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November 7, 2014

The Honorable Chester A. McPherson, Acting 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 Acting Commissioner McPherson:

Pursuant to Order No. 14-MIE-005, please find enclosed an original and two copies of DC Appleseed's rebuttal filing in the matter of Surplus Review and Determination for Group Hospitalization and Medical Services, Inc. (GHMSI).

Our filing consists of two documents: a rebuttal by DC Appleseed as well as a rebuttal from Mr. Mark Shaw, Senior Consulting Actuary at United Health Actuarial Services, Inc.

We appreciate the opportunity to present our views for your consideration.

Sincerely,

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Enclosures

Rebuttal Statement

*D.C. Department of Insurance, Securities and
Banking: Surplus Review of Group Hospitalization and
Medical Services, Inc. (“GHMSI”)*

Filed by DC Appleseed Center for Law & Justice
November 7, 2014

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EXECUTIVE SUMMARY

The Proceeding Before the Commissioner

When the D.C. Council passed the Medical Insurance Empowerment Amendment Act (MIEAA) in 2009, its “primary motivation” was to ensure that Group Hospitalization and Medical Services, Inc. (GHMSI) complies with its “community health reinvestment obligation.” *D.C. Applesseed Ctr. for Law & Justice v. D.C. Dep’t of Ins., Secs., & Banking*, 54 A.3d 1188, 1214 (D.C. 2012). That obligation is “a crucial factor in judging whether a surplus is ‘unreasonably large’ for purposes of MIEAA.” *Id.* at 1214.

In September 2012, the D.C. Court of Appeals reversed the D.C. Department of Insurance, Securities and Banking’s (DISB’s) approval of a \$687 million surplus for GHMSI, primarily on the ground that the Milliman model that DISB relied on to approve the surplus was not shown to comply with MIEAA. The Court specified three ways in which DISB had not met its burden to justify GHMSI’s surplus under the statute: (1) DISB did not explain why “it was necessary to have such high confidence levels,” *id.* at 1218, and did not “calibrat[e]” those confidence levels in light of GHMSI’s statutory obligation to engage in community health reinvestment to the maximum feasible extent, *id.* at 1219; (2) DISB took no account of the requirement that surplus must be “efficient” within the meaning of MIEAA, *id.*; and (3) DISB failed to explain the assumptions used in the model, an explanation that was particularly important in light of the model’s complexity, *id.*

The Court of Appeals remanded this matter for a redetermination of GHMSI’s permitted surplus in accordance with the opinion. *Id.* at 1220–21. On remand, DISB initiated this proceeding, to review GHMSI’s surplus as of the end of 2011. At that date, GHMSI’s surplus was \$998 million—more than \$300 million higher than the \$687 million the Court said had been improperly approved in the prior proceeding.

GHMSI’s Failure to Justify its Surplus under MIEAA

Under the standards laid down by the Court of Appeals, GHMSI’s \$998 million surplus should not be approved. GHMSI seeks to justify its surplus based on the same model it used in the previous proceeding, and it now espouses Rector’s use of that model—the “Modified Milliman Model.” But neither Rector nor GHMSI has shown that Rector’s use of the model complies with the Court’s requirements.

In fact, Rector’s use of the model fails all three of the Court’s requirements. Rector has not “calibrated” its use of a 98% confidence level to take account of the community reinvestment obligation. Rector has not explained how it derived the specific assumptions it used in the model so that the Commissioner could be confident that those assumptions meet MIEAA’s requirements. And Rector has not applied MIEAA’s “efficiency” requirement to ensure that the assumptions in the model produce a surplus designed to address reasonably probable outcomes.

As a result, Rector’s use of the Modified Milliman Model cannot be relied upon to justify GHMSI’s surplus. The same is true of Milliman’s own use of its model, as well as all the previous actuarial analyses of GHMSI’s surplus that GHMSI invokes. Because none of those

analyses complies with the Court's requirements, all of them are insufficient as matter of law to justify GHMSI's \$998 million surplus for 2011.

The June 25 testimony of Mr. Chet Burrell (CareFirst's CEO) does nothing to change that result. Although Mr. Burrell claimed the company needs such a large surplus to guard against possible contingencies, he never explained why that surplus meets the Court's three key legal requirements.

DC Appleaseed's Adjustments to the Modified Milliman Model

D.C. Appleaseed's actuarial expert, Mark Shaw, has adjusted the Modified Milliman Model to comply with the Court's legal requirements. To facilitate the Commissioner's proper "calibration" of the confidence level, Mr. Shaw's work shows the significant increases to community reinvestment made possible by small reductions in the confidence levels—reductions that do not undermine the company's financial soundness and that are in keeping with MIEAA's "efficiency" and "community reinvestment" requirements. This work also shows that small gains in the probability of avoiding 200% RBC—which all agree is the level to be avoided—become ever more costly in terms of the additional surplus that those small gains require and that subscribers must pay for.

Mr. Shaw's work also shows how Rector's assumptions in the model concerning key contingency factors should be adjusted to reflect GHMSI's actual experience and to estimate the surplus GHMSI will need to address only those contingencies that are reasonably probable—as required by MIEAA's "efficiency" requirement.

The Inherent Limits of the Modified Milliman Model

If employed in a way that complies with MIEAA, the Modified Milliman Model can assist in determining an appropriate surplus for GHMSI. But the model is only that—a model; its ability to identify the surplus that GHMSI needs to cover reasonably probable future contingencies is inherently limited and imprecise. The need to integrate model results into a larger judgment about appropriate surplus under MIEAA is underscored by Rector's admission that it never actually considered whether the 13 probability distributions that were the outputs of the stochastic model were based on reasonably probable real-life events. A model assists, but is not a replacement for, the ultimate legal judgments the Commissioner must make.

In aid of those judgments, the Commissioner should test whatever results the model produces—whether those results are produced by Rector, Milliman, or Mr. Shaw—to assess whether they reasonably reflect probable outcomes, take fair account of GHMSI's actual historical record, faithfully balance the factors MIEAA says should be considered, and adequately reflect relevant, real-life, common-sense considerations.

DC Appleaseed's Proposed Surplus

Mr. Shaw shows that when the Modified Milliman Model is adjusted to accord with MIEAA's requirements, the model calls for a surplus that is hundreds of millions of dollars lower than the \$998 million that Rector recommended and GHMSI supports. In fact, Mr. Shaw's

adjustments show that a surplus below \$400 million would be appropriate looking solely to the Modified Milliman Model and applying a properly calibrated confidence level.

Even though the corrected model, if relied on exclusively, would justify a figure below \$400 million, DC Appleaseed proposes conservatism in selecting the level of allowable surplus and therefore proposes that the Commissioner adopt a somewhat higher figure between \$400 and \$500 million. A surplus in this range takes into account a properly adjusted Milliman Model, a statistical confidence level consistent with MIEAA's efficiency requirement, and several additional, practical considerations:

First, the Modified Milliman Model used correctly shows that \$400 to \$500 million is more than adequate to protect the company from all reasonably probable contingencies.

