 Attribution Study, which was just completed in
10 2009.

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

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

17 COMMISSIONER BARLOW: You don't
18 have one?

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

22 MR. DOBSON: Shall I continue?

1 COMMISSIONER PURCELL: You may
2 continue.

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

14 In the 2008 Optimal Surplus Study,
15 based on changes to GHMSI's risk profile
16 between the two studies, we recommended that
17 the plan operate with surplus in the range of
18 750-1,050 percent of RBC. In the Attribution
19 Study, we opined that a reasonable way to
20 allocate surplus, based on our understanding
21 of the legislation that requires attribution,
22 is residency of the subscribers. The

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

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

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

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

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

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

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

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

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

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

22 Third, interest rate, and

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

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

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

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

1 development of new products, or response to
2 legislation.

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

16 Based on these simulations, we
17 identified the levels of cumulative, multi-
18 year losses that represent the 90th, 95th, and
19 98th percentile, respectively, of all possible
20 losses. Again, this is looking forward. The
21 90th percentile, for example, means that 90
22 percent of the simulated losses are at or

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

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

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

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

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

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

1 health plan loss patterns and operating
2 environment.

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

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

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

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

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

1 least two fully qualified professionals.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 Second, we do not directly use the

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

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

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

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

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

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

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

22 The Pennsylvania Commissioner did

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

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

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

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

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

12 COMMISSIONER PURCELL: Thank you.

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

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

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

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

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

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

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

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

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

22 We have worked on behalf of the

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

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

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

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

1 375 percent as a threshold below which
2 additional reporting and monitoring with
3 regard to surplus levels is required.

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

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

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

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

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

1 reasonable range.

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

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

1 90 to 95 percent confidence that surplus would
2 not go below the 375 percent RBC levels, and
3 the 98 percent confidence that surplus would
4 not go below the 200 percent RBC levels.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 to community benefits for the years 2005 to
2 2010.

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

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

1 to act prudently.

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

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

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

1 appropriate.

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

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

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

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

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

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

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

22 MR. BURRELL: Well, I think the

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

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

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

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

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

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

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

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

21 COMMISSIONER PURCELL: Right.

22 MR. BURRELL: We sponsored that in

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

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

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

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

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

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

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

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

18 COMMISSIONER PURCELL: Okay.

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

22 COMMISSIONER PURCELL: Okay.

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

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

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

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

1 your level of investment in the community?

2 MR. BURRELL: I think -- my own
3 perception, and I have been with the company
4 20 months, and one of the reasons, I might
5 add, that I came to the company, perhaps the
6 principal reason I did, was by being attracted
7 to its mission, and, particularly, to its not-
8 for-profit mission. Could it have a positive
9 effect in the community? I believed it could,
10 and should, and that if I were ever the CEO,
11 I would be dedicated to that proposition.

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

22 I know every Board member

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

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

9 MR. BURRELL: That purchase our
10 products?

11 COMMISSIONER PURCELL: That's
12 right.

13 MR. BURRELL: Which means our
14 insurance plans.

15 COMMISSIONER PURCELL: Your
16 insurance plans.

17 MR. BURRELL: Yes.

18 COMMISSIONER PURCELL: Correct.

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

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

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

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

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

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

3 MR. BURRELL: Yes, they have.

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

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

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

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

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

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

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

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

22 COMMISSIONER PURCELL: But there

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

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

17 COMMISSIONER PURCELL: Right.

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

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

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

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

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

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

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

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

5 COMMISSIONER PURCELL: And your
6 opinion on that is?

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

1 what Congress, in fact, intended.

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

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

12 COMMISSIONER PURCELL: What other
13 types of services?

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

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

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

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

3 MR. BURRELL: It doesn't count
4 tax.

5 COMMISSIONER PURCELL: Okay.

6 MR. BURRELL: Tax is on top of
7 that.

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

13 MR. BURRELL: Well, I think the
14 answer to that is very direct, and very
15 obvious. We want premium rates that cover
16 costs. We're non-profit. We are not in this
17 to make a profit. For-profit insurance
18 companies typically run profit ranges of 6 to
19 10 percent. In the last decade, we have
20 averaged a percent to 2 percent. We operate
21 on extremely skinny margins. In fact, I often
22 say to people, if you ever ran a multi-billion

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

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

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

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

10 MR. BURRELL: Current subscribers.

11 COMMISSIONER PURCELL: Only
12 current subscribers.

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

16 COMMISSIONER PURCELL: And a
17 community member.

18 MR. BURRELL: And a member of the
19 community, and we do give to the community.

20 But the -- when you ask about who is a
21 subscriber, it is somebody that is covered by
22 a policy of our's that is paying premium.

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

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

10 COMMISSIONER PURCELL: Okay.

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

13 COMMISSIONER PURCELL: Okay.

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

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

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

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

9 MR. BURRELL: As a larger
10 community role.

11 COMMISSIONER PURCELL: Okay.

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

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

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

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

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

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

3 MR. BURRELL: Well, again, I think
4 it's all a matter of balance. If I could, or
5 we could know that by investing in a certain
6 way, we could cause subscriber premiums to be
7 1, 2, 5 percent less by doing certain things,
8 and I include not in that list cutting them
9 off from benefits, but things that would
10 actually productively restrain the rise in
11 healthcare costs, on the one hand, and know
12 what those investments would look like, and on
13 the other hand, say let's give to worthy
14 causes in the community, this, on lowering the
15 trend in healthcare costs may be, probably is
16 the single-most important thing we could do.
17 Because without doing it, we think that in a
18 few years time, it becomes flat out
19 unaffordable for everyone. And I would put
20 this in concrete terms, \$1,800 family premium
21 in the District of Columbia right now, our
22 most common product for a family of four.

1 If healthcare costs keep going up
2 10 percent a year, in seven years that number
3 will double. Who affords \$3,600 a year, a
4 month? Who? And what degree of cost shift
5 will have occurred at that stage? And what
6 small employer group is going to pay that
7 premium, or 60 percent of that premium? And
8 what individual subscriber will pay a \$10,000
9 deductible, if we see the rise of deductibles
10 continuing the way they are? So, the concern
11 we have is that that's the fundamental
12 challenge.

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

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

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

1 COMMISSIONER PURCELL: Please.

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

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

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

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

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

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

1 the general community?

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

17 MR. BURRELL: I think we've
18 already stated our view, or I've stated mine.

19 COMMISSIONER PURCELL: Okay.

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

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

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

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

21 MR. BURRELL: Sure.

22 COMMISSIONER BARLOW: On page 2 of

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

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

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

22 And so is there an incentive to

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

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

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

11 MR. BURRELL: Yes.

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

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

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

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

11 Can you explain the difference in
12 those two things?

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

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

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

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

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

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

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

22 COMMISSIONER BARLOW: Right. I

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

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

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

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

22 Could you explain that to me?

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

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

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

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

1 company in the optimal range.

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

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

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

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

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

1 you're at the lower end of the range.

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

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

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

22 COMMISSIONER BARLOW: Okay. I had

1 a couple of questions to just get a better
2 understanding of the Blue Cross/Blue Shield
3 375 percent requirement.

4 MR. BURRELL: Yes, yes.

5 COMMISSIONER BARLOW: Could you
6 explain what happens --

7 MR. BURRELL: Yes.

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

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

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

1 approval. It means that the company is very
2 solid.

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

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

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

1 removed.

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

6 There's a higher level, which is
7 500, which begins to make them sit up and take
8 notice. We report to them. They monitor very
9 carefully what it is our surplus levels are,
10 this because a number of plans around the
11 country have from time to time run into
12 difficulty. They want to minimize that so
13 that the name remains synonymous with the
14 security that comes with Blue Cross and Blue
15 Shield.

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

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

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

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

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

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

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

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

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

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

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

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

4 MR. BURRELL: Right.

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

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

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

11 MR. TOOLE: Sure.

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

21 The second is administrative
22 services only contracts with large employers

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

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

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

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

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

1 it can vary.

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

5 MR. BURRELL: Yes.

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

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

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

22 Use of it raises all kinds of

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

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

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

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

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

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

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

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

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

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

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

1 cents. Why pay that?

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

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

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

16 One question on the intercompany.
17 I guess it's really for Mr. Dobson. In the
18 modeling, did you consider either the
19 potential risk to GHMSI if Carefirst of
20 Maryland dipped below the 375 or the potential
21 safety net to GHMSI if GHMSI stepped below the
22 375? Did either of those aspects factor into

1 your modeling?

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

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

17 MR. BURRELL: No.

18 COMMISSIONER PURCELL: There are
19 not. Okay.

20 Skip.

21 MR. MYERS: Thank you.

22 Just a couple of questions. Back

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

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

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

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

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

1 to take that kind of risk.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 it, and I think --

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

12 The main thing that we would want
13 to reinsure against, in addition to that
14 catastrophic event is multi-year cycle losses,
15 and for those who think the underwriting cycle
16 may be dead, and it's always gains, 50 percent
17 of the Blues' plans in the first six months of
18 2009 had underwriting losses. GHMSI is one of
19 them.

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

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

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

12 MR. MYERS: Okay. Thank you.

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

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

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

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

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

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

20 MR. MYERS: Yes.

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

1 MR. MYERS: That's right.

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

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

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

22 But to develop below realistic or

1 market pricing on a sustained basis is not
2 viable.

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

8 MR. BURRELL: Right.

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

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

1 another to current subscribers.

2 And that has its own consequences.

3 It creates certain changes in the market, has
4 certain downstream effect os artificially
5 depressing price for some period of time for
6 some component of our subscriber base, and the
7 consequence of that is hard to understand
8 fully in the marketplace.

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

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

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

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

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

12 MR. MYERS: Thank you.

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

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

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

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

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

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

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

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

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

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

1 pension contribution.

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

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

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

21 MR. CHANEY: I wasn't suggesting
22 that.

1 COMMISSIONER BARLOW: right.

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

7 COMMISSIONER BARLOW: Okay. And
8 could you explain? For like the previous
9 three years up to 2007, your authorized
10 control level RBC was roughly 70 million, and
11 then in 2007 and 2008 it jumped up to roughly
12 80 million. Can you discuss if there was a
13 reason for what gives an appearance of a spike
14 up in the ACL?

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

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

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

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

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

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

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

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

8 COMMISSIONER PURCELL: Are there
9 any subsidiaries of GHMSI?

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

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

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

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

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

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

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

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

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

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

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

1 insurance company as opposed to a for-profit?

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

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

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

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

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

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

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

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

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

22 MR. BURRELL: Well, I think the

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

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

1 through.

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

9 If we were to have a material loss
10 in enrollment, then reserves presumably would
11 go down in absolutely dollars. Whether the
12 reserve goes down in relative terms as
13 measured by RBC is a different issue.

14 Typically usually the smaller you are the
15 higher the RBC because the smaller, the more
16 likely you are subject to volatile changes,
17 particularly if you're a one product company
18 the way we are.

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

22 COMMISSIONER PURCELL: How does

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

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

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

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

1 could.

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

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

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

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

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

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

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

1 those claims cost. So we looked at that.

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

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

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

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

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

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

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

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

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

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

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

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

22 Did you look to the residence of

1 the individuals in each of those?

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

9 MR. DOBSON: All based on
10 residence, yes.

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

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

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

1 what you did.

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

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

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

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

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

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

14 MR. DOBSON: Yes.

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

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

22 MR. RECTOR: With the same

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

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

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

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

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

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

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

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

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

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

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

1 by jurisdiction?

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

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

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

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

1 something?

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

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

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

21 MR. DOBSON: No.

22 MR. RECTOR: For the FEP, I think

1 that's going to be the contract which you sign
2 onto, and for the ASO it would be the
3 administrative services agreement document,
4 and we may or may not think that some of those
5 latter portions work into the calculations.

6 We don't know, but we're required to at least
7 consider those factors according to the MIAC.

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

10 MR. RECTOR: Yes.

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

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

17 COMMISSIONER PURCELL: It's
18 actually in the regs.

19 MR. RECTOR: It's 4699.2.

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

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

1 sorry. Yeah, 4699.2.

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

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

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

22 Do we have any data that shows the

1 split between what an employer pays versus an
2 employee?

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

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

17 MR. BURRELL: We know in a general
18 way.

19 MR. RECTOR: Yeah.

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

1 lot different than the general trend.

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

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

10 MR. RECTOR: Yeah.

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

14 MR. RECTOR: Page?

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

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

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

1 medium employers is now at about the 50
2 percent mark.

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

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

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

14 MR. BURRELL: yes.

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

18 MR. BURRELL: Yes.

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

22 MR. BURRELL: We do.

1 MR. RECTOR: Okay. What's that?

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

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

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

22 MR. BURRELL: No doubt that the

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

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

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

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

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

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

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

9 MR. DOBSON: Sure.

10 MR. RECTOR: Okay.

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

14 MR. RECTOR: That's fine.

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

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

22 MR. BURRELL: Yes, yes.

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

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

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

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

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

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

21 MR. RECTOR: Right.

22 MR. BURRELL: -- which is what the

1 law requires.

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

7 MR. BURRELL: The group is.

8 MR. RECTOR: -- the group is.

9 MR. BURRELL: But the group's
10 members are more typically in the pattern of
11 9010.

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

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

17 COMMISSIONER PURCELL: Okay.

18 Thank you.

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

1 Thank you.

2 (Whereupon, the foregoing matter
3 went off the record at 1:14 p.m.
4 and went back on the record at
5 1:35 p.m.)

6 COMMISSIONER PURCELL: Okay.

7 We're going to reconvene.

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

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

16 MR. RECTOR: Thank you,
17 Commissioner.

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

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

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

17 You've come up with your optimal
18 range of 750 to 1050 RBC. Is that in your
19 mind, is that the same range as the range of
20 financial soundness so that if you fall below
21 750 you're financially unsound or is financial
22 soundness a different number, a different

1 method, a different calculation?

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

4 MR. BURRELL: Well --

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

8 MR. BURRELL: Go ahead.

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

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

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

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

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

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

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

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

6 But if you took our situation, the
7 one that we proposed, it comes out with an
8 11.6 percent of the total GHMSI reserve.
9 That's a very small piece. It is
10 proportionate generally to the membership
11 where they reside.

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

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

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

1 definitions of financial soundness, right?

2 MR. RECTOR: Right. Could be.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10 MR. RECTOR: Please.

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

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

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

4 I think that what Milliman has
5 done here and what the company has done is
6 looked at the first element of that, and the
7 report goes to whether our surplus is
8 unreasonably large. I think the conclusion
9 has to be in reading the analysis that it
10 isn't unreasonably large.

11 You don't get to the second part
12 of the analysis of whether we are meeting our
13 community health reinvestment obligation and
14 the associated issue of financial soundness
15 until you make a determination that the
16 surplus is unreasonably large.

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

1 where the actual surplus is.

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

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

14 MR. RECTOR: Okay.

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

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

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

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

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

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

22 That would be basically the board

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

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

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

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

16 MR. BURRELL: Yes.

17 COMMISSIONER PURCELL:
18 Appropriately.

19 MR. BURRELL: Yes, I believe so.

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

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

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

11 MR. HOGAN: Well, I believe that
12 the Milliman report goes to the issue of
13 whether the reserves of the company are
14 unreasonably large or not, and they've come to
15 the opinion that our range should be between
16 750 and 1050 RBC. In applying the facts that
17 are in the world that we know, the RBC in 2008
18 was at 845. I think that answers the question
19 of whether we have an unreasonably large
20 reserve or not.

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

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

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

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

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

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

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

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

1 the --

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

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

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

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

1 unreasonable.

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

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

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

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

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

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

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

1 investment income or does that include
2 investment?

3 MR. BURRELL: It does not.

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

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

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

19 MR. BURRELL: It's short.

20 MR. RECTOR: Okay.

21 MR. BURRELL: I think.

22 MR. HOGAN: You are talking about

1 this?

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

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

7 MR. BURRELL: "Aforesaid."

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

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

12 MR. RECTOR: Okay.

13 (Laughter.)

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

18 MR. BURRELL: Certainly.

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

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

6 MR. DOBSON: Right.

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

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

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

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

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

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

6 MR. RECTOR: So it would be 750 to
7 some number that -- your belief is that if you
8 only had the second criterion that the range
9 would be 750 to some number probably less than
10 1050, but 750 to some --

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

14 MR. RECTOR: I understand that.

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

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

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

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

6 COMMISSIONER PURCELL: Jim -- oh,
7 sorry.

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

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

22 MR. BURRELL: Yes.

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

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

11 MS. SCHROEDER: Right.

12 MR. BURRELL: CFI.

13 MS. SCHROEDER: I'm having trouble
14 finding though in what we have the specific
15 numbers of those total expenditures both for
16 2008 and thus far or projected in 2008.

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

19 MS. SCHROEDER: That would be
20 wonderful. Okay.

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

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

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

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

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

1 relations efforts.

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

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

17 MR. BURRELL: We can do that.

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

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

1 GHMSI.

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

6 MR. BURRELL: no.

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

9 COMMISSIONER PURCELL: Jim.

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

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

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

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

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

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

1 percent range.

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

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

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

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

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

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

1 that we didn't expect.

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

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

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

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

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

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

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

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

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

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

1 You're still solvent, right?

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

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

7 MR. DOBSON: Right.

8 MR. TOOLE: Okay.

9 MR. DOBSON: Right.

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

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

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

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

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

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

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

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

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

1 NAIC prescribed --

2 MR. TOOLE: That's correct.

3 MR. DOBSON: -- calculations.

4 MR. TOOLE: Yes.

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

9 MR. TOOLE: And in that
10 calculation --

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

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

19 MR. TOOLE: Yes.

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

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

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

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

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

1 evolved?

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

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

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

22 In the early '80s, I was involved

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

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

14 MR. TOOLE: I'm sorry.

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

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

1 did, I wasn't personally involved in that.
2 There were certain criticisms made by the
3 Commissioner that we did reflect in later
4 versions of the model. So we continue to
5 refine is what I'm getting at. We continue to
6 make changes as people look at it and give us
7 suggestions or as we find things that don't
8 really meet the client's needs or the
9 regulator's needs.

10 MR. TOOLE: Can you describe how
11 you modeled the three what I would call lines
12 of business and how the income streams for
13 each were handled?

14 MR. DOBSON: Well, that's all
15 based on the company's pro forma financial
16 projection. So we established the three
17 different risk cells, one being the non-FEP
18 risk, FEP by itself, and then the ASC risk,
19 and we're using the company's financial
20 projections and looking at that, but we make
21 a simpler model to be used for our purposes
22 that reproduces that in their instance and

1 then that we can put our probability
2 distributions in the adverse loss cycles into
3 that kind of model.

4 MR. TOOLE: Briefly describe the
5 different risks. I know that you have the
6 seven risks, which I affectionately call the
7 seven sisters, and you have the FEP and the
8 ACS. Can you describe how the FEP was modeled
9 in the pro forma and the ASC and how that's
10 different than these others?

11 MR. DOBSON: Well, in terms of our
12 assumptions, the FEP is treated totally
13 differently because we don't have the -- we
14 don't apply the rating risk, which is the big
15 driver. This is that number one risk, the
16 rating risk, which is partially medical trend,
17 but it can be other factors in the rating
18 formula, any sort of mistake that the company
19 makes or any sort of fact that the assumed
20 results don't occur gets reflected in that
21 first one. That does not apply to FEP. That
22 does not apply to ASC.

