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July 23, 2014

The Honorable Chester A. McPherson, Commissioner
District of Columbia Department of Insurance, Securities and Banking
810 First Street NE
Suite 701
Washington, D.C. 20002

Re: Surplus Review and Determination for Group Hospitalization and Medical Services, Inc.

Dear Commissioner McPherson:

We thank you for your ongoing efforts to review the surplus of Group Hospitalization and Medical Services, Inc. (GHMSI) in accordance with the Medical Insurance Empowerment Amendment Act of 2008 (MIEAA).

We understand that you are considering submitting follow-up questions to witnesses who presented at the June 25 hearing. We also understand that you would be open to considering suggestions from us concerning possible questions you might submit. We appreciate that opportunity and present our suggestions below.

Suggested Questions for GHMSI

1. GHMSI indicated that its administrative expenses are "in the middle of the pack" when compared with other Blues. Transcript of Group Hospitalization and Medical Services, Inc. Surplus Review Hearing, D.C. Department of Insurance, Securities, and Banking, June 25, 2014, Washington D.C. ("Transcript") at 112. Please provide a copy of the study or documentation supporting this assertion.

2. GHMSI referred to the possibility that if it were to misjudge rates on the low side by 1%, it would lose $40 million, and if it misjudged by 5%, it would lose $200 million. Transcript, at 295-97. Please explain this calculation.

   a. In doing so, please confirm whether this calculation includes FEP premiums, Medicare Supplement premiums, and other non-comprehensive premiums. Also, please address how this risk is captured in the Milliman model.

   b. In the past 10 years, how often and by how much has GHMSI misjudged individual and non-FEP group rates, such that GHMSI's medical loss ratios exceeded its expectations? How, and how quickly, did management address the problem?

   c. What was GHMSI's effective MLR, calculated according to the specifications in the ACA for the calculation for MLR,

for comprehensive health business other than FEP during the years GHMSI built its surplus to its current level?

3. GHMSI noted that, in the last few years, its RBC has declined by 166 points—from 1098% to 932%. Transcript, at 176. Please say what part of this decline GHSMI regards as community reinvestment resulting from GHMSI's decreasing of rates to reduce surplus.

4. GHMSI stated that it expects a decline of 80 to 100 points in RBC in 2014. Transcript, at 129. Please say what part of this expected decline is owing to the effort Rector described to subsidize rates as part of GHMSI's community reinvestment obligation. Transcript, at 51.

5. GHMSI stated that other Blues over the last 5-7 years averaged margins of 3%. Transcript, at 98. Please provide data showing which other Blues GHMSI is referencing and their margins on non-FEP business.

6. GHMSI stated that GHMSI has never approached these levels of margin; however, it appears that GHMSI achieved this margin on its non-FEP business as recently as 2010. In years that GHMSI did not achieve a 3% margin on its non-FEP business, is this because GHMSI spends more on community reinvestment than other Blues or due to the company intentionally reducing margins? Are there other reasons for GHMSI's lower margins as compared to other Blues plans?

7. Milliman stated in its most recent study that GHMSI can increase surplus by establishing rates with a premium margin that includes a "surplus contribution factor." Milliman, Inc. CareFirst, Inc. Group Hospitalization and Medical Services Inc., Development of Appropriate Surplus Target and Optimal Surplus Target Range, June 27, 2014, at 8. Does GHMSI agree with this?

8. GHMSI argued that it is under order from the Maryland Commissioner to increase GHMSI's surplus by 200 points. Transcript, at 117. Can GHMSI confirm that the applicable order is Exhibit 15 of GHMSI's pre-hearing report? What steps has GHMSI taken to respond to this? Is the company under similar order to increase surplus for CFMI? If yes, what steps have been taken to respond to that?

9. At several instances in its testimony GHMSI made comparisons to other Blues plans, yet GHMSI advised Rector that a peer analysis would not be helpful. Please explain then why the analyses you cite are probative.

Suggested Questions for Rector/FTI

1. Mr. Toole of FTI testified that his assumptions in the model are based on exactly what he thought would happen. Transcript, at 29. Does this mean that for premium growth, equity portfolio, and rating adequacy, FTI's assumption for each of these at the 50% probability level reflects its best estimate of what would actually happen with regard to each of those factors? What was FTI's best estimate for each of these three factors as reflected in the model? How do 2013 actual results compare to these assumptions?

2. In his testimony, Mr. Toole stated that FTI built its own model to validate the results from the Milliman model. Transcript, at 20.
    a. Please clarify whether this validation was in reference to the pro forma model or the stochastic model (or both)?
    b. Please confirm that FTI did not validate any assumptions used by Milliman and instead served only to confirm that the Milliman model produced the types of results that would be *expected* given the chosen assumptions?

3. Rector testified that that the Court of Appeals decision "requires GHMSI to engage in community health reinvestment *right up to the edge* of where doing more would present an inappropriate risk of GHSMI becoming financial unsound or inefficient." Transcript, at 31 (emphasis added). How does Rector reconcile the requirement that GHMSI invest "right up to the edge" of becoming unsound, with the $165 million range around the estimated surplus target? If GHMSI is permitted to have surplus that is $82.5 million above target surplus, does this not necessarily show that GHMSI is not investing in community health "right up to the edge" of becoming unsound?

Thank you for your consideration.

Sincerely,

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