Second, such an amount as a practical matter would be sufficient to guard against the company ever falling to 200% RBC given the interventions that both management and DISB would provide in the event of serious economic losses. The fact is, in the extremely unlikely event that GHMSI began sustaining large losses, GHMSI's management, the Blue Cross Blue Shield Association (BCBSA), and DISB would all take steps to prevent further losses. There is every reason to believe that such measures would be successful, given GHMSI's inherent strengths—dominance in the individual and small group markets, a uniquely powerful brand, territorial exclusivity in the use of that brand, and the breadth of its provider networks. A surplus above \$400 million would provide opportunity for intervention well before surplus reached any amount even approaching 200% RBC.

Third, historical experience shows that a figure between \$400 and \$500 million is more than adequate to protect the company from significant economic risk. Experience during the recent Great Recession provides a good dose of realism here: during the worst downturn in 50 years, the company's surplus actually increased. Further, the actuarial analyses have all been keyed to risks over three-year periods. Based on GHMSI's surplus changes over each three-year period beginning with 1995 and continuing through 2013, the chance of even a \$50 million loss in any three-year period is 2%, or once in every 102 years.

Fourth, a surplus of \$400 to \$500 million is consistent with the surplus that Rector's model showed in the last proceeding was appropriate for avoiding 200% RBC. Rector's analysis then showed that \$453 million would be sufficient to avoid 200% RBC with 98% confidence. Rector has been unable fully to explain the subsequent increase in its recommendation, and its partial explanations do not withstand analysis.

Fifth, and finally, it is significant that the DC Council passed MIEAA in reaction to GHMSI's failure to respond adequately to Commissioner Mirel's determination that GHMSI's surplus of \$501 was more than adequate and should be spent down. Subsequent events, and an appropriate use of the Modified Milliman Model, have confirmed the correctness of the Council's and Commissioner Mirel's determinations.

Determining the Portion of GHMSI's Surplus that is Fairly Attributable to DC

GHMSI's excess surplus should be allocated to the District, Maryland, and Virginia according to the amount that each jurisdiction contributed to surplus. Earned premiums that

derive from contracts written in each jurisdiction is an appropriate measure of contribution to surplus. Approximately 66.9% of GHMSI surplus was derived from premiums on contracts written in the District between 1999 and 2011.¹

Before determining the portion of any excess surplus that is fairly attributable to the District, the Commissioner should consult with the Commissioners of Maryland and Virginia. The Commissioner should seek through that consultation to reach consensus concerning both the amount of any excess surplus and a fair method for allocating the excess among the three jurisdictions.

If consensus cannot be reached, under GHMSI's congressional charter, it is the District's law and the District's determination on these issues that is controlling. However, the Commissioner may determine and approve the spend-down *only* of excess surplus attributable to the District. Maryland and Virginia will determine for themselves whether and how to spend down the portion of the excess surplus attributable to their respective jurisdictions.

INTRODUCTION

The purpose of this proceeding, as the Commissioner noted at the June 25 hearing, is to “determine whether GHMSI's surplus is excessive as defined by law.” June 25, 2014 GHMSI Surplus Review Hearing Transcript (“Tr.”) 5:22–23. As the Commissioner also noted, that determination “is not a simple exercise. It requires thoughtful analysis of complex facts and laws.” *Id.* 5:23–25.

The Commissioner has been presented with widely divergent conclusions by actuaries (or, in the case of Rector, by economic consultants aided by an actuary) concerning the surplus that GHMSI requires. Part of the divergence arises from the use of differing confidence levels. The expert evidence can demonstrate the consequences of this or that confidence level, but which trade-off to choose is a matter for the Commissioner to decide, applying the goals and standards of MIEAA. MIEAA brings to bear an explicit recognition by the community, through the D.C. Council, that the accumulation of surplus by this non-profit, charitable and benevolent organization must be balanced against the community health reinvestment that its mission also requires. Actuaries have neither the expertise nor the responsibility for performing this balancing, and no deference is owed to the confidence levels the actuaries have urged. (As the Commissioner is aware, Mr. Shaw did not urge a particular confidence level.) Nor, within the already high range that is at issue (90–98%) is deference owed to GHMSI itself. GHMSI has amply demonstrated, both before and after MIEAA, that it does not consider its non-profit status or charitable mission to present any distinctive or meaningful constraint on its accumulation of surplus. But the Council enacted MIEAA precisely because of this fact.

Further, MIEAA requires that the statutory purposes and standards be integrated into the actuarial analysis itself with respect to the assumptions—the probability distributions—fed into

¹ See Mark E. Shaw, *Rebuttal Report to the D.C. Department of Insurance, Securities and Banking Group Hospitalization and Medical Services Inc. MIEAA Surplus Review* 33, ch.18 (Nov. 7, 2014) [hereinafter Shaw Rebuttal].

the stochastic model. Yet the disagreements among the experts with respect to the probability distributions do not reflect equally serious attempts by each of them to apply MIEAA. Milliman and the other actuaries that GHMSI invokes did not acknowledge MIEAA at all. Rector, while professing to adhere to MIEAA, fell very wide of the mark (and never mentioned the “efficiency” standard in its initial report). For these reasons, this is not a “battle of experts” in which all of the experts conducted their analyses according to the same rules. MIEAA requires what the Commissioner and the parties are characterizing as “middle of the fairway” assumptions—assumptions that are not skewed toward extremely remote contingencies and that, instead, identify reasonably probable contingencies as realistically as possible. Only Mr. Shaw’s assumptions satisfy that requirement.

MIEAA changes the paradigm for the regulation of surplus. While preserving financial soundness as essential, it establishes that, beyond a level that reasonably ensures soundness, more surplus is not better—a fundamental point that neither GHMSI nor Milliman has acknowledged. While the missteps of the prior Commissioner resulted in an unfortunate delay of community health reinvestment and unnecessary costs for ratepayers, they also created a benefit. They secured judicial confirmation that MIEAA means what it says: the “maximum feasible” obligation must inform each step in the analysis and any watering down of MIEAA will not be permitted in the courts and may not occur at the DISB.

In this rebuttal submission, DC Appleseed makes five points that we believe must guide the Commissioner in determining whether GHMSI’s surplus is excessive and, if so, how then to proceed:

- (1) The surplus levels that GHMSI and Rector propose, and which rely on results from the Modified Milliman Model, do not meet the requirements of MIEAA and the Court of Appeals decision.
- (2) Correcting the Modified Milliman Model to comply with MIEAA and the Court of Appeals decision results in a target surplus that is dramatically lower than the level Rector and GHMSI propose.
- (3) The surplus for GHMSI that best complies with MIEAA, protects the company from reasonably probable contingencies, and reflects conservative judgment by the Commissioner is a point between and \$400 and \$500 million.
- (4) GHMSI’s surplus should be allocated to the District, Maryland, and Virginia on the basis of earned premiums based on insurance contracts written in each jurisdiction.
- (5) As a matter of law, the District’s determination controls the level of GHMSI’s permissible surplus attributable to the District, notwithstanding any finding by the Maryland or Virginia Commissioners. However, in this proceeding, the D.C. Commissioner would be requiring a spend-down *only* of the portion of the excess surplus allocable to the District, leaving Maryland and Virginia to determine whether the surplus attributable to those jurisdictions is excessive and, if so, how to spend down the excess portions.