1 MR. TOOLE: So let me stop there
2 because if there's no rating risk, it feels to
3 me that the RBC calculation might put too
4 much weight on FEP in their analysis, thereby
5 driving up RBC ratios to levels which may not
6 be necessary for the singular company GHMSI,
7 which has the bulk of the FEP risk.

8 MR. DOBSON: I see where you're
9 going with that. I don't think that would
10 affect our results. It might affect the
11 percentage.

12 For example, if you change the
13 NAIC prescribed formula and made that .1
14 percent instead of one percent, it will have
15 a much lower RBC. The recommended ranges
16 would then be much higher ranges.

17 MR. TOOLE: Okay.

18 MR. RECTOR: I'm sorry. Just to
19 follow up on that, so if they had done that,
20 the companies reported RBC you're saying might
21 be lower, but the Milliman recommended ranges
22 even would stay the same or would even be

1 higher. Is that the point?

2 MR. DOBSON: We develop it as a
3 chance of getting to the various levels.

4 MR. RECTOR: But I think if the
5 NAIC changed so that they went from line one
6 percent to .1, what it would change from the
7 NAICs would be the authorized control level
8 RBC. That would go down.

9 MR. DOBSON: Yes, but --

10 MR. RECTOR: So I think the
11 multiple would actually be a higher multiple.

12 MR. RECTOR: -- change in itself,
13 too.

14 MR. RECTOR: Is that --

15 MR. DOBSON: Yes, I would have to
16 look at that. That could have some impact.
17 I'm not sure about that now that you mention
18 it.

19 MR. RECTOR: You haven't thought
20 of that. That's --

21 MR. DOBSON: I see a different
22 aspect of it I wasn't think though.

1 MR. TOOLE: Okay. That's why I'm
2 here.

3 You have really a rich history in
4 your model, but can you talk about some
5 limitations that you see in the approach both
6 from the standpoint of your company's specific
7 assumptions and maybe in model design? What
8 are your strengths and your weaknesses?

9 MR. DOBSON: The strengths?

10 MR. TOOLE: Yeah. I think we've
11 heard the strengths. It's the standard, but
12 what maybe does it not capture?

13 MR. DOBSON: Well, not model is
14 perfect.

15 MR. TOOLE: Right.

16 MR. DOBSON: There's always
17 simplifying assumptions, of course. I'm sure
18 there could be a lot of things one could look
19 at and think, well, gee, we could do this a
20 little bit better or that a little bit better.

21 The biggest thing I can think of
22 offhand that we might want to refine going

1 forward is the reflection of size. We have
2 introduced reflection of size now, but it's
3 still not very sensitive to size. So that
4 might be something that we look at changing in
5 future iterations.

6 MR. TOOLE: How does your model --
7 well, as it stands, it's my understanding that
8 the model is independent of management
9 actions. So can you describe specific
10 interventions that management could take to
11 mitigate losses or discretionary during a down
12 cycle?

13 MR. DOBSON: I'm not sure I would
14 have described it as independent of management
15 interventions, but I can see you describing it
16 that way because in the loss cycle we assume
17 that that loss cycle is going to occur, and it
18 may be in spite of management's intentions and
19 various interventions that management might
20 do.

21 The other thing that counters that
22 a little bit is if management is not actually

1 getting the margins that we assume, we do
2 assume that those margins are being built in
3 the rates. So to the extent that those aren't
4 into it going in, you know, maybe there's a
5 lack of conservatism to that element. So that
6 may counter that just a little bit.

7 Again, it's impossible for a model
8 to exactly replicate what would happen in
9 reality.

10 MR. TOOLE: Then I guess I'd throw
11 out to management then if we're in a down or
12 an adverse cycle, what sorts of investments in
13 infrastructure can be delayed.

14 MR. BURRELL: Well, you're talking
15 about administrative things?

16 MR. TOOLE: Well, I know that
17 you're in your long-term plan. You have quite
18 a bit of plan investments in infrastructure,
19 and they do contribute to the down cycle. So
20 I guess --

21 MR. BURRELL: Well, it has a very,
22 very minor --

1 MR. TOOLE: I mean, management has
2 to matter. So what steps can you take during
3 an adverse loss cycle to mitigate that?

4 MR. BURRELL: Let me just put it
5 in perspective. Our admin as a percentage of
6 our revenue last year was 10.8 percent. It
7 might vary a fraction of a percent year to
8 year as we go forward. It's not a very big
9 difference year to year, will never have by
10 itself a huge impact on the cycle.

11 Things that relate more to the
12 cost of care, what care actually costs and
13 what trends are actually in the market, I
14 mean, we are always looking at ways to improve
15 the way we contract with providers, provide
16 incentives for high quality, cost effective
17 care, ability to measure it, see it, reward
18 it.

19 But in terms of the actual
20 administrative expense, it's a small piece of
21 the total equation, and even minor foreseeable
22 changes in that don't have much impact on the

1 whole.

2 MR. TOOLE: Sixty million dollars.

3 MR. BURRELL: Well, and billions.

4 MR. TOOLE: I recognize that, but
5 that's the difference between --

6 MR. BURRELL: -- over a period of
7 years it's capitalized. It's not all in one
8 period.

9 MR. TOOLE: And your long-term
10 plan and in this year there were specific
11 expenditures for \$60 million.

12 MR. BURRELL: It's counteracting
13 forces. By making the investment we become
14 more efficient. The net off that we're trying
15 to get if you just look at just the
16 administrative dollar is to cut the
17 administrative dollar, not add to it. So the
18 investment is almost always in that context.

19 MR. TOOLE: Okay. One of the
20 drivers of the range was the amount of growth
21 that was assumed in a down cycle. Can growth
22 be managed?

1 MR. BURRELL: Do you mean
2 enrollment growth or premium growth?

3 MR. TOOLE: Correct.

4 MR. BURRELL: Well, it goes to the
5 heart of our mission. We put ourselves out
6 there for the community, to attract
7 subscribers because we offer products that
8 they perceive having value. We don't say to
9 people, "We attracted you and we'll turn you
10 away in order for us to limit our growth."
11 That is antithetical to our mission.

12 So we take the growth we get, and
13 we seek to manage that, the costs of that
14 growth, by constantly becoming more efficient,
15 which comes to the investment question.

16 With regard to the yields in our
17 revenue, we have consistently in recent years
18 produced less revenue than our rating formulas
19 would indicate because employer groups buy
20 down their benefits. They reduce their
21 benefits.

22 So just as an example, to pick a

1 simple example, if a group had a ten percent
2 rate increase and didn't want to pay a ten
3 percent rate increase, they would increase
4 their deductible or introduce other limits in
5 their benefit plan design to cut that increase
6 down.

7 And the biggest thing that has
8 happened, as I mentioned in my testimony, in
9 recently years, and it has been very fast, I
10 think unprecedented, is the movement towards
11 high deductible health plans. As I mentioned
12 three years ago there was virtually none of
13 it, and today more than half the market in
14 Maryland in the small group market has a high
15 deductible health plan, and that's what's
16 happening now by degrees in the District, same
17 pattern, just a slight stagger later.

18 So what happens is the premium is
19 quoted. The groups reduce the scope of their
20 benefit, and they don't have the rate increase
21 that they would have had otherwise, but
22 they're also offering to their members less

1 benefits, and that has had an effect on the
2 growth of the company's revenue for sure, and
3 that has been the biggest single factor is
4 that buy-down process, and that is not in any
5 way unique to us. That's basically going on
6 all over the country.

7 And it's a response, the first
8 wave of response, if you will, to the high,
9 unaffordable price of health care coverage.

10 MR. TOOLE: thank you.

11 How many companies have you
12 advised with regard to their surplus levels do
13 you think, Milliman, using this model?

14 MR. DOBSON: We've tallied that up
15 at one point. I don't know if I recall the
16 exact number. I think it would be somewhere
17 between ten and 20.

18 MR. TOOLE: And are all of them in
19 a public hearing situation or some of them
20 just --

21 MR. DOBSON: No, some of those are
22 non-public.

1 MR. TOOLE: Okay.

2 MR. DOBSON: And did you put a
3 time frame on that?

4 MR. TOOLE: No, I really didn't.

5 MR. DOBSON: Okay. Because I was
6 speaking over a number of years.

7 MR. TOOLE: Yeah. Have you been
8 in a situation where you've had to talk to a
9 company where their surplus was too little,
10 below the range?

11 MR. DOBSON: Oh, that they had--

12 MR. TOOLE: That you advised,
13 below their advised range.

14 MR. DOBSON: I'm sorry. That
15 their surplus was below the --

16 MR. TOOLE: Outside of the range.

17 MR. DOBSON: Outside of the range?

18 Not that I've personally been involved in.

19 I'm certain that's happened. I've certainly
20 been in situations where companies had too
21 little surplus.

22 MR. TOOLE: True. Have you been

1 in situations where you have advised companies
2 where there surplus is too high?

3 MR. DOBSON: I think there have
4 been some situations, none that I can recall.
5 I couldn't point you to a single one, but I
6 certainly concede that that could have
7 happened, yes.

8 MR. TOOLE: It would be wonderful
9 to have that sort of information if it's
10 available.

11 MR. DOBSON: Yeah, I can try to
12 find out certainly.

13 MR. TOOLE: So what are some
14 potential downsides to accompany having too
15 much surplus in a market where they have a
16 dominant position?

17 MR. DOBSON: Are you addressing
18 that to me or to the company?

19 MR. TOOLE: I guess it's to the
20 panel.

21 MR. BURRELL: Downside of too
22 much?

1 MR. TOOLE: Are there any
2 downsides to competitiveness for a company
3 having too much surplus when they are the
4 controlling force in the market?

5 MR. BURRELL: I don't know that
6 there's any controlling force in a market.

7 MR. TOOLE: Well, let's call it a
8 monopoly status where you've got 80 to 90
9 percent of the market.

10 MR. BURRELL: Okay. As I
11 explained earlier, every group comes to us
12 pass through extensive filters, if you will,
13 consultants who advise, who tell them what
14 their best value is, they don't listen to us
15 entirely. We make our case. They decide with
16 expert advice, without exception on the big
17 end, and on the small end we are always
18 virtually spreadsheet against the competition.

19 MR. TOOLE: Okay.

20 MR. BURRELL: Our value compared
21 to every other competitor. No market is
22 perfect, but to say that that is a control

1 situation, I think, is not the right way to
2 look at it. One thing about holding a reserve
3 that has been helpful and helpful to
4 subscribers is that the earnings on the
5 reserve itself are available so that you
6 don't have to get those from the premiums
7 themselves, and that has a moderating effect
8 on premium.

9 We do have a substantial portion
10 of our bottom line come from the earnings on
11 our reserve, and we return that, in effect, in
12 the form of lower premiums than we otherwise
13 would have charged because we don't need to
14 get it from premium because we're getting it
15 from the earnings on the reserve itself, and
16 so that helps the subscriber. It helps make
17 it more affordable. The lower the reserve
18 gets, the lower the earnings go and the less
19 it helps.

20 MR. TOOLE: but there's no
21 situation where you talked about large
22 companies trying to enter the market and they

1 support lower rates coming in which are not
2 supportable on the other side of the equation
3 where you lower rates which are not
4 supportable in order to prevent competition.

5 MR. BURRELL: Again, we are, in
6 terms of our connection to this community,
7 seeking to be the most stable continuous force
8 here. We're not in the business of buying
9 business.

10 I would put something in
11 perspective. In the small group market, and
12 I don't know that it is in the District off
13 the top of my head, but I do know what it is
14 in the region overall. We cover 41,000 small
15 employer groups, and we cover another couple
16 of thousand groups that are between 51 and
17 199, and you could say those are medium size
18 groups, and we cover the jumbo groups that
19 have tens of thousands of people in them.

20 And the consequence of that is
21 that we also offer flexibility in benefit
22 design. So for 41,000 small employer groups,

1 there are literally hundreds of benefit
2 combinations that they could pick, and at any
3 point in time, depending on the need of the
4 group, the advice of the consultant or the
5 broker, they're picking different combinations
6 of those things. It's a very complex market.

7 What we try to do in the light of
8 that complex market is to say all things
9 considered, take all of that complexity, all
10 of the changes in the benefits, 45 percent of
11 our groups change benefits on renewal. So you
12 take all of the complexity and the benefit
13 designs, all of the churn in the market, all
14 of the changes in the membership, all of the
15 changes in the medical care trends, and you
16 try to say as a company can we get that right
17 within one percent.

18 And last year we had two-tenths of
19 a percent, and this year we aspire to the
20 lofty number of between half a percent and one
21 percent. And the consequence of these
22 millions of transactions that are going on is

1 such that it's hard to pin it down precisely,
2 but that's as precise as human beings can do
3 it, and we try to do that consistently over a
4 period of time so that it's not just one year.
5 It's multiple years.

6 COMMISSIONER BARLOW: A couple of
7 times in your testimony and in answer to, I
8 think, that last question, you seem to imply
9 there's a relationship between the level of
10 surplus that you have and the pricing of your
11 products. Is there an explicit component of
12 the pricing of your products that's related to
13 the amount of surplus that you have or --

14 MR. BURRELL: No.

15 COMMISSIONER BARLOW: -- it's --

16 MR. BURRELL: No, I think it's the
17 whole idea. If you take what we have said, we
18 try to establish on the best professional
19 advice we can get what an optimal range ought
20 to be. We try to stay within that range,
21 which is the net of all the things I just
22 described.

1 COMMISSIONER BARLOW: And an
2 optimal range of --

3 MR. BURRELL: The reserve.

4 COMMISSIONER BARLOW: Okay, but
5 I'm trying to understand how that impacts
6 pricing.

7 MR. BURRELL: Pricing policy is
8 affected by that because if you're below that,
9 you try to come back into it as moderately as
10 you can, which means you put a little more
11 margin in, and if you are in the range, you
12 don't have to put so much in. If you were at
13 the top of the range, you wouldn't put it in
14 at all or you would put very little in so that
15 you would come back down.

16 COMMISSIONER BARLOW: Okay. So
17 the way that the level of your surplus impacts
18 the pricing of your products is in the level
19 of the margin that you include in the pricing.

20 MR. BURRELL: Yes.

21 COMMISSIONER BARLOW: Okay, and so
22 there's not like a direct relation. You look

1 at your surplus and you --

2 MR. BURRELL: With all of the
3 product designs that we have, in all of the
4 group sizes that we have, with all of the
5 individuals we have, it's the net effect of
6 how all of that is interplaying against each
7 other. It's a complex situation.

8 MR. TOOLE: Bob. Sorry. Mr.
9 Dobson. We're going to go into some
10 assumptions. I don't want to bore everybody
11 in the room, but I want to get some stuff on
12 the record. Recognizing that each assumption
13 is different in those seven groups, can you
14 explain the general process that you went
15 through and company specific factors?

16 I know you had some stuff that's
17 general for the Blue Cross/Blue Shield and
18 then some stuff that's company specific. Talk
19 about how you did that.

20 MR. DOBSON: The assumptions
21 themselves are the series of distributions of
22 the contingencies around those risks that we

1 shared with you and went through. Most of
2 that is based on the experience of the
3 consultants doing it and looking at and
4 considering the individual characteristics of
5 the company. I wouldn't say at least none of
6 it I can think of offhand is based directly on
7 Blue Cross as a whole, other than the fact
8 that it affects our experience, I guess,
9 because we've worked with lots of Blue Cross
10 plans.

11 But the actual setting of each of
12 those is based on considering the company
13 we're working for at the time and what we see
14 from the experience and various analyses we
15 look at, you know, some of which I think we
16 discussed with you when you were in our
17 office.

18 I can't sit here now and tell you
19 exactly what we looked at for each one of
20 those unfortunately. I'd need the rest of the
21 team with me to be able to do that justice.

22 MR. TOOLE: There's a lot of

1 detail. Can you quickly describe -- you've
2 already mentioned it -- how prior industry and
3 the GHMSI prior underwriting cycles impacted
4 your future underwriting cycle loss
5 distribution?

6 MR. DOBSON: Well, we don't
7 actually set the loss distribution based on
8 those past ones. We look at those after the
9 fact as I described in my testimony. I would
10 say that this was going through the
11 assumptions related to the seven risks. We're
12 considering what happened in prior times, in
13 past adverse experiences. That's more
14 subjective in terms of setting those
15 assumptions about what might happen in the
16 future.

17 For example, on the trend or
18 rating factor miss, you know, we assign
19 probabilities that are literally within two
20 percent each way, you know, X percent
21 probability that within two percent each way
22 of expected, you know, Y percent that it will

1 be five percent deviation, and those are based
2 on our collective experience of all the
3 different operations we've seen over the years
4 and what we know about the company's pricing.

5 MR. TOOLE: Could you explain how
6 the margin that we just discussed is used in
7 your model, the pricing margins?

8 MR. DOBSON: Yes. The margins go
9 in, the assumed margins, and that does have an
10 impact because that directly goes into that
11 calculation of the trend. For example, if we
12 assume the company is going to be three
13 percent off on the trend, but we know they
14 build a three percent margin in, then that
15 financial impact of that is zero. So we
16 directly take that into account, and that's
17 why if the company increases or decreases that
18 margin it directly affects our results.

19 MR. RECTOR: Can I ask a quick
20 follow-up on that? In the adverse cycles, did
21 you take the margins down to zero or --

22 MR. DOBSON: No.

1 MR. RECTOR: -- I mean, the
2 adverse cycles I guess you'd increase the
3 margin, pricing margin.

4 MR. DOBSON: If you think about
5 margin perhaps the way Mr. Burrell is looking
6 at it of what they achieve, of course, that
7 can go to zero; that can go negative.

8 MR. RECTOR: Right.

9 MR. DOBSON: But the intended
10 pricing margin we give credit for. So if we
11 say the company is off by five points in the
12 rating factors, well, we know they've built in
13 a three percent margin. Then we say the
14 underwriting loss is going to be two percent.

15 MR. RECTOR: Yeah, I flipped it.
16 In the model as you're going through the
17 adverse cycles, and I'm coming back maybe to
18 Jim's earlier questions on management
19 intervention. In the model as you start going
20 in the adverse cycle, did you increase the
21 intended pricing margin?

22 MR. DOBSON: No, we don't. We use

1 the same one. One of the things I mentioned
2 in the testimony was we look at the adverse
3 loss cycle that are over two or two and a half
4 rating cycles, and then we use a three or a
5 four-year financial period, and we assume
6 that there's going to be three years of
7 positive margin in the three-year cycle, four
8 years of positive margin in the four-year
9 cycle.

10 So the four-year actually gives
11 less severe bottom line results because we've
12 got four years of margin coming in.

13 MR. RECTOR: Margin.

14 MR. DOBSON: Right.

15 MR. RECTOR: What's the standard
16 margin that you use throughout in the model,
17 if you recall?

18 MR. DOBSON: Is that considered
19 proprietary to the company?

20 MR. RECTOR: Well --

21 MR. BURRELL: I mean the actual
22 margin we achieve is --

1 MR. RECTOR: No, I'm talking about
2 in the model.

3 MR. BURRELL: In the model I
4 don't.

5 MR. RECTOR: You don't? Okay.
6 That's --

7 MR. DOBSON: Yeah, I think that's
8 considered proprietary to the company, and I
9 would be hesitant to answer that without their
10 permission, but that has been shared with Jim,
11 yeah.