I. THE SURPLUS PROPOSED BY GHMSI AND RECTOR DOES NOT COMPLY WITH MIEAA.

Based on the results from the Modified Milliman Model,² Rector has proposed that the Commissioner approve a “target” surplus for GHMSI of 958% RBC for the 2012–2014 period, and a permissible surplus range of 875%–1040% RBC for that period. GHMSI expressly supports Rector’s proposal on two grounds: it argues that all the previous actuarial analyses (including Rector’s) confirm the appropriateness of that surplus range and Mr. Burrell believes the company is facing future uncertainties and therefore needs such a large surplus.

To address Rector’s and GHMSI’s position on these issues, we show in this section that (1) GHMSI’s surplus must meet MIEAA’s requirements as interpreted by the Court of Appeals; (2) none of the actuarial studies relied on by GHMSI (including Rector’s) complies with those requirements; and (3) the arguments made by Mr. Burrell do not justify the surplus under those requirements. In Section II, we show how the Modified Milliman Model should be corrected to comply with MIEAA and the Court of Appeals decision.

A. GHMSI’s Surplus Must Be Shown to Satisfy the “Maximum Feasible” Standard

MIEAA obligates GHMSI to engage in community health reinvestment to the “maximum feasible extent consistent with financial soundness and efficiency.” GHMSI contended in the 2009 proceeding that the maximum feasible standard does not apply unless and until the Commissioner makes a prior determination, without regard to that standard, that GHMSI’s surplus is “unreasonably large.” GHMSI based this assertion on D.C. CODE § 31-3506(e)(2), which provides that surplus may be found to be “excessive” only if “the Commissioner determines that the surplus is unreasonably large and inconsistent with” GHMSI’s obligation to engage in community reinvestment to the maximum feasible extent.

The Court of Appeals roundly rejected this reading of the statute. It said:

Viewing the language of the statute as a whole, and considering its legislative history and purpose, we hold that, as a matter of law, the two determinations . . . —whether GHMSI’s surplus is “unreasonably large” and whether the surplus is “inconsistent” with GHMSI’s community health reinvestment obligations . . . — must be made in tandem, not *seriatim*, to give full effect to the statute.”

D.C. Appleseed, 54 A.3d at 1215. “Unreasonably large” and “maximum feasible” “are not only interrelated, but mirror each other.” *Id.* at 1214. It was legal error for the prior Commissioner to have “divorced these two determinations.” *Id.* at 1215.

Thus, there is no step in the proper application of MIEAA that does not integrate the components of GHMSI’s statutory obligation: “maximum feasible,” “financial soundness,” and

² The Modified Milliman Model is the Milliman model with the adjustments described in the December 9, 2013 Rector Report.

“efficiency.” This obligation affects each essential step in the application of MIEAA: the choice of confidence level; the approach to assumptions; the recognition that there is a point at which financial soundness is achieved, and beyond that point, the higher-valued use of surplus is for community reinvestment; and the ultimate judgment as to a compliant surplus. In order to implement this obligation, (a) the Commissioner must realistically “calibrate” the confidence level in light of the consequences of falling below the chosen floor (here, 200% RBC) and in light of the trade-offs between small changes in the confidence level and large changes in the amounts available for community reinvestment; (b) the probability distributions used in the stochastic modeling and pro forma modeling must be as realistic as possible—what the Commissioner, we, and Rector have characterized as “middle of the fairway”; and (c) there is a need for judgment to be superimposed on the results of any model, to take into account common-sense, real-life considerations that bear on what is feasible and to ensure a fair and practical implementation of the MIEAA standards.

As we now show, notwithstanding the Court’s in-tandem holding, GHMSI and Milliman have once again argued as if the Commissioner can simply adopt their estimation of a reasonable target surplus range, without regard to whether that range was estimated by first taking into account MIEAA’s community reinvestment and efficiency requirements. And Rector, while it acknowledged those requirements, did not in practice apply them.

B. None of the Actuarial Studies That GHMSI Invokes—including Rector’s—Complies with MIEAA

At the June 25 hearing, GHMSI repeatedly claimed that a number of previous actuarial analyses—not only Rector’s and Milliman’s but those done for the Maryland Commissioner—all confirmed that GHMSI’s surplus is not excessive. But, because these analyses do not comply with MIEAA as interpreted by the Court of Appeals, the Commissioner cannot rely on them in this proceeding.

As the Commissioner noted at the hearing in response to statements made by Mr. Burrell, GHMSI’s surplus has been the subject of multiple reviews, but “we also have to acknowledge that we’d only gotten legal clarity in 2012 from the DC Court of Appeals as to how to apply the legal standard.” Tr. 301. The Commissioner further indicated that “we may have to[] . . . look at this from a new perspective, at least from a perspective of the court’s decision” Tr. 302.

As the Commissioner’s comments suggest, *none of the reviews* GHMSI cites considers the factors the Court said in 2012 had to be taken into account: First, the surplus reviews do not calibrate the confidence level in light of the “maximum feasible” standard; second, their probability distributions do not conform to the “efficiency” requirement; and third, they do not clearly set out the basis for the assumptions underlying their work. We discuss these three points below. Then in Section II we discuss how the model should be adapted to meet the Court’s requirements. And in Section III, we state our conclusion concerning the proper surplus level.

1. *The Studies Cited by GHMSI Fail to Calibrate the Confidence Level In Light of the “Maximum Feasible” Obligation*

Put simply, the Court of Appeals instructed the Commissioner to consider the “maximum feasible” community investment obligation when determining whether GHMSI’s surplus is “unreasonably large.” The Court of Appeals expressly held that those standards must be applied “in tandem.” And the “maximum feasible” obligation in turn requires “*simultaneous consideration* of the requirement to engage in community reinvestment to the ‘maximum feasible extent’ consistent with ‘financial soundness and efficiency.’” *D.C. Appleseed*, 54 A.3d at 1218 (emphasis added). None of the surplus reviews that GHMSI relies on has applied these standards.

Milliman. Milliman conceded during the 2009 hearing that it had taken no account of the MIEAA factors.³ In its May 31, 2011, evaluation, Milliman followed the same approach as in 2009 and again took no account of MIEAA. And when it filed an updated evaluation with DISB on July 1 of this year—even though the Court made clear that Milliman’s method of assessing surplus does not comply with MIEAA—Milliman again made no changes to their method and made no mention of either MIEAA or the Court’s 2012 decision. As a result, Milliman commits again the same error it made in the last proceeding and that the Court of Appeals rejected as legally unsound—“divorc[ing]” the unreasonably large determination from the “maximum feasible” obligation. As a result, Milliman has never performed the required “in tandem” analysis at all, much less performed it in compliance with the Court’s directions.

Maryland. Neither do the analyses carried out for the Maryland Commissioner or by Rector consider the requirements of D.C. law. The analyses carried out for the Maryland Commissioner applied a Maryland statute that contemplates only whether a surplus is “unreasonably large;” none of those analyses considered either the “maximum feasible” or the “efficiency” requirements of MIEAA.

Rector. While Rector asserted that it had complied with the Court’s legal standard,⁴ in practice its analysis did not achieve compliance. Instead, like Milliman, Rector essentially followed *the same approach* in this proceeding that it used in the 2009 proceeding—an approach the Court of Appeals found insufficient as a matter of law to comply with MIEAA.

Specifically, the Court said that both the Milliman and Rector analyses—using the same methods as in their current analyses—were inadequate in that they gave “no consideration” to “calibrating the level of confidence” in light of the “maximum feasible” obligation. *D.C. Appleseed*, 54 A.3d at 1218–19. In fact, the Court was explicit in pointing out that “[t]he Commissioner’s own expert, Rector, did not . . . characterize the RBC-ACL ratios it determined as ‘acceptable’ or ‘optimal’ in light of this obligation.” *Id.* at 1219 n.42 (emphasis supplied). Nor

³ Tr. 197, *In the Matter of Surplus Review and Determination Re: Grp. Hospitalization and Med. Servs, Inc.* (D.C. Dep’t of Ins., Secs., & Banking Sept. 10, 2009) [hereinafter 2009 Tr.].

⁴ In its August 27 response to the Commissioner’s questions, Rector agreed “that the Commissioner needs to take the community reinvestment requirement into account when calibrating the confidence level.” And Rector said that “we vigorously disagree that we did not do so in our work.” Rector & Assocs., Questions for/Information Requested from Rector 25 (Aug. 27, 2014) [hereinafter Rector Aug. 27, 2014, Response].

did Rector specify “how surplus and community reinvestment are to be calculated and balanced.” *Id.* at 1215.

We acknowledge that Rector cited the community reinvestment requirement in its report. But that is not the same thing as *calibrating the confidence level and integrating the maximum feasible obligation as required by the Court.*

The fact that Rector did not do what the Court required became clear at the June 25 hearing. Rector explained that it first picked the RBC levels to be avoided (200% or 375%), it then picked confidence levels for avoiding those levels (98% or 85%), and then:

If GHMSI has more surplus than what is needed to meet those probabilities, then in our view it’s not giv[ing] to the maximum feasible extent and has excess surplus. If GHMSI has less surplus than what is needed to meet those probabilities, it has given more than the maximum feasible extent.

Tr. 43.

Subsequently, the Commissioner asked Rector: “did you consider the Court of Appeals’ requirement for the determination to be made in tandem—the surplus attributable to the District not being unreasonably large and inconsistent, and also the community health reinvestment to the maximum feasible extent feasible with financial soundness and efficiency?” Tr. 78.

In response, Rector reaffirmed that what it did was “look for, again, that number—the target number where if the company has surplus above that number, in our judgment, it is not giv[ing] to the maximum feasible extent.” Tr. 79.

In other words, Rector has simply done again what it did in 2009—it first calculated the appropriate surplus *without regard to the maximum feasible obligation.* It then concluded that so long as GHMSI achieves that surplus it has met that obligation.

This, of course, is what both Rector and Milliman did in the previous proceeding and it is precisely what the Court of Appeals rejected. It does *not* meet the Court’s “in tandem” requirement—that permissible surplus must be calculated in light of—*in tandem with*—the community reinvestment requirement. It does not meet that requirement because it fails to *calibrate the confidence level in light of the community reinvestment obligation.* And it does not meet the requirement to balance the surplus against that obligation: by using the same “virtual certainty” 98% confidence level that Milliman has always used, Rector *took no account of the community reinvestment requirement in continuing to use that level.*

Notwithstanding all of this, in its September 5 response to the Commissioner’s questions GHMSI asks the Commissioner to uphold the very approach the Court of Appeals has already specifically rejected. GHMSI contends that it “fully reinvests in the community when it keeps an actuarially sound level of surplus.” GHMSI Response to DISB’s Third Scheduling Order 1 (Sept. 5, 2014) [hereinafter “GHMSI Sept. 5, 2014 Response”]. GHMSI goes on to say that it meets its community reinvestment obligation “when it maintains its surplus at or below the target produced by a fair, unbiased actuarial analysis conducted using sophisticated actuarial models—

the same methods that have been used to gauge an insurer's financial soundness *both before the MIEAA and since*, in this jurisdiction and elsewhere.” *Id.* at 2 (emphasis added).

This is an astonishing statement. It is as if MIEAA had never been enacted and the Court of Appeals had never ruled. Of course any actuarial model that plays a role in the Commissioner's ultimate judgment under MIEAA should be fair and unbiased, and the more sophisticated the better. (As Mr. Shaw shows, Milliman's and Rector's analyses are in fact biased toward remote risk.) But the law does not say that any result reached by such a model in and of itself satisfies MIEAA. The law is not met by GHMSI simply developing a target surplus derived from “a fair, unbiased actuarial analysis using sophisticated actuarial models.” No matter how sophisticated the model may be, if, as the Court of Appeals explained, the confidence level used in the model does not meet MIEAA's in-tandem requirement (which includes a proper calibration in accordance with the “maximum feasible” obligation) and the assumptions fed into the model do not otherwise comply with the Court's standards (which is the case with Rector, Milliman, and the other analyses GHMSI relies on) the surplus produced by the model is *invalid as a matter of law*.

Because neither Rector, nor Milliman, nor any of the other actuarial analyses has performed the calibration that, among other things, takes account of the impact of an extremely high confidence level on community reinvestment as the Court required, none of the analyses meets the governing legal standard.

The Commissioner should do that calibration now. In fact, Rector acknowledged at the June 25 hearing that the Commissioner should make the determination concerning the appropriate confidence level, and Rector said: “There are no right or wrong answers [regarding the selection of the confidence level]. It's a matter of judgment, and, ultimately, it's a matter of the Commissioner's judgment.” Tr. 35. Rector also said that the Commissioner might select a different confidence level from 98% “as a matter of public policy.” *Id.* at 41.

We agree that the choice of confidence level is entrusted to the Commissioner and not to actuaries, but we do not agree that there “are no right or wrong answers” regarding the selection of the confidence level. And the “public policy” to be applied in selecting that level is established in MIEAA and the Court's decision: the confidence level must be calibrated in light of the community reinvestment obligation in order to meet the “in tandem” requirement of the Court's decision. We address how we think the Commissioner should do this calibration in Section II below; here our point is that none of the previous actuarial analyses—including Rector's most recent analysis—complies with the legal standard.