12 MR. TOOLE: So I'd like to change
13 over to Mr. Carlson, get you involved. You
14 mentioned in your statement what you based
15 your opinion on, and I marked up something
16 that based on our understanding of their model
17 and consideration of their assumptions. What
18 sort of access to their assumptions did you
19 have that you were able to review?

20 MR. CARLSON: We had the report
21 that was publicly available, and we also have
22 similar models that we run ourselves. So

1 based on their report, we interpreted, you
2 know, what we would have put into our similar
3 models based on the publicly available report.

4 MR. TOOLE: In the publicly
5 available report, there was no information on
6 any of the seven risk assumptions.

7 MR. CARLSON: Right.

8 MR. TOOLE: So you gave an opinion
9 without even looking at their risk
10 assumptions?

11 MR. CARLSON: We gave an opinion
12 based on what we felt were a reasonable range
13 of what we would expect for these types of
14 assumptions, and then we tested these ranges,
15 the high end and the low end, and we did not
16 run a Monte Carlo simulation as referenced in
17 the paper, but we were doing tests on the high
18 and low end.

19 So we were sort of testing the
20 extremes to see if we thought that our results
21 would have been in line with their results.

22 MR. TOOLE: So you took a somewhat

1 different approach in that you didn't really
2 have any assumptions, and you didn't run any
3 simulations. I'm having a hard time
4 understanding what your report -- how it --

5 MR. CARLSON: Well, you're
6 correct. We took a very different approach.

7 MR. TOOLE: Okay.

8 MR. CARLSON: And that is true.
9 And our approach was, you know, coming in at
10 a very high level and examining what we --
11 based on, you know, previous models that
12 we've run for previous Blues plans and some of
13 the basic, publicly available information on
14 GHMSI if we felt that the results that were
15 coming out of Milliman's model were in line
16 with results we've seen in other Blues plans
17 and, you know, modified for assumptions that
18 may be applicable to GHMSI or assumptions that
19 would be sort of on the, like I mentioned, on
20 the testing the edges of what would be a
21 reasonable assumption.

22 MR. TOOLE: So about how many

1 companies has your firm been involved in in
2 doing this sort of analysis?

3 MR. CARLSON: In the last ten
4 years it's been about five companies.

5 MR. TOOLE: Okay. Have any of
6 those companies been found to be outside on
7 the excess?

8 MR. CARLSON: Yes.

9 MR. TOOLE: Okay.

10 MR. CARLSON: Yes.

11 MR. TOOLE: That also would be of
12 great interest to us.

13 MR. CARLSON: Okay, and you know,
14 a lot of this is proprietary.

15 MR. TOOLE: I know.

16 MR. CARLSON: Or not in the public
17 forum. So we can look into what -- we can
18 describe this in more detail.

19 COMMISSIONER PURCELL: I have one
20 question for Mr. Carlson. On page five of
21 your testimony you state at the bottom of the
22 third paragraph, second full paragraph, there

1 are a number of additional risk factors and
2 individual market considerations that should
3 be considered when comparing surplus needs.

4 Can you detail or just summarize
5 what some of those are in distinguishing
6 Pennsylvania's example from the current GHMSI
7 issue?

8 MR. CARLSON: Sure. Well, I think
9 the one issue that really stands out at GHMSI
10 is the FEP contracts. GHMSI has the largest
11 FEP contract of the Blues plans, and the
12 Pennsylvania plans, you know, are certainly
13 much smaller in their federal business.

14 COMMISSIONER PURCELL: Okay. I
15 just was curious as to what those were since
16 you made the example.

17 Were there any other questions?

18 MR. RECTOR: I had one quick
19 question for Mr. Burrell. If the company --
20 I think you said you were on the Blue Cross
21 board and on the early monitoring board. If
22 a company, if a Blue Cross plan breaches the

1 375 percent threshold, is that public?

2 I mean obviously their RBC,
3 somebody could look at the financial
4 statements, but is there some sort of
5 announcement or anything that's --

6 MR. BURRELL: Not from the
7 association, but all of the company's reports
8 are obviously public as they have been filed.

9 MR. RECTOR: Okay, and I know you
10 talked about there being a 500 percent
11 trigger. Is there any trigger between the 200
12 and the 375 or is it -- so it's 200, 375, 500,
13 are the three triggers?

14 MR. BURRELL: I think that's the
15 way to think of it, yeah.

16 MR. RECTOR: Thanks.

17 COMMISSIONER PURCELL: Okay,
18 great. I think with that we will dismiss this
19 panel. Mr. Hogan, Mr. Burrell, Mr. Chaney,
20 Mr. Dobson, and Mr. Carlson, thank you.

21 We're going to deviate slightly
22 from the witness list because of a scheduling

1 issue, and, Mr. Smith, thank you for pausing
2 for one moment. We're going to hear from the
3 Maryland Insurance Commissioner, Mr. Ralph
4 Tyler.

5 MS. JOHNSON: Mr. Tyler, would you
6 raise your right hand, please?

7 Do you swear or affirm to tell the
8 truth, the whole truth, and nothing but the
9 truth, so help you?

10 Thank you.

11 COMMISSIONER PURCELL: Good
12 afternoon, Ralph.

13 MR. TYLER: Good afternoon,
14 Commissioner, and my thanks first for being
15 allowed to be here today to participate in
16 this important hearing and, secondly and not
17 insignificantly, I appreciate your taking me
18 out of turn, and I promise not to abuse that
19 privilege, and I will be brief because I know
20 there are others from whom you wish to hear.

21 My name is Ralph Tyler, and I'm
22 the Insurance Commissioner for the State of

1 Maryland, a position I've held since September
2 of 2007. I've submitted written testimony,
3 which I would propose to summarize and not to
4 read in the interest of time.

5 The first and perhaps most
6 important thing that I would like to say is
7 that we in Maryland are keenly aware and
8 appreciative of the importance of the hearing
9 in the matters you are considering. These are
10 matters in which we have a deeply shared
11 common interest because as you well know and
12 certainly confirm by the earlier testimony,
13 one of the unique features of the company
14 you're looking at, GHMSI, is that it operates
15 in three jurisdictions, including
16 significantly and importantly in Maryland.

17 We also share your interest in
18 insuring that the company meets its public
19 purpose obligations. We take those
20 obligations seriously in Maryland as you do
21 here.

22 We take no position on the

1 question of whether GHMSI has excessive
2 surplus. It's not because we're not
3 interested in that question. We are very
4 interested in that question. We take no
5 position on it for the reason that we are
6 ourselves in the midst of an examination of
7 that question. We've hired a consulting firm,
8 the Invotex firm that is working on that
9 question, and we expect to have a report from
10 them within approximately 45 days of now.

11 And what I wanted to specifically
12 say is we want to work with you and cooperate
13 with you throughout this. We certainly want
14 to make that report available to you.
15 Obviously the schedule you're on and the one
16 we are on don't match up perfectly, and
17 whatever might be done to accommodate that,
18 and whether you might consider issuing an
19 interim report so that you'd have the benefit
20 of the Invotex work, I mean, of course, I
21 leave that up to you.

22 But what I want to stress is that

1 we do want to cooperate and we are also
2 looking at these questions.

3 Now, there was a lot of discussion
4 from the earlier panel about the question of
5 attribution, and that, of course, is
6 important, and it's important to Maryland as
7 it is to you. The statute calls upon the
8 Commissioner here to review the portion of the
9 surplus of the corporation that is
10 attributable to the District, and I believe
11 that the questions that were asked by Mr.
12 Rector as well as others, we would associate
13 ourselves with that; that that is a difficult
14 question with considerably greater complexity
15 than the papers acknowledge, and we, too are
16 interested in that question, and that is one
17 of the questions upon which we expect to be
18 getting advice from the Invotex firm, and I
19 think that that is a difficult question, and
20 that it's important, again to all of us and to
21 our shared interest.

22 The final point I would like to

1 discuss is this, and that is the question of
2 the remedy, if you will, if the surplus is
3 determined to be excessive. Again, and for
4 present purposes I assume that such a
5 determination is made, albeit we don't take
6 a position on that because we are waiting
7 advice on that question.

8 And the District statute, and I
9 say this with no chauvinistic sense. It
10 happens to be true. The District statute here
11 was modeled on an existing Maryland law.
12 Again, I'm proud of Maryland, but it's a small
13 point, but it happens to be true. The
14 Maryland statute upon which the District
15 statute is modeled is Section 14-117(e) of the
16 insurance article of the Maryland code.

17 And the Maryland statute like the
18 District statute calls upon if in the event
19 that there's a determination that the surplus
20 is excessive and calls upon the corporation to
21 develop a plan, and then as to the plan, the
22 language in the District statute is as

1 follows. It says, "A plan submitted pursuant
2 to Paragraph 1 of this subsection may consist
3 entirely of expenditures for the benefit of
4 current subscribers of the corporation."

5 The Maryland statute is not
6 permissive in that regard. The District
7 statute says the corporation plan may consist
8 entirely. The Maryland statute, by contrast,
9 is mandatory. It says the distribution
10 ordered under Paragraph 2 of this subsection
11 may be made only to subscribers who are
12 covered by the corporation's nonprofit health
13 plan.

14 But my point would be this, that
15 in the event that there is a determination
16 that there is an excessive surplus, I think
17 this remedial provision is a very thoughtful
18 and correct one, that any excess exists
19 because subscribers paid, experience showed,
20 excessive rates, and so the appropriate plan
21 for distribution of any excess would be for
22 rate reductions or some other way to return it

1 to the subscribers, and that that importantly
2 answers concerns that the regulatory system
3 and the integrity of decision making would be
4 distorted by thinking that a finding of excess
5 would be a source of revenue for general use.

6 The corporation would have it
7 within its rights, again, under the plain
8 language of the statute to come forward with
9 a plan consisting entirely of expenditures for
10 the benefit of current subscribers, and we
11 would suggest that that would be an
12 appropriate plan and, indeed, the only
13 appropriate plan.

14 With that, I will stop and I would
15 be happy to answer any questions. And, again,
16 I thank you for allowing me to be here.

17 COMMISSIONER PURCELL: Thank you
18 for your testimony.

19 And it's inspired that you speak
20 of that because my question to you was going
21 to be your thoughts on that distinction in the
22 Maryland law, that restriction of distribution

1 which we don't have as clearly written in
2 ours.

3 I will say I'm not patently averse
4 to your suggestions in terms of working
5 together, collaborating. I've expressed to
6 you that's something I'm willing and able to
7 do. I will definitely take into consideration
8 the suggestions you made about possibly doing
9 interim order. Of course I'm limited and
10 restricted to the duties that I've been
11 assigned, but I will certainly keep you
12 informed as I hope I have been doing.

13 MR. TYLER: You surely have.

14 COMMISSIONER PURCELL: I don't
15 have any specific questions for you. I think
16 that we will talk a lot over the next few
17 weeks hopefully. I am interested in seeing
18 the suggestions that come in your report from
19 Invotex. I'm in the information gathering
20 stage right now, and so I think to the extent
21 you're willing to make that part of the
22 record, we are on board and would appreciate

1 that.

2 MR. TYLER: Certainly.

3 COMMISSIONER PURCELL: Any
4 questions from the panel?

5 (No response.)

6 COMMISSIONER PURCELL: No. Thank
7 you, Mr. Tyler, very much.

8 MR. TYLER: Again, thanks to all
9 of you. Thank you very much.

10 COMMISSIONER PURCELL: Thank you.

11 At this time we will proceed by
12 calling Mr. Walter Smith, Executive Director
13 for D.C. Applesed Center for Law and Justice
14 and his witness panel.

15 Good afternoon. After we've sworn
16 you in, if you could just introduce yourself
17 and let me know in what order you'll be
18 providing your testimony.

19 Thank you.

20 MS. JOHNSON: Would you all raise
21 you right hands to be sworn in, please? Do
22 you swear or affirm to tell the truth, the

1 whole truth, and nothing but the truth so help
2 you?

3 WITNESSES: I do.

4 MS. JOHNSON: Thank you.

5 MR. SMITH: Good afternoon. I'm
6 Walter Smith, the Director of D.C. Appleseed.
7 I have with me here Deborah Challet at my far
8 left from Mathematica. This is Mr. Cory Zass
9 from ARM. This is Mr. Mark Shaw, also from
10 ARM, and this is Kurt Calia from Covington &
11 Burling.

12 As you know, we have filed both a
13 prehearing report and are submitting testimony
14 today, and it's the collective effort of all
15 of these folks at the table, but because we
16 only have 20 minutes what we're going to try
17 to do, Madam Commissioner, is I'm going to
18 speak for just a few minutes about some
19 overall points that we want to make, and I'm
20 going to try to make them in furtherance of
21 the conversation you've already been having
22 rather than trying to read what is the

1 prepared testimony.

2 And then I want you to hear from
3 our actuarial experts who we engaged to try to
4 assist you in this process.

5 And I should say at the beginning
6 the reason why we engaged actuarial experts
7 was because when we read the submission from
8 Carefirst, as we interpreted it, the whole of
9 their case comes down to Milliman range.
10 Everything they're asking you to do comes down
11 to them asking you to accept the Milliman
12 range, and that thought was confirmed further
13 by what I heard here today because they
14 believe, I think that the range that Milliman
15 has urged them to adopt equates to financial
16 soundness, drives their position that they're
17 meeting the maximum feasible, and has driven
18 where they set the community reinvestment.

19 I think in an exchange with you,
20 Madam Commissioner, Mr. Burrell said they know
21 how much to spend on community reinvestment
22 once they know how much is available given

1 their surplus range.

2 The reason why we think it is so
3 critical to scrutinize the Milliman range,
4 since that's their whole defense, is that it
5 is in the interest of the public that they get
6 that range right and that you get that range
7 right because if you don't, the twin
8 requirements of the statute can't be served,
9 that is, financial soundness, on the one hand,
10 and maximum feasible, on the other. If you
11 don't get the range right, you're not going to
12 serve the public's dual interest in those two
13 somewhat competing policies because if you
14 don't give them enough for financial
15 soundness, you threaten their solvency, of
16 course, but if they don't meet maximum
17 feasible, here's what happens, and especially
18 if they've been following the surplus range to
19 set maximum feasible.

20 It means, as they candidly admit
21 in their documents, they are overcharging
22 subscribers because the source of the surplus

1 is revenues that came from the subscribers,
2 and as they say, if they've got a surplus,
3 they've overcharged them and they should
4 refund it.

5 And the longer they're in a
6 surplus range that may be inappropriate, the
7 longer they're overcharging. Now, here's why
8 it's important though for an additional
9 reason.

10 Another exchange that Mr. Burrell
11 had with you, and he invoked the President
12 from last night, I'd like to do the same
13 thing. We live in an economy right now where
14 a lot of people are having difficulty getting
15 access to affordable health care, and as
16 premiums go up, it's harder for them to get
17 that health care. One of the tremendous
18 things that this company could do if it has
19 excess surplus is, in fact, make it easier for
20 the people Mr. Burrell is solicitous about to
21 get access to affordable health care. Because
22 if he continues to have low community

1 reinvestment, and if he continues to have a
2 surplus range that is too high, he is to that
3 extent not using the company's ability to
4 assist people to get access to affordable
5 health care.

6 Some people are under insured.

7 Some people are uninsured, but the net at the
8 end of the day is this public asset, our D.C.
9 Attorney General has told us, this company is
10 an asset of the public, and it could be used,
11 if there's excess surplus here, to help the
12 public get access to more affordable health
13 care.

14 And in our view, that is why it is
15 so important that you get this right, and it
16 is why, since we saw their whole position is
17 based on Milliman, we engaged actuarial
18 experts.

19 Now, let me say -- let me see how
20 much have I used up. I'm going to take three
21 or four more minutes.

22 When we submitted the report from

1 our actuarial experts, I apologize to you and
2 to Carefirst and to Milliman and to Lewin. If
3 they read any disrespect toward their
4 professional judgments, none was intended. We
5 realize though, and I can say this as a non-
6 actuarial expert, these are difficult and
7 complex judgments being made where
8 professionals can reasonably disagree, and the
9 smallest shift in an assumption produces
10 movements of millions of dollars, millions of
11 dollars that if they made an unsound
12 assumption would have been available to bring
13 to more people affordable health care.

14 So that's why we wanted you to
15 have the benefit of our actuarial experts
16 thinking about, and the primary purpose of
17 what they did was to show how three or four
18 assumptions that seemed to us to drive the
19 Milliman report produced differences of
20 hundreds of millions of dollars with regard to
21 a permissible range.

22 Let me say one thing about Lewin.

1 I have great respect for Lewin. At the
2 beginning of this project we tried to see if
3 we could hire them. We couldn't afford them,
4 but there's a very important sentence in the
5 Lewin report. I'm sure you caught it, but I
6 just want to bring it to your attention.

7 I do not believe the Lewin report
8 should be read as a second opinion validating
9 the particular ranges that have been produced
10 by Milliman. If you read pages 45 and 47 of
11 the Lewin report, they are very careful to
12 say, and the Lewis Group are very careful
13 people, that they cannot endorse the specific
14 ranges that were produced by Milliman.

15 They endorse the methodology, if
16 used correctly. So would we. They endorse
17 the proposition that you would have ranges.
18 So would we. But I do not believe it is so
19 that Lewin endorses the particular ranges.

20 I want to say one last thing. At
21 the beginning of Mr. Burrell's comments there
22 was quite, I would say, complimentary attack

1 on D.C. Appleseed. Let me tell you that we're
2 not so powerful that we have produced the
3 statute in front of you. In our view what has
4 produced the statute in front of you is a long
5 string of decisions by the Insurance
6 Commissioner in this jurisdiction, the
7 Insurance Commissioner in Maryland, the
8 legislature in Maryland, the legislature in
9 the District of Columbia, the Attorney General
10 in Maryland, the Attorney General in the
11 District of Columbia, all of them questioning
12 whether or not this publicly owned asset is
13 being managed in the public interest. That is
14 why we've been engaged in this process, and I
15 believe that's why the legislation you have in
16 front of you was passed.

17 The council finally said they
18 needed to have a system of accountability for
19 this company, and that is what you are about
20 here.

21 I am going to make one more point.
22 Much was said at the beginning in Carefirst's

1 presentation that D.C. Appleseed and other
2 have in mind taking money from subscribers to
3 give it to non-subscribers so that we can set
4 up a dual between them. Nothing could be
5 further from the truth.

6 As you know, the statute, if you
7 find excess surplus, authorizes the company to
8 develop the plan, and as was point out by Mr.
9 Tyler, in fact, to spend all of the excess
10 surplus found for subscribers.

11 The truth of the matter though is,
12 as the D.C. Attorney General has made clear
13 and as Commissioner Burrell made clear, they
14 have the discretion to spend money on other
15 than for subscribers, and they have been doing
16 it for years, in our view to their credit.

17 So there's a contradiction in what
18 they're saying. They label money that they
19 would spend on other than subscribers of
20 confiscation, but on the other hand, I think
21 they recognize that spending money on other
22 than directly for subscribers advances their

1 public service mission, but at the end of the
2 day it will be their choice. They will
3 develop the plan for your review. So neither
4 we nor anyone else is going to force them to
5 spend money on other than subscribers,
6 although the statute does authorize it, and as
7 the work we have done throughout this long
8 issue that we've been working on, we believe
9 that the federal charter likewise contemplates
10 that money can be spent on past subscribers,
11 current subscribers, and for the benefit of
12 future subscribers.