2. *The Studies Cited by GHMSI Fail to Apply the “Efficiency” Standard*

As we have noted, the in-tandem holding requires integration of the “maximum feasible” obligation in all aspects of the analysis. That obligation in turn requires “simultaneous”

consideration of the “efficiency” standard. Rector, Milliman, and the other analyses fail to meet that standard.⁵

The Court of Appeals reversed the 2010 DISB decision in part because that decision’s “overriding concern appears to have been with financial ‘soundness’ without any discussion of the statute’s *equal focus* on ‘efficiency.’” *D.C. Appleseed*, 54 A.3d at 1219 (emphasis added). The Court was explicit that “the statute’s reference to efficiency adds another consideration to be taken into account in the Commissioner’s determination of what constitutes an ‘unreasonably large’ or ‘excessive’ surplus.” *Id.* at 1219 n.43.

And yet, none of the analyses done to date has taken the efficiency factor into account—not Rector in its December 2013 report; or Milliman *ever* (including in its analysis submitted to DISB on July 1 of this year); or the analyses done in Maryland, which consider only the Maryland statute.

When Rector belatedly attempted to address MIEAA’s efficiency requirement, it was apparent that Rector did not apply that requirement in the context of the statute and the Court’s decision. At the June 25 hearing, Rector testified that:

Our December report highlighted the ‘financial soundness’ phrase consistent with the fact that the bulk of our report contained the financial results calculated pursuant to the projection amount. However, we also concluded that GHMSI could adhere to the RBC surplus target and benchmark set out in our report without becoming inefficient.

Tr. 33.

Perhaps recognizing that this conclusory statement would be insufficient to constitute the “efficiency” *analysis* required by the Court’s decision, Rector went on to say that: “In that regard, we also were aware that GHMSI now is subject by law to certain medical loss ratio requirements that would cause it to return a portion of its surplus to subscribers if it does not operate within the legal limits of efficiency set out in the law.” Tr. 33.

Associate Commissioner Barlow followed up on the latter point and asked Mr. Rector whether he believed that MLR “is a measure of efficiency or the measure of efficiency.” Mr. Rector responded that “I would say a measure of efficiency would be how I would describe it. It is a statutory measure of efficiency.” Tr. 76.

⁵ In our Pre-Hearing Report, we explained that, if “a risk does not exist, or is extremely remote . . . the benefit of avoiding it is at or close to zero. Accordingly, community health reinvestment is the higher-valued use for these dollars under the MIEAA priorities [adopted by the Council]. Their unnecessary diversion to surplus would violate the ‘efficiency’ standard and deny the District ‘feasible’ community health reinvestment.” *D.C. Department of Insurance, Securities and Banking: Surplus Review of Group Hospitalization and Medical Services, Inc.* 18 n.11 (June 10, 2014) [hereinafter DC Appleseed Pre-Hearing Report]. “Unrealistic probability distributions and financial projections will yield surplus levels that violate the ‘efficiency’ standard because they result in projections of surplus that are higher than is reasonably necessary for financial soundness.” *Id.* at 21.

We agree that MLR is a statutory measure of operating efficiency under the ACA that GHMSI must comply with going forward. But *it has nothing to do with the “efficiency” requirement the Council adopted in 2008 to govern the surplus that GHMSI has built up over the last two decades.* The ACA MLR standard is designed to ensure that the company is providing value to its subscribers with respect to the revenues it devotes to meeting medical claims. In contrast, as we explained in our June 10 pre-hearing brief and referenced in our June 25 testimony, MIEAA’s “efficiency” requirement applies to accumulated surplus and requires that that surplus be sufficient to cover *reasonably probable* future contingencies. *See Public Hearing to Review the Surplus and Community Health Re-Investment of GHMSI Before the D.C. Dep’t of Ins., Sec. & Banking* 6 (June 25, 2014) (Testimony of Walter Smith, Exec. Dir., DC Appleseed) [hereinafter “DC Appleseed Testimony”]; DC Appleseed Pre-Hearing Report 23.⁶

Yet, as Rector made clear at the June 25 hearing, that is *not* the approach it took in using the Milliman model. Instead, Rector testified that “the scenario we’re seeking to protect against . . . would be one where GHMSI were to lose approximately \$700 million in surplus in just three years.” Tr. 38–39. Accordingly, as Rector explained in its December Report, “the assumptions that [it] used in the modeling process take into account extremely adverse events that could occur, including the possibility that multiple adverse events could occur simultaneously.”⁷ Rector & Assocs., *Report to the D.C. Dep’t of Ins., Sec. & Banking: Grp. Hospitalization & Med. Servs., Inc.* 2, 13 (Dec. 9, 2013) [hereinafter “Rector Report”]. That is the same approach Milliman and all the other actuarial analyses took. And because none of them estimates the surplus needed to address reasonably probable contingencies, *all of them fail to meet MIEAA’s “efficiency” requirement.*

Belatedly, and perhaps because it now realizes that none of the analyses it relies on meets the “efficiency” requirement, GHMSI appears to have produced a new theory for the efficiency

⁶ As we addressed in our June 10 pre-hearing brief, MIEAA requires a distinction between “reasonably probable” and “extremely remote” contingencies. DC Appleseed Pre-Hearing Report 23. This distinction does not categorically preclude ever including a low probability loss in a probability distribution. Mr. Shaw, for example, includes two contingencies for which the probabilities are 3.6% and 5%. *See* Mark E. Shaw, Report to the D.C. Dep’t of Ins., Sec. & Banking, Surplus Review of Grp. Hospitalization & Med. Servs., Inc. 17 tbl., 26 ch.9 (June 10, 2014) [hereinafter “Shaw Report”]. In such instances, it is the magnitude assigned to the probability that becomes critical in avoiding risk-inflation violative of the “efficiency” standard. A contingency may be too remote because of either the probability or the magnitude assigned to it. We note that the ultimate choice of confidence level is a wholly separate question from the proper construction of the probability distributions that generate the stochastic results from which the confidence level is chosen. Both steps in the analysis, however, must reflect the MIEAA standards and balancing. A confidence level (98%) that protects against a 2% risk of falling to 200% RBC addresses a contingency that is too remote, even if the magnitude of the loss at that percentile was generated by reasonable probability distributions (and Rector’s probability distributions were not reasonable).

⁷ While Mr. Shaw, like Rector, assumes some loss outcomes to which he assigns low probabilities, his assumptions are consistent with the efficiency standard. That is, they are within the range of “reasonably probable” outcomes: either they directly reflect the historical record or they are departures from the historical record that are explicitly justified and explained. Thus, they are within the range of “reasonably probable” outcomes. Rector, on the other hand, assumes loss outcomes that are “extreme,” have no basis in the company’s actual experience, and are not otherwise justified.

requirement in its September 5 filing, and a new justification for Rector’s failure to apply the requirement in the Modified Milliman Model. GHMSI now argues that “efficiency” should be construed as “a cap on the Company’s reinvestment obligation,” rather than “a limit on GHMSI’s surplus.” GHMSI Sept. 5, 2014 Response, at 3–4. There are several answers to GHMSI’s new argument.