13 But that is not nearly as
14 important, as I said at the beginning, as the
15 range. If you proceed to review their work
16 based on the Milliman range, then that drives
17 everything the company has asked you to do,
18 and that is why we have engaged the folks that
19 we have, and I want you to speak to them next.

20 Thank you very much.

21 COMMISSIONER PURCELL: Thank you.

22 MR. ZASS: Good afternoon. My

1 name is Corwin Zass.

2 First I'd like to make a quick
3 comment. I know we're given a limitation on
4 time. So my written testimony will be
5 obviously a little different than what I'm
6 going to verbally talk about here.

7 I'm a principal and consulting
8 actuary of Actuarial Risk Management. I'm an
9 associate of the Society of Actuaries, a
10 member of the American Academy of Actuaries,
11 and a Fellow of the Conference of Consulting
12 Actuaries.

13 I'd also like to welcome my astute
14 colleague Mark Shaw who joins me in being
15 available to help explain our conclusions.
16 Mark is a Fellow of the society, a charter
17 enterprise risk analyst with the Society of
18 Actuaries, a member of the academy as well.

19 Both I and Mr. Shaw are actuaries
20 in good standing with the American Academy of
21 Actuaries, and we conducted this assessment in
22 a professional and ethical manner, and we

1 followed actuarial standards of practice in
2 providing our August 31st, 2009 report, and
3 honor any code of professional conduct in
4 which we conduct this expert testimony.

5 To echo Walter's comments, I agree
6 a difference of opinion does not imply
7 unprofessionalism.

8 Actuarial Risk Management is a
9 global actuarial risk provider and independent
10 member of the BDO Seidman Alliance Program.
11 We provide BDO, the fifth largest global
12 accounting firm, with audit and non-audit
13 support across very similar practice areas as
14 Milliman.

15 ARM's business model relies on a
16 deep resource pool which currently consists of
17 approximately 50 well tenured and technically
18 savvy, qualified actuaries, risk managers, and
19 benefit specialists. Many of the ARM experts
20 available to us have previously held practice
21 leader positions with accounting firms, other
22 large national and international consulting

1 firms, as well as chief actuary roles in
2 insurance arenas.

3 I must admit that Mr. Burrell's
4 adds to some of the confusion with his
5 interchange on labeling reserves and surplus.
6 This is not a discussion, in my opinion, on
7 reserve adequacy. It's a question or a
8 comment on the excess or the deemed excess of
9 surplus, not reserves.

10 In this engagement we assessed and
11 reported our findings in an objective manner.
12 Before I make any comments specific on
13 Milliman, I'd like to make a couple of general
14 comments on a model review and assessment that
15 we conduct.

16 Specifically, a good model can be
17 very useful in managing future unknowns only
18 if -- and I stress "only if" -- a model's
19 methods are sound and the assumptions
20 reasonably combine the past knowns with common
21 sense and educated expectations and, finally,
22 have model approaches and results conveyed in

1 a very transparent manner.

2 Models have been the backbone of
3 the actuarial professional for many centuries
4 and will continue well into the future. I
5 instill in every ARM engagement that we must
6 enter a project with healthy skepticism. This
7 cautious approach engages ARM to identify
8 situations in the models that are simply wrong
9 where others might take for granted as not
10 being possibly wrong. Our approach to models
11 in general includes the asking of questions
12 like this:

13 How well does the model predict
14 the future?

15 Another question, how many
16 variables or assumptions are used in a model?

17 This gives a model reviewer some
18 sense of complexities using the model. Over
19 the years I've witnessed some very simple
20 models that were very useful, but on the other
21 hand, I've seen some complex models simply
22 missing the mark.

1 This leads to the next question.
2 Yet another inquiry would be are those models
3 and the assumptions used correctly? Again, to
4 reiterate, transparent models, when properly
5 constructed by experts, with the
6 understandable and defensible assumptions, are
7 very important in the management of the future
8 unknowns.

9 Now I'll give you some insight
10 into the models, the modeling, the modelers.
11 I will, albeit briefly, discuss our findings
12 of our assessment of GHMSI's surplus position.

13 Before I do this, I must stress
14 that ARM requested a comprehensive list of
15 items we needed to thoroughly assess GHMSI's
16 surplus. However, we received little other
17 than the GHMSI's public financial statements
18 along with any information we garnered from
19 simple searches.

20 Using these sources, we conducted
21 our assessment. As previously discussed,
22 transparency is key. We deemed the lack of

1 transparency in the model as a black box
2 characteristic. That's why we used that
3 throughout our report.

4 We identified four key Milliman
5 assumptions which we believe distorted the
6 Milliman model and, thus, the results which
7 overstated the needs of GHMSI's surplus. As
8 described in our submission, the following
9 points were submitted in written testimony and
10 summarized our findings.

11 I will now take a few minutes
12 first to comment on Carefirst testimony. On
13 page 1 and 2 of Mr. Dobson's testimony, he
14 discussed the information relevant to the
15 model. However, this was information
16 available to Milliman internally only.

17 We also note that Mr. Carlson of
18 Lewin said on page 3 of his report, akin to
19 what Mr. Toole had raised, that there was
20 really no review of the assumptions
21 themselves, nor was there any performance of
22 extensive modeling. We do note that.

1 We wanted to comment on some black
2 box aspects, or what we've deemed as non-
3 transparent assumptions in the Milliman
4 report. These are just simply examples and
5 submitted in the written testimony.

6 On page 46, they discuss the range
7 of possible values for each risk in contingent
8 categories, but there is really no explanation
9 on the breakdowns or what those were.

10 Page 46 to 49, the complete range
11 of Monte Carlo results before application of
12 pro forma modeling, again, there's no real
13 information here other than providing some
14 insight.

15 The assumptions in the pro forma
16 on page 53 to 54 discuss the modeling relative
17 to the FAP. Again, there is no real
18 information on the pro formas, which as we
19 have found out was really the basis of GHMSI's
20 own internal models.

21 Speaking further on Mr. Dobson's
22 submission, which it specifically does mention

1 on page 3, we find out for the first time that
2 Milliman did use GHMSI's internal models for
3 the pro forma model. We asked did Milliman
4 validate those models.

5 Secondly, on page 5, we see no
6 evidence that Milliman offset the potential
7 underwriting losses. Again, we have
8 transparency concerns. For us to be able to
9 ascertain that that was offset, we'd actually
10 like to see it.

11 On top of page 6, the comment with
12 respect to considering the growth of First
13 Care Blue Choice, we certainly see this as
14 being an irrelevant statement and bears no
15 meaning to what this assessment was and the
16 surplus of GHMSI.

17 Also on number five, Milliman has
18 not disclosed before that they tested this
19 eight percent growth rate. They said that
20 they would not change the lower end of the
21 range. What did change would be our kind of
22 comment there.

1 Furthermore, Mr. Dobson under
2 further testimony stated that Milliman takes
3 the company's pro forma models and converts it
4 to a simple model. We talk about complexity
5 of the models, and then we hear a comment
6 about simple models. I'm not sure which one
7 it is.

8 Speaking of another comment, there
9 was a statement in reference to earnings. I
10 do note that GHMSI did lose about \$6 million
11 in underwriting loss for year to date 2009,
12 but ended up showing a bottom line income of
13 \$16 million positive.

14 But I also note that the surplus
15 dropped \$2 million, and primarily driven by a
16 change of \$20 million in the not admitted
17 assets. Again, we have made comments in the
18 past about the non-admitted assets in our
19 submission.

20 We'd also like to point out on
21 Carefirst's filings, it's their consolidated
22 financial statements and other financial

1 information for 2008 with the report of the
2 independent auditors. On page 37 they quote,
3 "Management has determined based on the
4 company's long-term history of operating
5 earnings and its expectation for the future
6 that income of the company will more likely
7 than not be sufficient."

8 This simply implies positive
9 earnings into the future.

10 In closing, given the fact that we
11 have not had access to much other than public
12 information, financial statements and so forth
13 that we could garner from the Carefirst
14 Website and from the DISB Website as well, we
15 are confident that adjusting the four
16 assumptions that we have submitted will
17 produce a more realistic range of 400 to 525
18 percent RBC.

19 We do have a desire to look under
20 the hood of Milliman's model, but in the
21 interim, we have assessed the methods and
22 assumptions in a very independent fashion with

1 a healthy dose of skepticism.

2 Thank you very much.

3 COMMISSIONER PURCELL: I'm going
4 to give everyone an opportunity just to make
5 a brief statement even in light of the time
6 since we're here.

7 MR. SMITH: All right. Well,
8 thank you very much.

9 COMMISSIONER PURCELL: Who's next?

10 MS. CHELLET: Thank you very much,
11 Commissioner.

12 I don't have a prepared statement
13 for today, but I would like to make a few
14 points.

15 Number one, I think the importance
16 of this hearing is obvious, and I agree with
17 Mr. Smith that the range of the surplus is
18 critical. I think there is ample reason to be
19 doubtful about the high level of this surplus
20 range that Milliman has produced, and that
21 relates largely to the ranges of its clear
22 competitors in the D.C. area and other

1 companies that are similarly situated with
2 similar ACL levels and the ranges in which
3 they operate.

4 It has always struck me, and I
5 speak as an economist, not as an actuary, but
6 it always has struck me that somebody has to
7 be right; that if this company is so much more
8 heavily reserved than other companies, then
9 other companies must be under reserved because
10 they face similar risks.

11 And I say that simply as an
12 empirical observation.

13 The other thing that I'd like to
14 point to is with respect to the research that
15 I and Mathematica have done with respect to
16 community needs. A number of years ago, and
17 this was a report that was commissioned by
18 D.C. Applesseed, we went to community leaders
19 in Maryland, the District and Virginia and
20 asked them about the role of a dominant
21 insurer, like GHMSI, and what an insurer like
22 this could do that would benefit not only

1 their subscribers, but also the general public
2 and the community at large.

3 And my written statement lists
4 some of those items that I think are certainly
5 within the role of a community leader like
6 GHMSI and certainly would be of value to its
7 subscribers and the community that the company
8 serves more broadly.

9 Thank you.

10 COMMISSIONER PURCELL: Thank you.

11 MR. SHAW: Thank you for the
12 opportunity to speak, Commissioner.

13 Again, my name is Mark Shaw, and I
14 will just comment briefly on the attachment to
15 Walter Smith's testimony that goes into our
16 review, ARM's review, of potential attribution
17 of surplus if there is a finding that there is
18 excess surplus.

19 Again, not having the benefit of
20 some of the information that perhaps Milliman
21 looked at in addition to what is available
22 publicly, we based our report and looked at

1 it, a couple of different approaches based on
2 publicly available data, and most of it coming
3 directly from the statutory annual statement
4 that GHMSI is required to file with the
5 District on a regular basis.

6 We believe that the way insurance
7 is regulated, that is, the District of
8 Columbia regulates insurance contracts entered
9 into the District as opposed to the insurance
10 owned by persons that reside in the District
11 is the way to look at things, and it is also
12 the way that GHMSI's annual statements I would
13 point out summarizes the way that premiums are
14 allocated by jurisdiction.

15 So as we looked at the way that
16 the annual statement addresses the premiums
17 that GHMSI reports on an annual basis by
18 jurisdiction, I will just describe to you
19 what's on pages 5 and 6 of the attachment,
20 basically take you through the ARM methodology
21 looking at it not only by residence approach,
22 but by looking at the data that's reported in

1 the annual statements of GHMSI from 1999 to
2 2008, the same time period, I would point out,
3 that Milliman looked at by looking at
4 different data.

5 I would point out, first of all,
6 that 23 percent of the current surplus of
7 GHMSI existed at the beginning of this period
8 and 77 percent of the surplus emerged during
9 this period as it grew from what it was at
10 12/31/98, but we took the data from the annual
11 statements as follows.

12 We took from the five-year
13 historical page, data page, in the annual
14 filing the total surplus, the change in
15 surplus, net underwriting gain, net investment
16 income.

17 We took from Schedule T total
18 premium income, District non-FEP premium, and
19 District FEP premium, and from the analysis of
20 operations by line of business exhibit of the
21 statement, we took net underwriting gain for
22 FEP and net underwriting gain for all other

1 lines of business as our key input.

2 From that data we calculated the
3 D.C. total profit for a given year as the sum
4 of the net underwriting gain for FEP and with
5 a percentage of the net underwriting gain for
6 all other lines of business, that percentage
7 of use being the proportion of non-FEP premium
8 in D.C. versus all non-FEP premium in all
9 jurisdictions.

10 We also calculated the D.C. net
11 investment income for a given year as GHMSI's
12 total net investment income for the year
13 multiplied by the proportion of all GHMSI
14 premiums in D.C. for the year to the total of
15 all GHMSI premium in all jurisdictions for
16 that year, and then we calculated the D.C.
17 percentage of the surplus change for a given
18 year as a sum of D.C. total profit and D.C.
19 net investment income for a given year divided
20 by the sum of total profit and total net
21 investment income for the year.

22 Following these steps, we

1 calculate that the percentage of surplus
2 attributable for D.C. for the years 1999
3 through 2008 is 56.7 percent, and as reported
4 by GHMSI, D.C. premium was 78.8 percent of all
5 premium for GHMSI during this time period, and
6 even 31.7 percent of all non-FEP premium
7 during this time period.

8 We point out again that this
9 calculation, the 56.7 percent, is almost 77
10 percent of the surplus that has emerged since
11 12/31/98. If the prior surplus arose more
12 akin to the way that the premiums were in 1999
13 and 2000, that is, approximately 70 percent of
14 it from the District, then we would calculate
15 in total that approximately 60 percent of the
16 total surplus in the District, total surplus
17 of GHMSI, is attributable to the district.

18 Then, as a second approach to
19 determining the appropriate amount of
20 attribution to the District, we looked at an
21 exhibit that has appeared in the annual
22 statements of GHMSI since 2002. We would have

1 looked at it before that if it had existed,
2 but it didn't, and it's called the exhibits of
3 premiums, enrollment, and utilization, and
4 what this exhibit lists is the total member
5 months of insurance by jurisdiction, and there
6 are separate pages for Maryland, Virginia, and
7 D.C., and we looked at that and looked at what
8 it was over the time period, and 63.4 percent
9 of the member months during the time period
10 from 1999 to 2008 were for D.C. member months.

11 So our conclusion in looking at
12 these two approaches is that roughly 60
13 percent, since they're fairly consistent, that
14 roughly 60 percent of the surplus that is
15 currently held by GHMSI is attributable to the
16 District.

17 COMMISSIONER PURCELL: Thank you.

18 MR. CALIA: Good afternoon,
19 Commissioner Purcell. I appreciate the
20 opportunity to speak.

21 I am Kurt Calia of Covington &
22 Burling, and like Ms. Chellet, I didn't

1 actually have any prepared remarks.

2 But I did want to speak briefly to
3 the issue of the legal obligation that has
4 arisen here because there has been some
5 discussion about that in the context of the
6 charter, in the context of the act that's at
7 issue here today and otherwise. So I wanted
8 to very quickly see if I could address some of
9 the statements that were made with the earlier
10 panel.

11 It was charged that the theories
12 that D.C. Applesseed has espoused with regard
13 to the legal obligation in characterizing
14 GHMSI as a charitable and benevolent
15 institution and saying that their assets
16 belong to the public and saying that the
17 assets or that GHMSI exists to serve the
18 public is a D.C. Applesseed theory, that's not
19 correct. Mr. Burrell got that wrong.

20 That language flows directly from
21 opinions from the D.C. Attorney General and is
22 entirely consistent with observations that

1 have been made by prior Insurance
2 Commissioners.

3 But what I'd like to do in looking
4 at that legal obligation is actually start
5 with the charter, and I know that, I guess, a
6 copy of the charter is going to be provided to
7 this group.

8 Section 8 of the GHMSI charter
9 declares it to be a charitable and benevolent
10 institution. In his remarks Mr. Burrell said
11 that was for the purpose of establishing the
12 company as a tax exempt organization.

13 We disagree with that reading of
14 the charter and, indeed, Congress has plenary
15 power over taxation and has created tax exempt
16 status for organizations without also taking
17 the step of declaring them to be charitable
18 and benevolent organizations.

19 We don't think that's a correct
20 reading of the charter. Indeed, in Section 8
21 of the charter itself, there are some margin
22 notes, and there is pretty clear case law that

1 says the margin notes in a congressional
2 charter make clear Congress' intent, and in
3 the margin notes in Section 8 it says,
4 "Purposes declared."

5 So Congress intended to declare
6 this company as a charitable and benevolent
7 institution. Well, what does that mean? And
8 I think the charter actually sheds some light
9 on that, in addition to some other things that
10 I'll talk about.

11 So Section 3, which was the
12 subject in some earlier discussion refers to
13 the corporation being conducted for the
14 benefit of certificate holders.

15 In addition to the fact that
16 there's case law, that means that the
17 obligation applies not to just current
18 certificate holders, but prospective policy
19 holders or certificate holders, and indeed, we
20 cite some of that authority in the 2004,
21 December 2004, D.C. Appleaseed report in
22 Section 2, page 17, and I believe that's part

1 of this record, but if not, we will certainly
2 provide it.

3 But also the precise language of
4 Section 3 of the charter itself supports this
5 view that the obligation doesn't exist only
6 with regard to current subscribers. So
7 Section 3 refers to, as I stated, the
8 obligations of the corporation extending to
9 certificate holders.

10 Actually the language is
11 "aforesaid certificate holders." So in order
12 to understand who the aforesaid certificate
13 holders are, you actually have to look to
14 Section 2 of the charter, and that refers to
15 groups or persons including those with whom
16 GHMSI is empowered to enter into contract into
17 the future.

18 In other words, it's prospective.
19 Specifically Section 2(c) of the charter
20 states that GHMSI is authorized to "cooperate,
21 consolidate, or contract with individuals or
22 groups or organizations interested in

1 promoting and safeguarding the public health,"
2 in other words, prospective certificate
3 holders as well as actual.

4 There is further case law which we
5 cite in the December 2004 report, Section 2 on
6 page 24, a Supreme Court case, the Jones case
7 and the Geisinger Health Plan case, and I
8 commend those to you.

9 Now, beyond the charter there are,
10 as has been discussed, some legal opinions
11 from the Attorney General and from the
12 Insurance Commissioner that bear on this issue
13 about the scope of the obligation, and I
14 wanted to make sure that we had clarity in the
15 record as to some of the statements that have
16 been made.

17 In March 2005, then Attorney
18 General for the District was looking into this
19 issue about the legal obligation, and in an
20 opinion published on March 4th of that year
21 stated that D.C. Applesseed is correct in
22 concluding that GHMSI, which was chartered by

1 Congress as a charitable and benevolent
2 institution, has an obligation to pursue a
3 public health mission, and that this
4 obligation is not inconsistent with its
5 obligation to operate for the benefit of its
6 subscribers.

7 At page 2, the Attorney General
8 went on to state, "GHMSI cannot simply fulfill
9 its mission simply by allocating its
10 percentage of specified premium to charitable
11 activities. GHMSI is to devote its entire
12 operation to serving directly or indirectly
13 the purposes for which it was chartered."

14 He then goes on to write on page
15 4, "It is true that under both District and
16 common law GHMSI's assets belong to the
17 public, and unlike a for-profit company, GHMSI
18 exists to serve the public."