First, the argument is inconsistent with the Court’s decision. As the Court said, “the statute’s reference to ‘efficiency’ adds another consideration to be taken into account in the Commissioner’s determination of what constitutes an ‘unreasonably large’ or ‘excessive’ surplus.” *DC Appleseed*, 54 A. 3d at 1219 n.43 (emphasis added). In other words, “efficiency” must be taken into account in determining whether a surplus is “excessive”—rather than in setting “a cap on the Company’s community reinvestment obligation,” as GHMSI now says.

Furthermore, it is not clear what difference GHMSI thinks its new distinction makes. Provided “efficiency” is properly defined and applied, it will effectively set a limit on surplus *and* a limit on the maximum feasible amount available for community reinvestment. In other words, allowing community reinvestment but only so long as surplus is at an efficient level, or limiting surplus to an efficient level in order to allow for community reinvestment is the same exercise: in both cases the Commissioner will be asked to determine whether surplus is at an efficient level.

Moreover, under either reading, the probability distributions used in the model must be “efficient” in that they guard against reasonably probable outcomes; if instead they rely on improbable or remote outcomes, they will produce an “inefficient” surplus and one that is “unreasonably large,” D.C. CODE § 31-3506(e); the result will be to inflate surplus with dollars that could in fact “feasibly” be directed to community health reinvestment, and that must be so directed in order to comply with the directive to engage in such reinvestment to the “maximum feasible extent.”⁸

GHMSI does not suggest, nor could it possibly do so, that its reading somehow means that the Commissioner should ignore probability distributions that depart from relevant history and skew toward inflated risk without strong justification. Probability distributions must be based on reasonably probable outcomes. The prohibition of “unreasonably large” surplus and the requirement for “maximum feasible” community reinvestment “mirror each other.” *D.C. Appleseed*, 54 A.3d at 1214. The Court’s interpretation of “efficiency” requires that reasonable probabilities be taken into account in determining whether the surplus is “unreasonably large.”

Finally, this interpretation of “efficiency” is consistent with the approach taken in Pennsylvania. As we discussed in our Pre-Hearing Report at pages 19–20, the D.C. Council very much had in mind Pennsylvania’s concept of “efficiency” as applied to Blues *surplus*. And that

⁸ In its Pre-Hearing Report, DC Appleseed discussed the criteria for probability distributions in its discussion of the “efficiency standard.” DC Appleseed Pre-Hearing Report 18. DC Appleseed recognized, however, that the “maximum feasible” standard also bears on the probability distributions. *See id.* at 18 n.11 (surplus dollars that reflect inflated risks “would violate the ‘efficiency’ standard, and deny the District ‘feasible’ community health reinvestment”).

concept embraced the diminishing marginal utility of surplus dollars when they are retained against unduly remote risks. That concept applies squarely to the probability distributions at issue in this case and, accordingly, to the surplus levels that such distributions generate.

Ironically, as we pointed out at the June 25 hearing, we and GHMSI agree on general language that may be used to define MIEAA's requirement for "soundness and efficiency." Tr. 194–195:4. In its June 10 pre-hearing brief, GHMSI defined "soundness" as avoiding "reasonably foreseeable undue risk to the institution" and defined "efficiency" as ". . . serving of a purpose or performance of a task in the best possible manner" GHMSI, *Pre-Hearing Brief: DISB Review of GHMSI Surplus Pursuant to the Medical Insurance Empowerment Amendment Act of 2008, D.C. Code § 31-3501, et seq.* 14, 15 (June 10, 2014) [hereinafter GHMSI Pre-Hearing Brief].

However, neither Milliman nor Rector nor the other actuarial analyses calculated surplus in a manner consistent with those definitions. In our view, and as we said at the June 25 hearing, applying GHMSI's own definitions to the Modified Milliman Model would require adopting the approach of the Pennsylvania decision; that decision provided that an efficient Blue maximizes community reinvestment by ensuring that its surplus is calculated to guard against reasonably foreseeable contingencies—not remote, extreme ones.

Perhaps realizing the implications of its own definition of efficiency, GHMSI cast that definition in a startling new light in its September 5 filing. It contends that the approach to "efficiency" we have proposed "amounts to an argument that the Commissioner should ignore risks to the Company, and paint a factually distorted and unduly rosy future for GHMSI, for the sole purpose of forcing GHMSI's surplus down below what a responsible actuarial analysis would require." GHMSI Sept. 5, 2014 Response, at 27. This is patently untrue—and in fact, the exact opposite is the case.

MIEAA establishes that the way to protect subscribers efficiently is to protect them from reasonably probable risks and not allow GHMSI to continue to collect premium dollars to protect against artificially inflated, extremely remote risks. What we have proposed throughout this proceeding is that (1) a "responsible actuarial analysis" must apply MIEAA as interpreted by the Court of Appeals; and, (2) in order to accord with MIEAA's "efficiency" requirement, that analysis must adopt assumptions—probability distributions—that are as realistic as possible; the middle-of-the-fairway projections that cover reasonably probable risks but not more than that. This is *not* what Milliman, Rector, or the other actuarial analysts have done and therefore the Commissioner cannot rely on the results of their analyses—including Rector's conclusions from the Modified Milliman Model.⁹

⁹ At the June 25 hearing, GHMSI seemed to suggest that the MIEAA "efficiency" requirement is not, as the Court said, an element to be considered in determining whether the surplus is "unreasonably large," but instead relates only to market disruption from rate actions by GHMSI to reduce excess surplus. Tr. 294:15–20. But this could not possibly provide "equal focus" and weight with the central consideration of "financial soundness." Nor could it provide a measure of whether the surplus is in fact "unreasonably large." Moreover, the market disruption that GHMSI invokes could arise even in theory only if GHMSI adopted a spend-down plan consisting of rate reductions, (and the Commissioner approved the plan as "fair and equitable.") It is a completely unreasonable reading of the

In Section II, we address how the efficiency requirement should be met. Here our point is that GHMSI's heavy reliance on Milliman, Rector, and those other analyses misconstrues or otherwise ignores MIEAA's efficiency requirement.

3. *The Studies Cited by GHMSI Fail to Explain the Assumptions*

In addition to requiring that the Milliman model comply with the substantive requirements of MIEAA, the Court of Appeals set an additional bar for the Commissioner in this case, stating that use of the Milliman model, or any model, must be “fully and clearly explained.” *D.C. Appleseed*, 54 A.3d at 1216. Furthermore, the Court noted that “[t]he more technical and complex the subject matter, the more explanation the agency ought to provide for its decision.” *Id.* at 1217.

The Commissioner rightly observed at the hearing that “the issues surrounding this proceeding are complex.” Tr. 12. Because of this complexity, “the agency must sufficiently explain the assumptions and methodology used in preparing the model” and it has “the burden to consider all relevant factors and to identify the stepping stones to its final decision.” *D.C. Appleseed*, 54 A.3d at 1217 n.38 (quoting *Sierra Club v. Costle*, 657 F.2d 298, 333 (D.C. Cir. 1981)).

The Commissioner, however, cannot use the information supplied by Milliman and Rector to meet his obligation to explain because neither Milliman nor Rector has “fully and clearly explained” the factual bases for their assumptions or provided the “stepping stones” to their decisions.¹⁰ Shaw Rebuttal 1. Rather, both Milliman and Rector have simply listed the general information they considered and the probability distributions they used in the model. But neither has offered details about the specific information they relied on for any of the three key factors that have the biggest impact on output from the model, nor have they explained the stepping stones between that specific information and the probability distributions they used. And this is so even though, as will be shown, the Commissioner asked follow-up questions asking that this information be provided.

As Rector indicated at the June 25 hearing, other than the selection of the confidence level, the three factors in the model that had the biggest impact on its surplus recommendation were: (1) rating adequacy and fluctuation; (2) equity portfolio asset values; and (3) premium growth. Tr. 72. Indeed, Mark Shaw's June 10 pre-hearing statement confirmed that these three

statute to conclude that, when the D.C. Council adopted the “efficiency” standard as a central element in the statutory test, it intended that the standard come into play only in the remedial phase, and only then in the event of a contingent circumstance that would be of GHMSI's choosing.

¹⁰ Recognizing that this information would be necessary for the Commissioner to reach a reasoned decision, we have consistently requested that Rector explain the bases for the assumptions entered into the Milliman model. *See, e.g.*, Letter from Walter Smith, Exec. Dir., DC Appleseed Ctr. for Law & Justice, et al., to the Honorable Chester A. McPherson, Comm'r, D.C. Dep't of Ins., Secs. & Banking, Attachment A, at 1 (Jan. 29, 2014) (requesting documents used by Rector to determine probability distributions (probabilities and magnitudes) associated with each risk and contingency factor). Rector provided the probability distributions associated with each risk factor, but never disclosed *how* it derived these probabilities and magnitudes.

factors are the most important. Shaw Report 3–4. However, as explained below, both Rector and Milliman failed the Court’s standards for “fully and clearly” explaining how they used those factors to justify their recommendations.

a) Rating Adequacy and Fluctuation

Rating adequacy and fluctuation factor (RAAF) is used in the model to assess “the risk that actual claims and expenses differ from the amounts for which provision is made in premium rates.” Milliman, *CareFirst, Inc., Group Hospitalization and Medical Services, Inc.: Development of Optimal Surplus Target Range 15* (May 31, 2011) [hereinafter Milliman May 31, 2011, Report]. We agree with Milliman and Rector that “modeling choices relating to [RAAF] are crucial in the methodology used to select a loss outcome.” Rector Report 21. We also agree that surplus should be assessed with an eye toward protecting against the risk of inadequate rates, and that any *genuine* constraints imposed by the ACA should be taken into account in assessing that risk. And precisely because this factor can have a substantial impact in the model, significantly increasing the estimated need for surplus, it is important that the basis for the factor be thoroughly justified and explained (as the Court required). But neither Milliman nor Rector did this.¹¹

Instead, Milliman and Rector have simply stated, in a conclusory fashion, the probability distributions they used in the model. *But the Commissioner cannot assess their reasonableness or the reasonableness of the assumptions underlying them unless Milliman and Rector identify the specific data they relied on, how those data were used, what assumptions were derived from those data, and how those assumptions were translated into the probability distributions fed into the model.* None of this has been provided.

Milliman’s only justification for its probabilities was that they were “based on historical data, our observations of similar results in combination with our work at various BlueCross and BlueShield plans, interpretation of that in light of the current and anticipated future operating environment of GHMSI, and professional judgment.” Letter from Phyllis A. Doran, Principal & Consulting Actuary, Milliman, to Jeanne Kennedy, Vice Pres. & Treasurer, CareFirst BlueCross BlueShield 2 (Feb. 27, 2014) [hereinafter Doran Feb. 27, 2014, Letter]. And further, Milliman stated that: it “relied on data and other information provided by CareFirst” and that it had not “audited or verified this data and other information.” *Id.* This plainly is an insufficient basis to justify Milliman’s RAAF probability distributions under the standards established by the Court.

The same is true of Rector. Rector has stated only that “the values and probabilities for the model’s risk and contingency categories were determined based on a number of factors that required Rector to exercise actuarial judgment” and that “*it is not feasible or appropriate to quantify the reasons behind our revisions to the rating adequacy and fluctuation factor.*” Letter from Chester A. McPherson, Interim Comm’r, D.C. Dep’t of Ins., Secs. & Banking, to Walter Smith, Exec. Director, DC Applesseed Ctr. for Law & Justice 27 (Apr. 1, 2014) (emphasis added).

¹¹ In Section II.B., we discuss why the probability distributions in the Modified Milliman Report do not in fact provide middle-of-the-fairway inputs for the stochastic model.

While Milliman and Rector apparently believe it is enough that they “exercised their actuarial judgment” on the basis of a number of broad categories of data—including unidentified CareFirst data that they did not audit or verify—the Court could not have been clearer that this is insufficient. In order for the Commissioner to rely on the results from the Milliman model, he must thoroughly explain both the assumptions in the model and why he found them reasonable. He cannot possibly do that if he does not know what those assumptions are and how they were derived.

If a private company wants to rely on such unexplained advice for its own private dealings it may of course do so; but this is a public proceeding, concerning hundreds of millions of dollars of public assets, the disposition of which must be governed by a well-documented decision of a public agency. As we noted in our June 10 pre-hearing report, Rector itself explained in the 2009 proceeding why the data from Milliman and Rector were inadequate. D.C. Applesseed Pre-Hearing Report 29. As Rector said, referring to Lewin’s work in that proceeding, the Lewin Report “did not contain sufficient actuarial detail . . . to determine exactly what the Lewin Group did or what its key assumptions were. In other words, in many ways, [its] report was a ‘black box.’” Rector & Assocs., Inc., *Rebuttal to Sept. 3, 2010 Supplemental Report on Effects of Federal Health Care Reform as Submitted by Group Hospitalization and Med. Services, Inc.* 5 (Sept. 20, 2010) (emphasis added) [hereinafter Rector 2010 Rebuttal]. The same is true of Rector and Milliman in this proceeding.

The Commissioner has, in post-hearing questions, asked Rector to further explain its work. Specifically, with regard to each of the thirteen factors Rector used in the Modified Milliman Model, the Commissioner asked Rector to (a) describe “how you arrived at the conclusion that the probability distribution and associated surplus impacts were reasonable and ‘middle of the fairway’ assumptions”; (b) describe “the specific data relied upon in reaching this conclusion”; and (c) describe “any validation tests you ran for specific assumptions and the outcome of those tests.” Third Scheduling Order, *In the Matter of Surplus Review & Determination for Grp. Hospitalization & Med. Servs., Inc.*, Order No. 14-MIE-005 exh. A, at 2 (D.C. Dep’t of Ins., Secs. & Banking Aug. 7, 2014) [Third Scheduling Order].