19 There was also a hearing --

20 COMMISSIONER PURCELL: If I may,
21 Mr. Calia, I apologize, but I'd like to enter
22 the question and answering period just in

1 light of the time.

2 MR. CALIA: That's fine.

3 COMMISSIONER PURCELL: And perhaps
4 we'll touch on some of the issues that you
5 were going to summarize.

6 Speaking on allocation, what in
7 your opinion -- and this is to the panel -- is
8 the appropriate method for allocating surplus
9 to the extent it is determined to be
10 unreasonably large?

11 What is the appropriate method for
12 allocating the amount that's attributable to
13 the District?

14 MR. CALIA: Sure, and I can speak
15 to that. Let me first and foremost preface my
16 comments about the allocation or attribution
17 method, however you want to characterize it,
18 by saying at the outset that we agree with the
19 comments that Commissioner Tyler made, and I
20 think, Commissioner Purcell, that you made
21 earlier, that I think under the circumstances
22 it really does make sense for the

1 jurisdictions that would be affected by the
2 evaluation of any excess surplus to coordinate
3 their efforts in looking at this issue. It is
4 a complicated one.

5 Having said that, as we look at
6 the attribution method, there are really two
7 aspects to it. The first is that there has to
8 be initially obviously a determination that
9 the surplus is, indeed, excessive. That is
10 independent really of figuring out what the
11 attribution is. The attribution goes to what
12 the remedy is and how the remedy associated
13 with the spending down of any excess surplus
14 is to be implemented.

15 It's our view that the attribution
16 method should be based on where the contracts
17 are written, where the insurance contracts are
18 written, and there are really three reasons
19 for this.

20 First, in defining the remedy, the
21 act itself states that in the event that there
22 is excess surplus and GHMSI does not dedicate

1 to community health reinvestment in a fair and
2 equitable manner in a manner to address that
3 excess surplus, that the Commissioner "shall
4 deny for 12 months all premium rate increases
5 for subscriber policies written in the
6 District."

7 So I think within the act itself
8 there is support for the notion that it's
9 really the jurisdiction where the policies are
10 written that help define the remedy that's at
11 issue.

12 Secondly, I think there was some
13 discussion about Schedule T. I'm not sure
14 that there was clarity in terms of how it has
15 been used. The fact of the matter is that
16 GHMSI, in fact, allocates revenue based on
17 where contracts are written, where the
18 policies are written. Attached to their
19 annual report, they have this Schedule T,
20 which breaks out by jurisdiction the
21 percentages and the amounts of policies based
22 on where they're written, not based on where

1 the ultimate insured reside, but where the
2 policies themselves are written.

3 What this means, we believe is for
4 group plans, it's the location of the
5 principal place of where the employer is, and
6 for individual plans it would be the
7 residence, which presumably for individual
8 plans is information that's readily
9 ascertainable.

10 The third reason why we think the
11 touchstone here is really where the contract
12 is written, is based on what we've observed in
13 our neighboring jurisdiction, Maryland. So
14 there was a discussion earlier about how in
15 Maryland there is a premium tax imposed. That
16 premium tax is on revenues that are reasonably
17 attributable to business conducted within the
18 state. That's the language of the statute.

19 Now, there is an exemption, which
20 was also referred to earlier, equal to the
21 amount that is spent in a manner that serves
22 the public interest, and I believe it was said

1 that it was capped at two percent.

2 Well, in late 2008, the Maryland
3 Insurance Commissioner was evaluating that
4 very issue about whether GHMSI has complied
5 with the Maryland law related to premium tax,
6 and in so doing, the Commissioner relied on
7 Schedule T in making the determination about
8 what falls within the scope of a business
9 within the state.

10 Thus, certainly at least
11 implicitly, if not explicitly, the Maryland
12 Insurance Commissioner had embraced this
13 notion of Schedule T and the fact that it's
14 where the contract is written for purposes of
15 attribution at least in the context of
16 evaluating this exemption to the premium tax.

17 COMMISSIONER PURCELL: Thank you.

18 Mr. Smith, I just want to keep
19 going.

20 MR. CALIA: Surely.

21 COMMISSIONER PURCELL: Mr. Calia,
22 we'll get back to that.

1 The whole issue of surplus and
2 Carefirst's statement that their duty extends
3 to their subscribers, and so if a
4 determination was made that this reinvestment
5 plan needed to be formulated and approved,
6 that I think what I heard was that they would
7 concede that it would extend to the
8 subscribers only, present subscribers only.

9 What are your thoughts on that?

10 Do you feel that the reinvestment obligation
11 extends past present subscribers only?

12 MR. SMITH: Well, under the
13 statute they are permitted to develop a plan
14 that would spend the surplus only on the
15 subscribers. So, I mean, that's within the
16 prerogative of the company, I believe --

17 COMMISSIONER PURCELL: Okay.

18 MR. SMITH: -- under the statute.

19 COMMISSIONER PURCELL: Right.

20 MR. SMITH: I would add that I
21 think they under the statute again have the
22 prerogative to extend it beyond just current

1 subscribers.

2 COMMISSIONER PURCELL: And are you
3 rooting that in the charter interpretation
4 that we just heard or in the community
5 mission, benevolent status generally, or --

6 MR. SMITH: I believe the statute
7 is controlling here. I mean, different people
8 may have differed as to whether or not they
9 thought it was good to authorize a spend down
10 plan that was limited only to current
11 subscribers, but that is what the statute
12 says, and I think I heard Mr. Burrell say this
13 morning that if they were to develop a plan,
14 they indeed would limit it to current
15 subscribers.

16 COMMISSIONER PURCELL: In your
17 report you suggested a range, a surplus range.

18 MR. SMITH: I did.

19 COMMISSIONER PURCELL: Could you
20 explain the rationale in determining a broad
21 range for reasonable surplus but then
22 requiring GHMSI to exist just at the bottom of

1 that range?

2 MR. SMITH: Yes, I'd be happy to
3 do that. There was a lot of conversation
4 earlier about how one applies the maximum
5 feasible standard, and we have argued in part
6 that one way to apply the maximum feasible
7 standard is first to develop reasonable ranges
8 for the surplus, which I assume you may do.
9 I don't know how you'll proceed. That's what
10 Milliman did, and in adjusting Milliman's
11 work, that's what we did.

12 But we believe once you've
13 developed a reasonable range of surplus on the
14 assumption that any number within the range
15 would be sufficient to insure financial
16 soundness -- and I think that's what Mr.
17 Burrell said was the case -- therefore, the
18 only way you can meet the maximum feasible
19 standard is to pick a number toward the lower
20 end of the surplus range that you've
21 developed.

22 COMMISSIONER PURCELL: Okay.

1 COMMISSIONER BARLOW: So but I
2 think as was mentioned earlier the first step
3 in the process would be to determine if the
4 surplus was unreasonably large.

5 MR. SMITH: Right.

6 COMMISSIONER BARLOW: So if the
7 surplus fell within the range, do you think it
8 would fail that first test and would still be
9 forced to be moved down to the low end of that
10 range?

11 MR. SMITH: I get your question.
12 My answer is yes. Our view is that the only
13 way to insure compliance with the statute with
14 regard to the maximum feasible requirement is
15 if you go the route of picking ranges first.
16 I think that the company needs to be toward
17 the lower end of the range in order to meet
18 the maximum feasible.

19 COMMISSIONER BARLOW: But again,
20 that, I believe, is the second part. The
21 first part is determining if the surplus is
22 unreasonably large. So if we determine a

1 reasonable range of surplus and the company
2 falls within that range, it sounds like you
3 are arguing that if they fall in the high end
4 of that range, it's unreasonably large even
5 though it falls within the reasonable range.

6 MR. SMITH: I think there are two
7 ways to look at that, but I think you get the
8 same result either way. You can say first
9 we'll see whether it's unreasonably large. It
10 has to be within the range. If you do that
11 without looking also at the same time to the
12 maximum feasible.

13 I think the unreasonably large
14 range has to be computed in light of the
15 maximum feasible, but if you do it as a two-
16 step process, you could first compute what you
17 think the reasonable range is and then apply
18 the maximum feasible as a second requirement,
19 and if you do it that way, I think you'd have
20 to conclude that in order to meet maximum
21 feasible, they need to be toward the lower end
22 of whatever range you develop.

1 COMMISSIONER BARLOW: Okay. I
2 guess I could try asking that question again,
3 but I don't guess I'd get a different answer,
4 but you --

5 MR. SMITH: I'm sorry. I do want
6 to be responsive.

7 COMMISSIONER BARLOW: Well, I
8 know. All right. You've suggested that a way
9 to do this would be to determine a range of
10 surplus.

11 MR. SMITH: Yes.

12 COMMISSIONER BARLOW: -- that's
13 appropriate.

14 MR. SMITH: Right.

15 COMMISSIONER BARLOW: If the
16 company falls within that range, then you
17 still want to say if they're at the high end
18 of that range, you still want to say that
19 their surplus is unreasonably large.

20 MR. SMITH: Either that or it has
21 to in addition meet the maximum feasible.

22 COMMISSIONER BARLOW: But if it's

1 not unreasonably large, then the second
2 criteria ceases to exist as an issue.

3 COMMISSIONER PURCELL: What would
4 need to happen is the range would be
5 established, and then we would evaluate and
6 discover that they are, in fact, over that
7 range. Then we have a finding.

8 MR. SMITH: Ah, if they're above
9 the range. Is that the hypothetical?

10 COMMISSIONER BARLOW: No. If
11 they're within the range, if they are within
12 the range, if they're within the range of
13 surplus that we have determined.

14 MR. SMITH: Yes.

15 COMMISSIONER BARLOW: So my
16 understanding of that range would be that
17 that's a reasonable range of surplus for the
18 company to have.

19 MR. SMITH: At least before you
20 apply the maximum feasible.

21 COMMISSIONER BARLOW: But if my
22 understanding of the laws are -- I'm not

1 lawyer -- but if we do not determine they have
2 unreasonably large surplus, then the second
3 part doesn't come into play.

4 MR. SMITH: Oh, I see. Now I
5 understand. Then I have an alternative
6 answer.

7 (Laughter.)

8 MR. SMITH: I think, as I said
9 before, in determining the appropriate range,
10 that range needs to be determined in light of
11 the maximum feasible requirement.

12 Let me give you an example of what
13 I'm talking about. The Pennsylvania Insurance
14 Commissioner noted that at some point there's
15 a tradeoff as you try to further limit
16 marginal risk by increasing surplus when you
17 could make alternative uses of the surplus and
18 not increase it.

19 I believe as you develop the range
20 that you think is a reasonable range, the
21 assumptions you make in determining that range
22 need to be informed by the maximum feasible

1 requirement. I think you need to give life to
2 that requirement of the statute.

3 One of the reasons why we think
4 some of the assumptions in the Milliman work
5 should be deemed unreasonable is they seem to
6 have taken no account whatever of the maximum
7 feasible requirement. There is a tradeoff
8 here. There is a balancing going on.

9 That's why I didn't mean to be
10 unresponsive, but you can do this in one step
11 or two. You can first compute a reasonable
12 range irrespective of maximum feasible, and
13 then if I had my way, you'll pick the lower
14 end of the range in Step 2, or you'll develop
15 the reasonable range as informed by the
16 maximum feasible. You may get to the same
17 place on either approach.

18 I hope I'm making better sense
19 now.

20 COMMISSIONER BARLOW: I don't
21 believe you would get to the same place on
22 both of those things.

1 MR. SMITH: Okay. Maybe you
2 wouldn't.

3 COMMISSIONER PURCELL: If it was
4 determined that the company had an
5 unreasonably large surplus and a portion is
6 attributable to the D.C., it's determined, and
7 it's detailed in a reinvestment plan, and it's
8 given back or however that proceeds, if it
9 happens, and then the company finds itself in
10 financial trouble, how can the company rebuild
11 its surplus without harming District
12 residents, District subscribers, in your
13 opinion? What would happen and how would we
14 proceed once that happened?

15 MR. SMITH: You're envisioning a
16 situation where you got it wrong or later
17 there was a development that so --

18 COMMISSIONER PURCELL:
19 Theoretically, yes.

20 MR. SMITH: -- the company?

21 COMMISSIONER PURCELL: Yes, yes.

22 MR. SMITH: What would you do

1 then?

2 COMMISSIONER PURCELL: I'm saying
3 what are your thoughts on how to proceed at
4 that point in light of the position we now
5 find ourselves in, the determination to be
6 made. It's made. Something is drastically
7 wrong.

8 MR. SMITH: I'm assuming that the
9 company would take steps on its own to remedy
10 the situation and would take it before it got
11 to the point that you're talking about. I
12 mean, certainly what Milliman has in mind is
13 that you'll have a lot of advanced notice that
14 you may have a decline in service. They have
15 tried to develop a formula that I believe is
16 so unduly conservative that the risk of ever
17 going down to 200 and 375 is very, very
18 remote, but it might happen. That's your
19 hypothetical.

20 COMMISSIONER PURCELL: Right.

21 MR. SMITH: I suppose the company
22 would take steps, and you would be working

1 with the company as it took steps.

2 I mean, can I add one other thing
3 though?

4 COMMISSIONER PURCELL: Sure.

5 MR. SMITH: I believe it is a
6 hypothetical that is extremely remote, but if
7 you permit them to develop their surplus range
8 based on really remote contingencies. It is
9 certain that in the meanwhile it will continue
10 to charge premium rates at the level that they
11 are, and it is certain they will have no funds
12 available to give back to the community to
13 address what they have acknowledge here today
14 is a very difficult situation for a lot of
15 people in the National Capital Area.

16 COMMISSIONER PURCELL: I guess
17 what I'm trying to solicit or get at is the
18 balance that Mr. Burrell discussed. What in
19 your opinion -- is there room for that
20 balance? What is your opinion on where that
21 balance sits right now? Has it been struck at
22 the right --

1 MR. SMITH: Oh, our view is it
2 won't surprise you to learn, is that they're
3 woefully out of balance right now, that
4 they're required to balance two things:
5 financial soundness and maximum feasibility.
6 I don't believe they've ever taken maximum
7 feasibility into account at all. Not a single
8 witness this morning in their presentations to
9 you described to you how it is either they or
10 the board weighed these two very important,
11 sometimes competing policies.

12 They simply -- and I mean no
13 disrespect to Milliman -- they simply used an
14 analysis that Milliman put in place without
15 ever looking at the statute at all, without
16 taking any account of maximum feasibility, in
17 fact, use an analysis they used in 2005
18 essentially before the Commissioner. So I
19 don't believe the balance has been fairly
20 struck at all. I don't believe this company
21 has come close to trying to see that there is
22 a balance to be struck and that the council of

1 the District of Columbia believes that maximum
2 feasible is important. I don't think they've
3 acknowledged that yet.

4 They said we picked a surplus
5 range, and so long as we're within that
6 surplus range we're done.

7 I don't hear any balance being
8 struck in that analysis at all.

9 COMMISSIONER PURCELL: What are
10 some examples of additional activities that
11 you think they should be engaging in?

12 MR. SMITH: They're listed in the
13 statute, but there are a lot of them. Mr.
14 Burrell fairly described them. There are a
15 lot of people in the National Capital Area who
16 are having more and more difficulty paying for
17 insurance, and he told you that they're losing
18 people trying to get insurance.

19 It's a very difficult time out
20 there for a lot of people, and as you know,
21 the council is trying to work with the company
22 to further expand the open enrollment program

1 to let more people have an opportunity to get
2 coverage.

3 And I have to tell you every time
4 Mr. Burrell talks about how much money they
5 will lose by meeting their primary mission. It
6 reminds me that they haven't struck the
7 balance yet. If what you're supposed to be
8 primarily about is delivering insurance to
9 people, particularly those who have difficulty
10 getting insurance, then that ought to be the
11 thing at the top of his list.

12 Right now for this company it is a
13 complete afterthought. So long as they get
14 their surplus range, if that allows for any
15 money for investment in the community, they
16 will do it. If it doesn't, they're done.

17 COMMISSIONER PURCELL: And in your
18 opinion is there a difference between maximum
19 feasible and maximum feasible consistent with
20 financial soundness and efficiency? Because
21 you use them interchangeably in your report.

22 MR. SMITH: I mean, I think they

1 have to be taken together. Don't
2 misunderstand me. I acknowledge to you that
3 those are two things to be balanced, but
4 they're both important. They are both
5 important.

6 We are Carefirst subscribers, we
7 at D.C. Appleseed. Okay? I care about both
8 parts of what the council has put into the
9 law. I want this company to be able to meet
10 claims, but I also want this company to be
11 what I believe the federal charter envisioned
12 them to be: someone with a public service
13 mission, and I think they're not doing it.

14 COMMISSIONER PURCELL: Well, how
15 does financial efficiency and capital adequacy
16 then fit into your analysis, your rationale?
17 I mean, are they to operate at that slim
18 margin right above RBC or perhaps even --

19 MR. SMITH: Well, no.

20 COMMISSIONER PURCELL: -- a few
21 hundred percent above RBC?

22 MR. SMITH: No, not necessarily.

1 COMMISSIONER PURCELL: Are they to
2 be every year --

3 MR. SMITH: I think there are a
4 lot of different ways that this could have
5 been analyzed, but what we did at least for
6 purposes of this hearing, because we didn't
7 have a lot of time, was to take the Milliman
8 approach, and Milliman offered that approach
9 to Commissioner Mirel, as you know, in 2005.
10 They offered it to the Pennsylvania Insurance
11 Commissioner, who did a lot of additional
12 analysis of her own, but I think the idea of
13 coming up with a reasonable surplus range
14 that's based on a number of reasonable
15 assumptions about what might happen in the
16 future to give you reasonable assurance that
17 you'll be able to make claims, I think that's
18 a sensible way to go about it.

19 I do not think it's sensible, as
20 the Pennsylvania Insurance Commissioner to go
21 about this in planning for every conceivable
22 contingency no matter how remote. She

1 rejected that, and Milliman's work was based
2 on that proposition, and even though you heard
3 earlier that the Pennsylvania Insurance
4 Commissioner didn't reject the Milliman work,
5 I urge you to look at that opinion and see if
6 that is not so.

7 And by the way, may I add also
8 that Commissioner Mirel also effectively
9 rejected the Milliman work when it was
10 presented to him. He said in the opinion --
11 you didn't hear this quoted before, and this
12 is back when their surplus was around 500
13 million -- he determined in 2005 that they
14 ought to be spending that surplus down. He
15 said there as no doubt that there was plenty
16 of room for them to be investing more in the
17 community than they were doing so.

18 Since then they have decreased the
19 amount they're investing in the community and
20 increased their surplus.

21 COMMISSIONER BARLOW: In your
22 report on page 1, you indicated that a surplus

1 in the range of 325 to 427,000, million would
2 put GHMSI in line with competitors and other
3 comparably situated nonprofits. I'm not sure
4 I understand comparably situated nonprofits.
5 Are you talking about other insurance
6 companies or non-insurance company nonprofits?

7 MS. CHELLET: We were talking
8 about other insurance company nonprofits.
9 That would include the comparable companies
10 that I listed in my written testimony. It
11 would include Kaiser Foundation Health Plan in
12 the District.

13 COMMISSIONER BARLOW: Okay. Now,
14 I mean, referring to the companies that you --
15 I mean, you identified, I think, kind of two
16 groups of companies. You -- I think it was
17 you who identified two groups of companies,
18 one set of competitors where in the D.C.
19 metropolitan area, where you said that
20 compared to these GHMSI has a high surplus.
21 I think United Health Care may have been
22 higher, but the rest of them were lower.

1 But if put GHMSI down at the range
2 that you proposed in the report, GHMSI would
3 be at the bottom of those companies. I mean,
4 so could you explain if near the top is no
5 good, why is near the bottom better?

6 MR. SMITH: Go ahead.

7 MS. CHELLET: Well, I think my
8 answer will be and Walter will no doubt
9 elaborate on this, that GHMSI has a unique
10 mission. It has a difference in its charter,
11 and a difference, I think that is very
12 material relative to especially his for-profit
13 competitors.

14 I also want to say that in the
15 2005 report that I also conducted for D.C.
16 Appleseed, I went and interviewed a number of
17 nonprofits. It included Harvard Pilgrim
18 Health Plan, Kaiser Foundation Health Plan,
19 High Mark Blue Cross/Blue Shield, and
20 especially with respect to entities like
21 Harvard Pilgrim and Kaiser Foundation Health
22 Plan.

1 The language of their mission was
2 very different than what you heard today. The
3 language about how they approached their
4 mission was that it was a preeminent concern
5 for them, that it was a balanced concern, and
6 so the discussion we had today reminded me of
7 those conversations, and I think Walter
8 Smith's comment that the company hasn't made
9 the balance also harkens to that. The
10 language is different, the sense of the
11 balance of the mission is different, and
12 that's why I think GHMSI should be held to a
13 very high standard in terms of how it serves
14 its mission.

15 MR. SMITH: Just to add a couple
16 of points, one is that only GHMSI, to my
17 knowledge, has this maximum feasible
18 requirement right in the statute, and I think
19 it needs to be given teeth, and if that means
20 as you balance the need for protecting against
21 marginal additional risk, which may or may not
22 occur, but today having the opportunity to

1 invest in the community, I think this statute
2 directs that the balance be towards investing
3 in the community, and I think that's
4 important.

5 The other point that I would make
6 though is that, as both of our actuarial
7 experts have said, what they did was because
8 of the lack of access to the kind of data that
9 they would want it to have, they simply took
10 Milliman's methodology and made four
11 corrections that they thought needed to be
12 made, and the range that produced is what came
13 out of that mathematical computation, is what
14 we've produced here.

15 We didn't do it to try to line up
16 the RBC range with other companies. We simply
17 took Milliman, made the corrections, and
18 wanted to show to you for purposes of your
19 work how big a difference you get based on
20 what assumptions you make when you use this
21 methodology.

22 COMMISSIONER BARLOW: Okay. So if

1 I understand what you're saying then, it
2 sounds like when determining where you believe
3 GHMSI's surplus should be, you are focusing
4 more on the maximum feasible than the
5 unreasonably large.

6 MS. CHELLET: No, I think that's
7 not true. I think this is the issue of the
8 balance. Do you make the most conservative
9 assumptions possible for this company or do
10 you make -- in which case there is almost no
11 surplus that's too large, and these very
12 conservative assumptions lead them to surplus
13 levels that are much higher than most of the
14 companies in the National Capital Area and
15 also some comparable companies outside that
16 have similar ACL levels outside of the
17 National Capital Area.

18 So do you retain these very
19 conservative assumptions or do you balance
20 those assumptions against the maximum feasible
21 standard?

22 So I think there is no one on this

1 panel who would say this company should be in
2 a vulnerable position, and I think the statute
3 doesn't envision that, but it does as we've
4 stated envision a balance.

5 MR. RECTOR: Philip, I think I'm
6 sure during the rebuttal time tomorrow, which
7 will probably be we'll hear some feedback on
8 it, but I think what I'm hearing the
9 difference as they're articulating the
10 standards, I think Mr. Hogan was saying you
11 first look to see whether it's unreasonably
12 large. If the answer is no, that stops your
13 inquiry. If the answer is yes, then you look
14 to see, you know, whether they've done the
15 maximum feasible consistent with financial
16 soundness.

17 I think D.C. Appleseed is saying
18 there are two things operating. So it's a
19 two-step process, as Mr. Hogan said, but it's
20 a sequential thing. You do the first step and
21 then after the first step you decide whether
22 to take the second step.

1 I think I'm hearing D.C. Appleseed
2 say there are two steps you're supposed to be
3 taking and two analyses you're supposed to be
4 taking simultaneously, and that either they
5 inform each other so that as you're trying to
6 determine what is reasonable, you try to
7 figure out. You have a simultaneous
8 obligation to do what's the most you can so
9 long as you're financially unsound or somehow
10 you have to deal with the two as side-by-side
11 steps. So I think that's the difference in
12 philosophy. I think that's what I understand
13 the difference in philosophy to be.

14 COMMISSIONER BARLOW: Okay. In --
15 again, I believe this is your report, Exhibit
16 C -- you took issue. Maybe that's too strong
17 a word, but you raised concerns about the non-
18 admitted assets of GHMSI and thought it might
19 be proper to add them back into surplus.

20 MS. CHELLET: I think that the
21 salient point is it might be. I don't have a
22 position that it would be, but in looking at

1 the reduction in surplus that occurred in 2008
2 one has to ask where did the money go, and
3 that is the most obvious place that the money
4 went.

5 So then I went to look at other
6 companies to see what they were holding in
7 non-admitted assets, and it's very small, if
8 anything, holding a non-admitted asset.

9 So my conclusion was that, number
10 one, I think that that should be looked at,
11 and number two, it appears that GHMSI is using
12 accounting conventions at least that are very
13 different from its competitors.

14 COMMISSIONER BARLOW: Well, I
15 mean, as I understood it from what GHMSI
16 explained earlier, the bigger of the two big
17 changes in non-admitted assets was the
18 deferred tax asset, and that was a change that
19 impacted both the assets and the liabilities.
20 So the net impact on surplus was zero for
21 that. So --

22 MS. CHELLET: I would have to

1 confirm that. I'm not saying that they're
2 misstating it, but I did not look to see the
3 liabilities drop by the same amount.

4 COMMISSIONER BARLOW: And also,
5 again, it does not seem unreasonable that one
6 might make a contribution to a defined
7 benefit pension plan in light of what happened
8 in the financial markets in 2008.

9 MS. CHELLET: That certainly is
10 reasonable, but I will tell you that their
11 competitors did not.

12 COMMISSIONER BARLOW: Okay.

13 MS. CHELLET: Not in the same way,
14 not with the same effect on their financial
15 statement.

16 MR. TOOLE: I'm sorry. You
17 introduced yourself as an economist?

18 MS. CHELLET: Yes.

19 MR. TOOLE: Are you a CPA as well?

20 MS. CHELLET: No, I am not.

21 MR. TOOLE: Okay.

22 MR. ZASS: I'd like to comment

1 there. If I look at the June 30th, 2009
2 GHMSI's NAIC filings, the \$186 million change
3 in the non-admitted assets flows directly to
4 the bottom line of the surplus. So I really
5 was taken back by the comment that there was
6 no impact on the financial statements by such
7 change in non-admitted assets between one
8 period and the next.

9 Thank you.

10 COMMISSIONER BARLOW: Okay. I
11 have just a couple of questions for Mr. Zass.

12 Now, have you done this kind of
13 analysis in other similar situations?

14 MR. ZASS: Have I conducted
15 similar assessments of companies' capital
16 requirements? Yes, I have.

17 COMMISSIONER BARLOW: Really? I
18 mean, have you done it for a third party in a
19 setting like this or something else?

20 MR. ZASS: Certainly not in a
21 hearing. I can confirm that has not happened
22 in the past.

1 COMMISSIONER BARLOW: And not as a
2 third party to the --

3 MR. ZASS: Me personally or the
4 firm? The firm that I'm associated with has
5 in the past done this kind of review.

6 COMMISSIONER BARLOW: Okay, and do
7 you tend to get access to company models when
8 you are acting as a third party in this kind
9 of analysis?

10 MR. ZASS: I'm not sure if that
11 can be completely stated as 100 percent. Yes,
12 we do not get what I would deem as proprietary
13 information. In some cases you may be deemed
14 depending if it was more of an M&A type of
15 arrangement, as Mr. Toole would probably
16 acknowledge, but from the standpoint of a
17 third party independently coming in and
18 looking at someone else's financials and the
19 surplus and so forth of the organization, no,
20 you have to use what you've been given.

21 COMMISSIONER BARLOW: Right, and
22 so would it be safe to say that, I mean, some

1 of the concerns you raised about the Milliman
2 model being a black box is not necessarily a -
3 - I mean, there shouldn't be a negative
4 implication to that. It's just that you don't
5 have access to the same information that they
6 have?

7 MR. ZASS: Well, I think what I
8 would want to comment on that is that any time
9 you look at a third party or another actuary's
10 work product that there are certain levels of
11 communication standards and the level of
12 transparency and assumptions that are going
13 into the actual model and the results of those
14 models that are used for that firm or that
15 entity's conclusions.

16 So such that in my opinion when
17 there is vagueness in and around model
18 assumptions, it gives you apprehension on the
19 bottom line results.

20 COMMISSIONER BARLOW: But
21 apprehension is just you don't know, not you
22 have information that there's something wrong.

1 It's you just don't know.

2 MR. ZASS: Well, based on the
3 information that was in the report, we can
4 definitely state that there are some
5 assumptions that were used that we would
6 question, and we've made that clear.

7 Is there a smoking gun in the
8 Milliman black box? You know, I have no idea.
9 Again, based on our assessment, we can simply
10 only go on the information we're provided.
11 The vagueness of the report for us to reach
12 our conclusions.

13 COMMISSIONER BARLOW: Okay, and, I
14 mean, it's certainly an appropriate thing to
15 question. I'm just trying to make sure that
16 there's not an implication or anything like
17 that that because you did not see their model
18 that there is something inherently wrong in
19 their model. It's just you have questions
20 about their model that if you had more access
21 to their model you might be able to answer,
22 but you raised concerns or issues that you

1 think we ought to look into with the model.

2 MR. ZASS: Well, I think any time
3 you provide further insight to someone in and
4 about the report or a model and the results
5 thereof should be enough ammunition, so to
6 speak, for the deciding party, which in this
7 case is you, to make your own determination
8 whether the things that we brought up are,
9 indeed, valid or not.

10 In essence, the things that we
11 brought up in this report we believe those
12 four items materially impacted the surplus
13 range to the tune of what discussed in the
14 report itself, in the submission.

15 COMMISSIONER BARLOW: Okay.

16 MR. ZASS: Had we have looked
17 under the hood, would we have thought that the
18 smoking gun would have refuted their range?
19 We don't think that if you would have looked
20 under the hood and looked at the assumptions
21 themselves, it is our opinion that we believe
22 that the range may even be lower.

1 COMMISSIONER BARLOW: Okay, and I
2 mean, we have taken seriously the issues that
3 you raised, and we are looking at them with
4 respect to the Milliman model.

5 MR. SMITH: Can I just add one
6 thought on this line of inquiry, please? No
7 one meant to suggest wrongdoing by Milliman
8 with regard to things we hadn't seen and
9 couldn't work out. We were simply
10 identifying the ways in which the thing wasn't
11 as transparent as one would have liked if one
12 was trying to replicate their work.

13 But I'll say this. I think the
14 Insurance Commissioner ought to be as
15 interested as possible in making what Milliman
16 did as transparent as possible, which is why
17 we said in our pleadings we are eager to take
18 them up on their invitation to meet with us
19 and to walk us through what they did so we can
20 have a better understanding of what it is they
21 did.

22 I mean, I took them at their word.

1 They meant that genuinely. They didn't want
2 it put it all up for all to see, but we're
3 doing our best to be a little bit of a
4 surrogate for the public here. We're not
5 perfect, but that is what we're trying to do,
6 and we would like to see more of what Milliman
7 did if you can help arrange that.

8 COMMISSIONER PURCELL: Have you
9 asked and been refused this information?

10 MR. SMITH: No, we did that in our
11 pleading because we didn't know they were open
12 to that till we saw their pleading.

13 COMMISSIONER PURCELL: Right.

14 MR. SMITH: But if that's
15 something you can facilitate and you think is
16 proper, I know that these two gentlemen would
17 be eager to look further under the black box.

18 MR. SHAW: May I add to Mr. Zass'
19 response, as the co-author of the report?

20 As actuaries, we often look at
21 confidential assumptions and do it in the
22 context of confidentiality agreements. That's

1 a very common process, whether it's an M&A
2 work, whether it is being hired by a client
3 simply that doesn't want their particular
4 assumption shared with anybody else.

5 And so to suggest that the
6 assumptions that have been used in the model,
7 you know, can't be exposed to other peer
8 reviewers with the expertise needed to make an
9 intelligent review, I think, is out of step
10 with how actuarial practice actually happens.

11 Secondly, I think what I would say
12 as someone experienced in these matters is
13 that the model description that they have put
14 in their actuary report that is creating a
15 Monte Carlo method and then doing some pro
16 forma reports is a very generic type of
17 description, and you will notice that we
18 didn't criticize that in our report.

19 What really makes a difference is
20 the assumptions that go into that type of
21 model. That's where all the action is, and as
22 some of the questions that were asked earlier

1 to Mr. Dobson were, for example, the fact that
2 the model does not appear based on his
3 response to be dynamic such that if there's a
4 loss period that it assumes that the amount of
5 surplus margin in the pricing goes up, which
6 is the normal response, would be of concern to
7 us.

8 Those are the types of issues that
9 we'd like to look at in the report to be able
10 to form a more full opinion as to the
11 appropriateness of their results.

12 COMMISSIONER PURCELL: Well, I
13 will go on records as saying I'm happy to
14 assist in having this done to the extent GHMSI
15 is willing and you are able. It could even
16 occur at our offices if necessary, although
17 I'm sure there may be some travel involved,
18 and if it could happen before the end of the
19 record so you could do some sort of analysis
20 and submit that, that would be great as well.

21 MR. SMITH: Thank you very much.

22 COMMISSIONER PURCELL: Is there

1 any further? Yes, Neil.

2 MR. RECTOR: I have just a couple
3 of questions. Mr. Shaw, you went through
4 pretty quickly today the -- if I have the term
5 and make sure I have the right report -- the
6 one that deals with the attribution.

7 MR. SHAW: Yes.

8 MR. RECTOR: I just have a couple
9 of questions. We've not looked at this. I
10 think this is new material. I don't think we
11 had this before; is that right?

12 MR. SHAW: You did not.

13 MR. SMITH: It was filed today.
14 This was part of our testimony today.

15 MR. RECTOR: Okay. On Approach 1
16 that you have, when you're determining the
17 percentages, are the percentages based on the
18 location of the master group policy holder for
19 the group business?

20 MR. SHAW: I believe that's the
21 case. We used Schedule T information, which
22 is how the company reported it to the

1 insurance department, and that is typically
2 done based on the location of the contract.

3 MR. RECTOR: Okay. So your
4 Approach 1, the numbers that you have are
5 based off of Schedule T in terms of
6 determining the percentages?

7 MR. SHAW: Yes.

8 MR. RECTOR: Okay. For Approach
9 2, the numbers are on the D.C. and the other
10 member months. Haven't really looked back at
11 that schedule in a while. Do you know if
12 that's also based on the location of the group
13 policy holder for -- do you know how the
14 member months are determined or calculated?

15 MR. SHAW: I believe it is also
16 consistent with Schedule T and that it's based
17 off of the location of the group if it's a
18 group contract or the location of the
19 individual if it's an individual contract.

20 MR. RECTOR: Okay. I had a couple
21 of questions for Ms. Chellet; is that?

22 MS. CHELLET: Yes.

1 MR. RECTOR: You had, and I think
2 Philip referred to these before; I think it's
3 pages 5 and also 8 of your report. On page 5
4 you talk about some other Blue Cross plans and
5 their RBC levels, and on page 8, I think you
6 go to competitors.

7 One of the things Mr. Burrell
8 talked about in his testimony was comparing
9 GHMSI's surplus to the surplus of the
10 companies that were the four Blue Cross plans
11 in Pennsylvania. Have you done any analysis?

12 I mean, he matched up one and said
13 he thought GHMSI's closest brother-sister was,
14 I think, the Capital Blue Cross/Blue Shield
15 Plan. Have you done any analysis to say
16 whether you agree with that, disagree with
17 that or --

18 MS. CHELLET: I was actually very
19 surprised at that because I would place GHMSI
20 somewhere between Highmark and Independence,
21 Blue Cross/Blue Shield, Highmark serving the
22 Pittsburgh area and Independence serving the

1 Philadelphia area, as much more likely
2 equivalent firms.

3 My understanding of Capital Blue
4 Cross, and I'll have to go back and look at
5 it, is that it serves a largely rural central
6 Pennsylvania area. So I just would not see
7 that as a company that would have similar
8 risks to a company like GHMSI which serves a
9 large metropolitan area.

10 MR. RECTOR: Okay. I think it
11 could be helpful for us if -- I think you are
12 also submitting materials in September and I
13 think you have another chance to. If there's
14 something that you could put together with
15 thoughts one way or the other regarding those
16 companies, and again, I'm sure that GHMSI will
17 do that as well.

18 I guess the last question I have
19 is for the lawyer from Covington & Burling.
20 You know, you heard a lot of discussion this
21 morning about or this afternoon about the
22 standard and what the standard is and we've

1 had a lot of discussion here, including
2 whether it's a two step, one step, and all
3 that stuff.

4 But I'm interested if you have
5 anything more to add without just repeating
6 what someone has already said as to what D.C.
7 Appleseed thinks is according to not what the
8 standard should be, you know, because everyone
9 can have their own public policy judgments,
10 but to what the standard actually is under the
11 MIA statute.

12 MR. CALIA: Yeah, I guess the only
13 thing I would add to what's been said is that
14 the maximum feasible extent part of the
15 standard is unique, and I think there has to
16 be just as a point of statutory construction
17 some life given to that part of the statute.
18 I think it's clear that the council had
19 something in mind when that became part of the
20 statute. I think it has to be given full
21 force and effect by purposes of this
22 evaluation of surplus.

1 I think the concept as I heard it
2 expressed from the folks from GHMSI was they
3 made their own determination of what they
4 thought was the optimal surplus range, and as
5 I understood what they said earlier, it was
6 without regard to that legal standard.

7 I think that legal standard has to
8 be the overriding principle that drivers the
9 analysis here. Otherwise it's surplus in the
10 statute and it has no meaning.

11 MR. RECTOR: Well, where I would
12 challenge you or at least challenge the
13 question is when you look at the statute, I
14 mean, it says the Commissioner determines that
15 the surplus is unreasonably large and
16 inconsistent. I mean the statutory words make
17 it look like it has to be both unreasonably
18 large and inconsistent, which I think comes
19 back then to Philip's question of if you've
20 got something within the range it could be
21 that the Commissioner completely has a
22 different range or whatever.

1 But if you have a range, if you're
2 within the range, somehow to meet the statute
3 you have to say, I think that it is both
4 unreasonably large as well as inconsistent,
5 and I'm trying to figure out how you read
6 that.

7 MR. CALIA: Yeah, the structure of
8 the statute actually refers to the maximum
9 feasible extent consistent with financial
10 soundness and efficiency. It really is before
11 you get to the unreasonably large aspects. So
12 as I read it, it's the overarching principle
13 that really drives the whole analysis here.

14 In view of that standard, when one
15 is evaluating what the appropriate surplus
16 range, if it is clear that in the face of that
17 standard it is unreasonably large, then this
18 statute sets forth steps that must be taken in
19 order to address that, in order to provide
20 essentially remedial measures for that.

21 I'm hoping I've answered your
22 question.

1 COMMISSIONER BARLOW: I think
2 maybe what we should do is ask anybody who's
3 willing to provide us their legal analysis.
4 I think I'm going to guess people understand
5 the question, and so if people would provide
6 us their legal analysis on that during the
7 period.

8 MR. RECTOR: I agree. That would
9 be very helpful.

10 MR. CALIA: We would be very happy
11 to do that.

12 MR. SMITH: We'll look further at
13 this.

14 COMMISSIONER PURCELL: Thank you,
15 Mr. Smith.

16 Mr. Calia and Mr. ARM -- Mr. Shaw,
17 rather --

18 (Laughter.)

19 COMMISSIONER PURCELL: -- Mr.
20 Smith, Mr. Zass and Ms. Chellet, thank you
21 very much. Thank you.

22 MR. SMITH: Thank you very much.

1 COMMISSIONER PURCELL: Okay.
2 We're going to keep plugging away. Next on
3 the list, Ms. Sondra Roberto from Consumers
4 Union.

5 Thank you for your patience. Good
6 afternoon.

7 MS. ROBERTO: Good afternoon. My
8 name is Sondra Roberto and --

9 COMMISSIONER PURCELL: One moment.
10 I just want to swear you in first.

11 MS. ROBERTO: Sorry.

12 MS. JOHNSON: Do you swear or
13 affirm to tell the truth, the whole truth and
14 nothing but the truth so help you?

15 MS. ROBERTO: I swear.

16 MS. JOHNSON: thank you.

17 MS. ROBERTO: Okay. My name is
18 Sondra Roberto, and I'm a staff attorney with
19 Consumers Union in San Francisco.

20 I thank you for giving me the
21 opportunity to speak to you today about GHMSI
22 surplus. I've come a long way to be here, and

1 it is because the question of whether a
2 particular health plan is holding too much
3 surplus is an important issue for health care
4 consumers.

5 I may deviate from my written
6 comments given everything that has gone on
7 already, but I would first like to start with
8 some background and a discussion of why these
9 proceedings are so important to our nation's
10 goal of making health care coverage affordable
11 for everyone.

12 CU views these surplus proceedings
13 as part of a widespread and ongoing effort by
14 regulators, advocates, and consumers to hold
15 nonprofit health care corporations accountable
16 to their missions.

17 For example, for more than a
18 decade CU and other groups have worked to
19 protect and redirect the charitable assets of
20 nonprofit insurers when they converted to for-
21 profit corporations to insure that these
22 assets continue to benefit communities and

1 help meet their health care needs.

2 This work is based on established
3 legal principles that hold that the assets
4 generated by a nonprofit corporation must
5 further the nonprofit's charitable mission and
6 purpose.

7 The same principles apply to the
8 surplus of a nonprofit plan. The plan's
9 surplus is an asset which must be used
10 primarily to fulfill the plan's mission as a
11 charitable and benevolent institution.
12 Maintaining adequate surplus is no doubt
13 important for the solvency of the plan and
14 fulfillment of its charitable mission, but we
15 have seen that for some nonprofit plans,
16 surplus has become excessive, to the point
17 where it no longer serves the best interest of
18 the plan's policy holders and the community in
19 which the plan operates.

20 CU supports your effort to
21 determine whether GHMSI has reached that
22 point. At a time when all of America is

1 debating how we can hold health plans
2 accountable, how we can extend coverage to
3 those in need and how we can make health care
4 more affordable, your proceedings here are an
5 extremely valuable contribution.

6 We welcome the attention that D.C.
7 is giving to the issue of excessive surplus,
8 and I think the value of this hearing is
9 already self-evident.

10 On this subject I note that GHMSI
11 has used considerable space in its prehearing
12 reports and its testimony today expressing
13 regret that D.C. has undertaken this effort.
14 For example, the company stated that it is
15 important to note -- and this is a quote --
16 "It is important to note that the usual
17 posture of regulators in the health insurance
18 field has been to focus on the solvency and
19 financial strength of insurers."

20 It has also stated, "In essence,
21 the most important question for the regulator
22 from the standpoint of protecting the

1 consumers who purchase insurance coverage is
2 whether come what may the company has the
3 solid financial footing necessary to meet its
4 obligations to pay claims."

5 GHMSI also believes that "the
6 notion that an insurer can offer its
7 subscribers too much in the way of financial
8 protection is at odds with historical concepts
9 of insurance regulation."

10 We agree that a regulatory focus
11 on health plan financial stability is critical
12 and must continue, but it need not be to the
13 exclusion of other consumer protections. Our
14 state insurance departments should exercise
15 their authority to the fullest extent possible
16 to increase the numbers of consumers getting
17 access to care and to make sure people are
18 getting their money's worth from their health
19 insurance.

20 We believe that more states should
21 and will begin to focus on excessive surplus
22 as premiums continue to escalate and community

1 health care needs go unmet. Other states will
2 look to D.C. as a precedent setting
3 jurisdiction to evaluate how you have
4 approached this problem. By adhering to
5 values of transparency, fairness, and
6 thoroughness, you will provide guidance for
7 similar proceedings to come.

8 We also disagree with GHMSI's
9 suggestion that an insurer can never have too
10 much surplus. Much of this has been touched
11 on, but if I may, for one, surplus that is
12 two, three, four, or more times greater than
13 the authorized control level for risk based
14 capital can indicate that the insurer is not
15 meeting its obligations as a charitable
16 institution. That's why scrutiny is
17 important.

18 Excess funds held in surplus can
19 and should be redirected toward more
20 affordable premiums for existing and
21 prospective policy holders, subscribers, and
22 for charitable giving to programs that help

1 the uninsured or under insured.

2 In addition, rapid growth in
3 surplus such as we have seen in the past
4 decade among many plans means that policy
5 holders and employers may be paying too much
6 in premiums. When surplus reaches a
7 comfortable level where insolvency is a very
8 remote possibility, subscribers should not
9 have to pay contributions to surplus.

10 Regulatory review of surplus is
11 important for these reasons. Moreover, surplus
12 review along with rate review is necessary to
13 make health insurance markets function as
14 efficiently as possible. Studies have shown
15 that most local health insurance markets
16 across the nation are concentrated with one or
17 two health plans holding a majority of market
18 share.

19 In D.C., as we've already
20 discussed, GHMSI is the dominant player. In
21 theory nonprofit plans with sufficient surplus
22 should be able to price aggressively. This

1 drives fiercer competition with for-profits
2 and leads to more competitive pricing for all
3 purchasers, but dominant insurers with market
4 power have little incentive to price
5 aggressively. Regulatory surplus and rat
6 review benefit everyone by helping to address
7 the problem of concentrated markets.

8 We also disagree with GHMSI's
9 argument that that any distribution of excess
10 surplus to public programs would mean that
11 existing GHMSI subscribers can be made to
12 shoulder not only their own costs, but those
13 of others who are not subscribers.

14 In reality, GHMSI subscribers are
15 already shouldering that burden. The federal
16 government estimates that right now hospitals
17 and doctors in the District of Columbia lose
18 more than \$141 million in uncompensated care,
19 which they often pass along to insured
20 families in the form of a hidden tax on
21 premiums, and again, this was discussed by the
22 President last night.

1 Remarkably, Milliman itself
2 conducted a recent study which found that in
3 2008 families across the nation paid an
4 average of more than \$1,000 in higher premiums
5 to cover more than \$42 billion in
6 uncompensated care.

7 Therefore, any community health
8 reinvestments that directly provide charitable
9 care or subsidize low cost insurance for those
10 who need it will benefit GHMSI's existing
11 policy holders or subscribers by helping to
12 alleviate the hidden tax.

13 Of course, for-profit health plans
14 also must be regulated and held accountable if
15 we are to make health care available and
16 affordable for everyone. But here in D.C.
17 where GHMSI has the highest market share, it
18 is best positioned to play the leader in
19 providing community health reinvestments.
20 These reinvestments can and should include
21 rate relief or cost sharing relief for
22 existing subscribers, low cost coverage for

1 prospective subscribers, and public health
2 programs that benefit the community at large.

3 The notion that the plan's
4 community health reinvestment requirement
5 benefits nonsubscribers to the detriment of
6 subscribers is false. The plan, along with
7 the Commissioner, can work to identify the
8 most important community needs and develop the
9 right mix of programs or products to address
10 those needs.

11 Now I'd like to turn to some
12 specifics about GHMSI's adopted optimal
13 surplus range of 750 percent to 1,050 percent
14 of risk-based capital authorized control
15 level. As stated in my pre-hearing letter, CU
16 urges you to reject this range for several
17 reasons. I don't intend to go into all of
18 those reasons here, but I will point out some
19 glaring shortcomings.

20 In the first instance I want to
21 agree with the prior testimony that we found
22 the Milliman report to be what they call the

1 black box, and one of our goals here today was
2 to urge you to seek more information from
3 Milliman about what assumptions and
4 probabilities that they used.

5 We gave the report to an expert in
6 health plan management, and he told us he
7 could not test or evaluate Milliman's analysis
8 because Milliman did not disclose its
9 underlying assumptions.

10 So what we want to say is that we
11 hope you would not accept that range as
12 optimal without learning the assumptions and
13 probabilities used to achieve the outcome.

14 Our expert also questioned among
15 other aspects of the report why Milliman used
16 growth rates of 12 percent to 14 percent when
17 GHMSI's growth rate has averaged about eight
18 percent with only one year above 12 percent.
19 The higher growth rates lead to the need for
20 more surplus.

21 Further, when questioned about
22 excessive surplus, nonprofit health plans,

1 including GHMSI, repeatedly argue that they
2 need larger stores of capital for
3 improvements, new products or the ability to
4 respond to market changes. They suggest that
5 it is easier for their for-profit competitors
6 to raise money because they can sell stock.

7 However, neither GHMSI or any
8 other nonprofit that we know of has put forth
9 evidence showing that for-profit health plans
10 regularly sell stock to raise capital. In
11 fact, in a surplus proceeding in Pennsylvania
12 which we've discussed, the Insurance
13 Commissioner cast doubt on this argument when
14 she pointed out that it misleadingly implies
15 that selling stock is a cheaper source of
16 funding than other forms of borrowing.

17 In addition to the questions
18 raised by our expert, Milliman's range is
19 simply too high. It would allow GHMSI to
20 maintain surplus up to five times higher than
21 RBC ACL. We don't see how GHMSI can maintain
22 surplus at these high levels and comply with

1 D.C.'s requirement that it engage in community
2 reinvestment to the maximum feasible extent
3 consistent with financial soundness and
4 efficiency.

5 On that note I want to deviate and
6 just address one of the issues that you had
7 brought up, and that was the question of how
8 can we rebuild surplus if something does
9 happen and it falls below the recommended
10 range. I just wanted to point out that in
11 Pennsylvania the Commissioner there sort of
12 looked at it as having two ranges. One she
13 identified as an efficient range, and one she
14 identified as a sufficient range.

15 The efficient range which started
16 at -- she said she really wouldn't identify a
17 lower level, but if we assume that it's 200
18 percent where there would be regulatory
19 intervention, then she said between that range
20 and 500 percent is an efficient range where
21 there is no risk of insolvency.

22 And then she said the sufficient

1 range at 550 to 750, and she said that if you
2 fall below that range and you're in the
3 efficient range, you're still not in danger of
4 insolvency, but what you can do is start
5 rebuilding your surplus.

6 So the idea is that you set a
7 range where if you go below it you can
8 gradually rebuild so there is no dramatic
9 premium increases in order to rebuild the
10 range, and I think that's a good approach, is
11 having sort of a cushion and then a range.

12 And I also wanted to reiterate
13 that the Commissioner rejected Milliman's
14 recommended optimal range in that case.

15 So if Milliman's range is too
16 high, what is an appropriate surplus range for
17 GHMSI? And is GHMSI's surplus unreasonably
18 large right now?

19 To conclude my testimony, I would
20 like to urge the Commissioner to take the
21 following steps to answer these questions.

22 First, seek more information from

1 GHMSI. As noted, we don't know how Milliman
2 reached its optimal range or why it used
3 certain assumptions.

4 Also, more information is needed
5 about GHMSI's other risk protection
6 mechanisms. For example, the Blue Cross/Blue
7 Shield Association requires all of its
8 licensees to participate in a guaranty fund
9 using alternate mechanisms such as a
10 subscriber protection account or in the
11 absence of either of these conditions,
12 maintain surplus at 800 percent of ACL. They
13 require this as an additional protection for
14 subscribers.

15 We would like to know how GHMSI
16 has satisfied this requirement. Is that
17 component of surplus or is there an additional
18 subscriber protection account out there that
19 would be used in the event of solvency?

20 We urge the Commissioner to
21 require GHMSI to annually report all
22 activities that meet the definition of

1 community health reinvestments and how much
2 money was used for each activity. This report
3 should be clear, comprehensive and made
4 public. Consumers need to be able to see
5 exactly how GHMSI is meeting the statutory
6 requirements.

7 We understand that the
8 Commissioner has hired independent actuaries
9 to determine an appropriate surplus range, and
10 we applaud you for that. We hope that that
11 surplus range will take into account the
12 requirement that GHMSI contribute to community
13 health reinvestment to the maximum extent
14 feasible.

15 After determining a sufficient
16 surplus range, the Commissioner should limit
17 contributions to surplus while GHMSI is
18 operating within the range.

19 We also urge you to use your
20 authority under D.C.'s prior approval statute
21 to consider surplus when reviewing rate
22 increase requests for individuals and small

1 groups. Rhode Island, for example, has
2 rejected requested increases based on the
3 amount of surplus held by that state's Blue
4 plan.

5 Rate approval should not be a
6 rubber stamp. Going forward we urge the
7 Commissioner to carefully consider in light of
8 GHMSI's surplus its need for increases or the
9 need for other measures imposing hardship on
10 its existing and prospective subscribers, such
11 as tightening underwriting requirements for
12 pregnant women and newborns as it did in July
13 2008, and that was at a time when it held over
14 \$780 million in surplus.

15 I'll conclude with a final comment
16 regarding the determination of surplus that is
17 attributable to the District. We believe that
18 using a residency standard as GHMSI believes
19 you should would lead to an unfair result.
20 After all D.C. employers paid for large
21 portions of the premiums that funded GHMSI's
22 surplus.

1 The Commissioner should work with
2 all jurisdictions involved to create a more
3 appropriate standard for this determination,
4 taking into account several factors, including
5 revenue and subscribers in each jurisdiction,
6 the contracting entities, the providers, and
7 the needs of the relevant communities.

8 Thank you for having me here today
9 and for engaging in this important process.

10 COMMISSIONER PURCELL: Thank you.
11 Thank you for coming and thank you for coming
12 across the country. I think it's important to
13 hear the voice of consumers, and I thank you
14 for representing them here today.

15 I did have one question for you.
16 The balance that we've been speaking of all
17 day, the notion that there is a prudent
18 balance to be reached between financial
19 stability and additional community
20 reinvestment, particularly in this situation.

21 What are your thoughts on this
22 from a consumer's standpoint? Is the consumer

1 care that businesses are required to strike
2 this balance and maintain this balance
3 ultimately they say for their own benefit?

4 Do you have an opinion on that?

5 MS. ROBERTO: Yes, and I think I
6 hinted to this in my testimony. I think that
7 consumers are very concerned about the
8 affordability and the increases that they've
9 seen, and to the extent that community health
10 reinvestments benefit everyone in the
11 community by making health care more
12 affordable, it becomes more affordable for
13 people who are already insured. We don't seem
14 to realize the impact that the uninsured have
15 on what we're paying right now, the cost that
16 they add to the system.

17 And so that these community health
18 reinvestments are beneficial to everyone.

19 COMMISSIONER PURCELL: Okay.

20 Thank you.

21 And one final question. In your
22 experience are there any similarly situated

1 nonprofit health insurers that perhaps are
2 doing a better job of striking that balance?

3 I know GHMSI is very specific in
4 the region that it operates and other factors,
5 but generally speaking.

6 MS. ROBERTO: Yes, I'm aware of
7 other nonprofits that are doing a great deal
8 more for community benefits, and there are
9 others who are not and who are in similar
10 positions as far as holding what we would view
11 as too much surplus.

12 COMMISSIONER PURCELL: If you
13 would be willing to provide a list or even a
14 short summary of both of those, those who are
15 doing it right, in your opinion, and those who
16 are not, I would be interested in seeing that.

17 MS. ROBERTO: Absolutely.

18 COMMISSIONER PURCELL: Thank you.
19 Thank you for coming.

20 Oh, I apologize. Hold tight.

21 Jim.

22 MR. TOOLE: At the top of page 8

1 of your prepared response you appear to have
2 skipped a paragraph, and I was just wondering
3 if there's a reason behind that or I was
4 briefly narcoleptic or --

5 MS. ROBERTO: No, I skipped it
6 because I felt we had gone over it a bit, but
7 I can read it to you if you'd like.

8 MR. TOOLE: Well, it says more
9 than I think --

10 MS. ROBERTO: Well, I wanted to
11 agree that -- the top of Paragraph 8 you're
12 talking about -- I wanted to agree that
13 bringing Lewin here today and having them do
14 another report really doesn't add much to the
15 debate or to the conversation. Lewin simply
16 said that, quote, that their review does not
17 allow us to comment as to whether we would
18 have produced the same range of surplus
19 requirements as shown in the Milliman report.

20 And I also wanted to note that in
21 reference to the Pennsylvania Commissioner's
22 decision Lewin decided that she had "set

1 reasonable bounds on the Pennsylvania Blue
2 plan's accumulation of surplus that were
3 unlikely to disrupt the Pennsylvania insurance
4 market.

5 So I'm not sure by having this
6 other huge player in this field come in really
7 added much to support Milliman's
8 recommendations.

9 Anything else?

10 COMMISSIONER PURCELL: Thank you.

11 MS. ROBERTO: Thank you.

12 COMMISSIONER PURCELL: Next we
13 will call Cheryl Fish-Parcham from Families
14 USA.

15 Ms. Parcham, you're allotted 20
16 minutes. Our timekeeper has stepped out. Oh,
17 here he is. You may begin.

18 MS. FISH-PARCHAM: Thank you.

19 And I --

20 COMMISSIONER PURCELL: Oh, one
21 moment. I apologize. Swear you in.

22 MS. JOHNSON: Would you raise your

1 right hand, please?

2 Do you swear or affirm to tell the
3 truth, the whole truth and nothing but the
4 truth so help you?

5 MS. FISH-PARCHAM: I do.

6 MS. JOHNSON: Thank you.

7 MS. FISH-PARCHAM: Thank you.

8 I've submitted my prehearing
9 statement, and I don't have an additional
10 written statement, but I'd like to summarize
11 some of the concerns in light of the testimony
12 that we heard today.

13 I'm Cheryl Fish-Parcham, and I'm
14 the Deputy Director of Health Policy at
15 Families USA. We are a national, nonprofit
16 health care advocacy organization. We work on
17 both national and state issues, and in D.C. we
18 have worked both on behalf of Medicaid
19 consumers and on behalf of uninsurable
20 consumers. So it's in light of those concerns
21 that I'm speaking today.

22 First, I am hoping that my

1 testimony will inform both you and the company
2 on what might be appropriate community
3 reinvestment if you find that there be excess
4 surplus, and I am not an actuary or an
5 economist, but just in reading the Carefirst
6 reports even if you take their assumptions,
7 they have defined a range that is an optimal
8 level. It's not minimum level for financial
9 solvency. It is an optimal level, and it
10 seems to me that the statute is requiring that
11 they spend the maximum feasible consistent
12 with remaining financially stable.

13 So even if you were to take their
14 assumptions, I don't understand why they would
15 above the minimum optimal level, and so that
16 seems to me already requires some spending on
17 behalf of the community, and I defer to
18 Appleseed and others about whether that range
19 should be lower.

20 But I want to talk about some of
21 the subscriber needs that Carefirst mentions,
22 making premiums affordable to subscribers is

1 among their primary missions, and I want to
2 talk about ways that they could better target
3 assistance to consumers.

4 And first, in my testimony, the
5 last page is a chart that I hope is accurate.
6 It was our best understanding of the rate
7 filings that are on the Website, and I want to
8 point out some of the rate increases that
9 appear to have occurred that seem inconsistent
10 with keeping premiums affordable.

11 The first is in conversion
12 policies. As I understand it, conversion
13 policies are the policies that must be sold to
14 people when their former group policies, their
15 former employers go bankrupt, stop offering
16 plans, and they must be offered instead in the
17 District a conversion policy to an individual
18 policy and maintain some coverage for them.

19 And it looks to me from the
20 filings that those policies increased 14
21 percent in January '08 or 24 percent in April
22 '09. I'm not quite sure what the two

1 different conversion policies are that are
2 listed here, but in either case, those are
3 very big increases to consumers who have just
4 lost their source of employer based coverage
5 at a time that the economy is tanking.

6 So that would be one way that
7 Carefirst could really help consumers, is by
8 lowering those premiums.

9 Small business premiums according
10 to page 7 of the last filing that's on the
11 Website have a different rate of offer than of
12 renewal that they are charging 414 per month
13 to new subscribers, but 572 a month to
14 businesses that are renewing their premiums.
15 So relooking at those policies are ways that
16 consumers could make or Carefirst could make
17 policies more affordable to businesses.

18 But now I want to turn to open
19 enrollment, which is an issue that I've been
20 tracking for a few years, and this is the
21 policy that is supposed to make coverage
22 available and affordable to individuals who

1 have preexisting conditions and cannot
2 otherwise get policies in the market, and
3 those policies increased. In one instance one
4 consumer wrote us about an increase from \$478
5 a month to \$591 this July.

6 Another consumer wrote to us about
7 a 41 percent increase in their couple
8 coverage. They're now paying over \$18,000 a
9 year in premiums.

10 There have been hearings over the
11 past year about what is an appropriate
12 enrollment obligation, and Carefirst says that
13 it anticipates spending \$5 million for that
14 product now. This is above what the premiums
15 earn for that product.

16 Yet their statements show that
17 whatever the premiums are that are
18 attributable to that product in the individual
19 market lying all together, they are earning
20 and underwriting gain. So it appears that
21 they're not dipping into their surplus to
22 subsidize premiums substantially. They are

1 instead using the conglomerate of how they
2 array their individual premiums, still earn a
3 profit for them.

4 The discussion over the past year
5 or so has been should other insurers share
6 this risk, and sure, we're all for other
7 insurers sharing this risk, and should
8 Carefirst be permitted to just spend \$5
9 million on this product or should they instead
10 put \$5 million into some other public-private
11 partnership that was going to serve people,
12 but my fundamental question is why is it just
13 \$5 million. Why isn't there money to increase
14 the commitment to help uninsurable residents
15 get coverage?

16 Another part of this product has
17 been the debate, has been how many people
18 should be served. So an appropriate use of
19 surplus would be to expand the number of
20 people that are served under this product.

21 And another big concern has been
22 benefit caps. These are the sickest D.C.

1 residents who cannot get coverage elsewhere.
2 They're denied coverage by definition, yet
3 they face a \$1,500 annual cap in their
4 prescription drug coverage.

5 We heard testimony this fall from
6 a consumer who testified in the city council
7 hearings about losing his job where he had
8 full drug coverage and now he had a disease
9 for which there are no generic equivalents.
10 His annual drug bills are \$20,000 of which
11 Carefirst was paying 1,500. And this is a
12 true unmet need of a current subscriber.

13 Just to mention quickly the one
14 assumption that I do know something about in
15 terms of risk, Carefirst lists one of the
16 variables in the coming year as being national
17 health reform, and I really question whether
18 they should be building reserves to deal with
19 national health reform.

20 As you know, national health
21 reform may help actually people who have
22 preexisting conditions to get coverage and

1 maintain coverage, but that is, in the bills
2 that we've seen so far, several years down the
3 line and there will be many measures taken
4 nationally to offset any potential losses to
5 insurers from that measure.

6 There is risk adjustment that is
7 built in. There is a larger insurance pool
8 created, perhaps an individual mandate,
9 subsidies, and for an insurer to be building
10 surplus now in anticipation of health reform
11 just does not seem appropriate to us.

12 And finally I'd like to comment
13 briefly on this distinction that's been talked
14 about between current subscribers and
15 community benefit. I think it's really an
16 artificial distinction. We heard testimony
17 from Consumers Union that we agree with about
18 the cost of uncompensated care to subscribers,
19 but moreover in the District there's really
20 very little distinction because the people who
21 might be served by public programs are the
22 same people who are not getting open

1 enrollment now because the premiums are too
2 high.

3 So as you make premiums -- you can
4 make premiums more reasonable or you can give
5 to public programs. You're still trying to
6 accommodate the same universe of people who
7 are uninsured and uninsurable.

8 And as this is played out with
9 Healthy D.C. and the Alliance and other
10 programs that the city has thought about
11 constructing, a big question has been sort of
12 what benefits will premiums support, and we
13 have concerns still about whether the sickest
14 residents will well be served by products that
15 are being created.

16 So one possible look at a
17 community giving obligation for Carefirst in
18 the future is to provide funding for
19 catastrophic benefits that are not covered by
20 their insurance plans, be they public or
21 private, to help fill in some of these gaps,
22 the gaps in prescription drug coverage that

1 Carefirst now has, the gap in mental health
2 coverage that the D.C. Alliance leaves, and
3 many other gaps that are yet to be determined.

4 So thank you.

5 COMMISSIONER PURCELL: Thank you,
6 Ms. Fish-Parcham.

7 I don't have any questions for
8 you. Your testimony is very thorough. We'll
9 certainly consider it. It's included in the
10 record as you know, in addition to the one
11 that was submitted before, and perhaps
12 Carefirst will respond to some of your
13 concerns in their rebuttal statement tomorrow.

14 Thank you.

15 MS. FISH-PARCHAM: Thank you.

16 COMMISSIONER PURCELL: Okay.

17 Continuing on, we have to be out of this room
18 by 5:00 p.m. So we have about 15 minutes. So
19 we could take another panel of three if the
20 next three on the witness list would like to
21 come up all at one time. We're going to stick
22 very strictly to our three minute time period

1 and hopefully have some time for a few
2 questions.

3 So JoAnn Lamphere, David Wilmot
4 and Ms. Barbara Lang. Good afternoon.

5 MS. JOHNSON: Please raise your
6 right hands to be sworn in, please.

7 Do you swear or affirm to tell the
8 truth, the whole truth, and nothing but the
9 truth, so help you?

10 WITNESSES: I do.

11 COMMISSIONER PURCELL: And, Ms.
12 Lamphere, you may proceed.

13 MS. LAMPHERE: Commissioner
14 Purcell, distinguished panel members, good
15 afternoon.

16 I know we're standing between you
17 and dinner. So I'll make my remarks short.

18 My name is JoAnn Lamphere, and I
19 serve as Director of AARP's State Government
20 Relations Health and Long-term Care Team. I'm
21 honored to testify in behalf of AARP's 91,000
22 members in the District of Columbia who are

1 concerned about excess reserve funds held by
2 Carefirst's D.C. affiliate GHMSI and its
3 inadequate community health reinvestment.

4 AARP appreciates your leadership
5 and the opportunity to participate in this
6 hearing. AARP believes that it's important
7 for the District of Columbia to insure that
8 Carefirst is fulfilling its public mission to
9 provide quality, affordable, and accessible
10 products and services to its customers and the
11 community.

12 We believe such reasonable
13 standards can be accomplished by Carefirst in
14 a viable and invigorated way.

15 It appears the amount of reserves
16 that Carefirst GHMSI holds in its possession
17 is unreasonably large based on information
18 that's publicly available. If you determine
19 that this surplus is excessive, we commend
20 that a portion of these excess funds be used
21 first to invest in proven health initiatives
22 to improve the overall health of the

1 District's population; also provide affordable
2 health coverage choices for the District's so-
3 called uninsurable adults; and third,
4 constrain rising health premiums for current
5 policy holders who are struggling under rate
6 increases.

7 Resources are needed more than
8 ever to assist struggling residents in the
9 District. As I listened to the sophisticated
10 testimony of Carefirst this morning, I was
11 struck by the effort of the company that it
12 has made to defend both its level of reserves
13 and community investments. I can only imagine
14 the millions of dollars that have been spent
15 securing expert consultation to advance this
16 perspective and how much health care coverage
17 these millions of dollars could have
18 supported.

19 I dream of a different kind of not
20 for profit insurance company serving the
21 District of Columbia and neighboring states
22 that does not view the idea of community

1 reinvestment in opposition to the idea of
2 benefit for subscribers. It seems Carefirst
3 is hampered by its 20th Century perspective
4 that is unable to envision how to meet 21st
5 Century community health commitments. Meeting
6 a not-for-profit community benefit obligation
7 means more than charitable contributions and
8 giving to worthy causes.

9 Indeed, many health insurance
10 companies across the United States have
11 figured out how to commit passionately to
12 filling in the cracks and service needs of a
13 broken health care system, to invest in
14 prevention and care management especially for
15 at risk populations, and third, to adopt
16 communities, actually adopt communities and
17 work in partnership to make them healthy.

18 These innovations have been found
19 to benefit these communities and the company's
20 bottom lines.

21 Most of us in the room value the
22 innovation that the private sector can

1 deliver. It is proper that this innovation
2 and creativity be harnessed by government on
3 occasion for the social good. While this
4 hearing by necessity has focused on financial
5 accounting details, we should not lose sight
6 of the overall community objectives that the
7 NEA legislation sought to achieve.

8 COMMISSIONER PURCELL: Ms.
9 Lamphere, could you please sum up?

10 MS. LAMPHERE: Okay.

11 COMMISSIONER PURCELL: Thank you.

12 MS. LAMPHERE: We believe
13 Carefirst should be required to devote more
14 resources to the health and coverage needs of
15 the Washington area community to the maximum
16 extent possible. Serious multiple chronic
17 conditions are harming the District, and
18 through a greater investment of evidence-based
19 community programs by Carefirst improved
20 assurances of health care and coverage can be
21 provided to members of our local community.

22 And we are happy -- we would be

1 delighted to work with you to further that
2 vision.

3 COMMISSIONER PURCELL: Thank you.
4 Thank you.

5 Ms. Lang.

6 MS. LANG: Thank you.

7 Good afternoon, Commissioner
8 Purcell and members of the department. I am
9 Barbara Lang, and I am pleased to be president
10 and CEO of the District of Columbia Chamber of
11 Commerce.

12 I'd like to thank you for allowing
13 me to testify on the determination of the
14 Group Hospitalization and Medical Services,
15 Inc. surplus.

16 I'm coming at this from an
17 entirely different perspective. I'm not going
18 to talk about charters or actuarial tables or
19 legal opinions. I am speaking purely in
20 support of a robust business community in the
21 District of Columbia.

22 The Chamber of Commerce would like

1 to urge that you leave the decision about the
2 appropriateness of GHMSI's reserves where it
3 rightfully belongs, with its board of
4 directors. Our concerns are similar to those
5 expressed at a hearing in 2005 when we
6 testified before Council Member Graham on this
7 same very issue.

8 And I will say that I've testified
9 several times on this very same issue. In
10 expressing our concerns, the Chamber
11 recognizes that the Medical Insurance
12 Empowerment Amendment Act of 2008 was narrowly
13 drafted such that it would apply to only one
14 corporate entity operating in D.C. The
15 corporate entity identified in the law that
16 Carefirst-Blue Cross/Blue Shield through its
17 Washington area affiliate GHMSI is an
18 important member of this business community in
19 D.C., so much so that we plan to honor them at
20 the Chamber's annual gala this October in
21 front of 1,200-plus guests. So we think very
22 highly of this business in D.C.

1 Not only are they an exemplary
2 member of this business community for its
3 sound management and strong financial
4 position, but it is also one of the largest
5 financial givers in the city. It's our
6 opinion that this company lives up to its
7 mission.

8 In fact, by all rights District
9 officials should be commending Carefirst and
10 GHMSI for their exemplary contributions to the
11 community instead of continuing to drag it
12 through burdensome regulatory and over sight
13 reviews, legislative mandates and lawsuits.

14 The lion's share of Carefirst's
15 members are individuals and small employers,
16 almost 5,000 businesses in total, nearly 70
17 percent of which have fewer than nine
18 employees. The reserves that are the subject
19 of this review were built by those premiums,
20 paid by those individuals and businesses and
21 those reserves are maintained for their
22 protection.

1 Any attempt to redirect some share
2 of those reserves for other purposes would
3 impair the company's ability to moderate
4 future premiums and insure that it will always
5 be there for its members no matter what.

6 For small employers, the decision
7 to provide health insurance is both a
8 necessity and a sacrifice. We believe that
9 any determined excess reserves should be
10 returned to the employers, employees, and
11 individuals who helped to create it.

12 GHMSI's board is charged with the
13 following major duties, and I see my time is
14 up. So it's in the written testimony.

15 But let me just say in closing
16 because I know we are out of time, is this is
17 a very slippery slope. While this legislation
18 is geared to Carefirst and their nonprofit
19 status, if we go down this pathway, we are
20 going to -- what other for-profit company are
21 we now going to go after? And that impairs
22 the ability to attract businesses and to

1 retain them in the District of Columbia.

2 Many times when I testify on the
3 Hill looking for more money I say being the
4 nation's Capitol is an honor and a privilege,
5 albeit a very expensive one. One of the
6 things that I do when we compare to
7 surrounding jurisdictions, it is almost 30
8 percent more to do business in this District
9 of Columbia than in Maryland and Virginia. So
10 why would anybody want to be here?

11 And so today I had a phone call
12 from CNN wanting me to do an interview on why
13 I want to bring business in D.C. and why it's
14 so great to be in the District. I am
15 considering not doing that interview because
16 it's very difficult to extol the virtues.

17 So I implore all of you not to
18 burden this company. We need them and their
19 1,500 people that they employ just in the
20 District of Columbia.

21 And so I thank you for the
22 opportunity to be here today.

1 COMMISSIONER PURCELL: Thank you.

2 MS. LANG: The other part of my
3 testimony is written.

4 COMMISSIONER PURCELL: And it will
5 be entered into the record.

6 MS. LANG: Thank you very much.

7 COMMISSIONER PURCELL: Thank you,
8 Ms. Lang.

9 Mr. Wilmot.

10 MR. WILMOT: Good afternoon.

11 COMMISSIONER PURCELL: Good
12 afternoon.

13 MR. WILMOT: Commissioner Purcell,
14 can you hear me? Thank you.

15 I'm Dave Wilmot. I'm the
16 Executive Director of the District of Columbia
17 Association of Health Maintenance
18 Organizations.

19 Our association consists of seven
20 managed care organizations, and at the time
21 that I took over, there were 19 such
22 organizations operating in the District of

1 Columbia, many of whom are no longer here
2 today, and it's directly related to the
3 conversations that will happen with respect to
4 their reserves.

5 They can't hear me?

6 COMMISSIONER PURCELL: Sorry.

7 Yes, just put the mic right in front of -- oh,
8 is it engaged? Push the green.

9 MR. WILMOT: Can you hear me now?

10 COMMISSIONER PURCELL: There you
11 go. thank you.

12 MR. WILMOT: Okay. Directly
13 related to the conversation that we're having
14 today.

15 You have my testimony. So what
16 I'd like to do is I'd like to turn to the
17 highlights. The association member plans
18 believe that it's important to maintain a
19 strong and competitive health insurance
20 industry in the District of Columbia. It's
21 something that I believe that you agree with.

22 At one time, the DCHMO Association

1 had as many as 19 member plans. As you're
2 aware, several of those companies had to cease
3 operations because they did not have adequate
4 reserves.

5 Carefirst affiliate, Group
6 Hospitalization and Medical Services, Inc. is
7 one of the largest insurers in the city, and
8 it is essential that the company remain
9 financially strong. We recognize that you are
10 mandated to conduct a review of the company's
11 reserves and to make a determination on
12 whether those reserves are excessive.

13 Specifically the Commissioners are
14 required to assess the reserves that are
15 attributable to the District. Typically
16 companies establish reserves based on their
17 entire business obligation. A number of our
18 member plans are concerned that a policy with
19 the stated objective to divide reserves based
20 on an individual's jurisdictions could weaken
21 the entire company as well as have an adverse
22 effect on other member plans as well.

1 In the health industry, the risk-
2 based capital standards set by the National
3 Association of Insurance Commissioners
4 establishes a minimum threshold to measure the
5 financial solvency. It is in no way the
6 standard that should measure excess.

7 If a company is operating at that
8 level, it should send off an alarm bell and
9 result in an intervention by the Insurance
10 Commissioner.

11 Health insurers and other
12 companies establish reserves to make sure that
13 they can effectively meet both expected and
14 unexpected business obligations. Establishing
15 an appropriate level of reserves is going to
16 be different for each company. The DCHMO
17 Association believes that it is the role of
18 the company's board of directors and its
19 management to make that determination.

20 We urge you to give careful
21 consideration to the important decisions you
22 have to make. As the Insurance Commissioner,

1 you have an obligation to protect insurance
2 consumers and to make sure insurance companies
3 provide quality service in accordance with the
4 law.

5 In order for an insurance company
6 to meet the obligation to its customers, the
7 company has to be effectively managed and
8 financially strong. That is where Carefirst
9 is now.

10 We hope that the first decision
11 you make in your role as Commissioner sets the
12 right balance.

13 Thank you for giving us the
14 opportunity to testify on this issue, and I
15 remain available for any questions that you
16 might have.

17 COMMISSIONER PURCELL: Thank you.

18 Thank you, Mr. Wilmot, and thank
19 you all for your testimony today.

20 I do not have any questions for
21 you. You all have very compelling and very
22 clear testimony. It will be entered into the

1 record and considered fully.

2 I want to thank you all for coming
3 today, all of the witnesses. Please note
4 again that the record will remain open until
5 September 25th, and I have one additional
6 request, and that is that you send an E-mail or
7 forward it to the attention of Leslie Johnson,
8 but also to my Executive Assistant Carmelita
9 Snowden either by mail or E-mail, and just to
10 insure that we have it.

11 And with that I will adjourn this
12 hearing. This hearing will resume tomorrow
13 morning at 10:00 a.m. in this room, and thank
14 you all again. Have a good evening.

15 (Whereupon, at 5:01 p.m., the
16 hearing was recessed, to reconvene at 10:00
17 a.m., Friday, September 11, 2009.)

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