The information the Commissioner is seeking is precisely what is needed to meet the Court of Appeals’ requirements. But unfortunately, Rector has not provided it. Rather, regarding the critical RAAF factor, Rector has *never* explained how it concluded that its probability distribution was reasonable and middle of the fairway. Instead Rector said only that it (1) “analyzed the probability distributions for each of the 13 factors”; (b) “revised the probability distributions that Milliman used for four of the 13 factors”; and (c) “took into account GHMSI’s historical experience,” as well as “credible industry data” and “anticipated future trends.” Rector Aug. 27, 2014, Response 5.

With regard to the specific data relied upon, Rector added only that the RAAF factor “incorporates a number of different variables” including “standard trend deviation,” “the HCI

index,” “GHMSI’s historical experience and industry data,” and “the effect of healthcare reform.” *Id.* at 6.¹²

And as to validation, Rector stated that it conducted validation testing but never cited any data it used for that testing and never responded to the Commissioner’s request to explain the outcome of that testing. Rector Aug. 27, 2014, Response 10–11. Instead, Rector offered only the conclusory statement that it “validated the Modified Milliman Model in a manner that demonstrated a reasonable distribution and that considered an appropriate dispersion of results.” *Id.* at 23. Yet nowhere in FTI’s February 7, 2014, memo, which explains Rector’s validation approach, did FTI mention evaluating “dispersion of results.” In fact, that memo did not indicate that Rector even validated the baseline assumptions for each factor in the stochastic model, but that it incorrectly validated only with respect to the median. *See* Shaw Report, 45–47.

These responses plainly did not answer the Commissioner’s questions or meet the Court’s standards. In the end, Rector—like Milliman—asks the Commissioner to find its probability distributions reasonable and “down the middle of the fairway” without any description of the specific data Rector relies on to show that its particular probability distributions meet that standard. Indeed, nowhere in its answers to the Commissioner’s questions does Rector even mention the actual probability distributions it used for the critical RAAF factor. Rector’s justification for that distribution is therefore inadequate as matter of law.¹³

b) Equity Portfolio Asset Value

Predicted equity portfolio losses (as measured by the equity portfolio asset value (EPAV) factor) had the second largest impact on Rector’s estimated surplus target compared with 2009. Shaw Report 28. Unfortunately, nowhere in its December 2013 report did Rector explain the derivation of this factor; instead it simply adopted Milliman’s probability distribution for this factor.

Because Milliman’s assumptions were also unexplained, it was critical that Rector fully respond to the Commissioner’s question regarding its use of this factor in the Modified Milliman Model. *See* Rector Aug. 27, 2014 Response to Questions 4 & 7. But again, Rector did not do so. Instead, Rector said only the following:

First, Rector said that its pro forma projection starts with a 3.75% expected earnings rate for GHMSI’s total investment portfolio. *Id.* at 5. Rector does not explain this rate other than to say it is “somewhat high given the current economic environment,” but that “it is consistent with GHMSI’s recent investment results.” *Id.* at 13.

¹² *See also* Memorandum from Jim Toole, FTI Consulting, to Rector & Assocs., ACA Reform and Surplus Requirements (Sept. 12, 2014).

¹³ As we discussed in our June 10 pre-hearing brief and at the June 25 hearing, we agree with Rector’s view that its probability distributions should be designed to reflect a middle of the fairway view as to actual reasonably probable outcomes; indeed, our view is that this approach is required by MIEAA’s “efficiency” requirement. DC Applesseed Pre-Hearing Report 19–21; DC Applesseed Testimony 6. We showed in Mark Shaw’s June 10 statement, and we show in this rebuttal how the RAAF factor distributions should be designed to comply with this requirement.

Second, to assess potential deviation from this 3.75%, Rector said that it took into account that equity values “have increased on average at a rate of 7.3% as measured by the S&P index over the last 50 years.” *Id.* at 5.

And third, Rector said that “[b]y comparing the deviations of the S&P 500 over a 50 year period, we were able to validate the equity assumptions in the stochastic portion of the model” *Id.* at 6.

But Rector makes no reference to how any of this relates to the particular Milliman probability distributions Rector relied on, and it nowhere addresses the Commissioner’s request that Rector explain how that probability distribution constitutes a middle-of-the-fairway assumption. Given that the most likely outcome in the Milliman probability distribution was a negative 3 percentage points, Doran Feb. 27, 2014, Letter, at Attachment A, ch. 5, it is difficult to see how this can be middle-of-the-fairway: by Rector’s own statement, the market’s average annual equity gain over the last fifty years has been 7.3%. The discrepancy underscores the importance of a full explanation as required by MIEAA, as the Commissioner has requested, and as Rector has failed to provide.

Rector stated that, while it is true that the probability distribution it adopted from Milliman assumed that this factor would be negative over half the time (53%), the negative factor represents only a deviation from the projected 3.75% return on the portfolio as a whole—not an absolute loss. Rector Aug. 27, 2014 Response, at 20. But Rector does not explain the portfolio distributions it uses, and nowhere does it mention or justify that it assumes that the most likely outcome—the one down the middle of the fairway—is a negative deviation of three percentage points which, based on the model, is applied against non-FEP premium rather than equity investments.

Rector seems to be arguing that its assumption of the most likely equity outcome being a loss of 3% has to be netted against the projected pro forma total portfolio return of 3.75%, resulting in the most likely portfolio return being 0.75%. But this misrepresents how the model works and results in Rector vastly overstating GHMSI’s need for surplus.

The stochastic model’s projection of losses to the equity portfolio does *not* result in a reduction to the 3.75% pro forma projection of returns to the investment portfolio.

Instead, the losses that the stochastic model projects for the equity portfolio are used solely and only to project losses that are *applied to non-FEP premium revenue, not to GHMSI’s portfolio*. Shaw Rebuttal 2. And, as Mark Shaw explains, the equity portfolio projected losses produce the largest projected losses to premium revenue of any non-RAAF factor in the model—and accordingly project the largest projected surplus increase of any other factor in the model.

Rector’s failure to explain and justify the probability distributions it adopted from Milliman for that factor—including the fact that those distributions project a 3% loss which applies to non-FEP premium as the most likely outcome in the face of average equity returns of 7.3% historically—means that Rector has failed to explain its use of this factor (as with the RAAF factor) and failed to show its use was in accord with MIEAA and the court’s decision.

c) Premium Growth Assumptions

The premium growth rate assumed for 2012–2014 is a key determinant of needed surplus as of the end of 2011. Shaw Report 19. Yet Rector has failed to consider GHMSI’s historical experience in selecting the growth rate for the model despite Rector’s acknowledgment that it must do so. *See* Rector Report 28 (“[T]o determine [the] appropriate premium growth level assumptions to include in the model, . . . it is important to take into account GHMSI’s historical premium growth experience.”). Instead, as Mr. Shaw showed, Rector used a 12.5% non-FEP growth rate as the most likely outcome for the years 2012–2014, even though during the most recent five years (2008–2013) the non-FEP average growth was 2.8% and the highest growth for any one year was 6.8%.

The result, as Mr. Shaw explained, was that the probability distribution used by Rector in the Modified Milliman Model “exclude[d] *any* possibility that either FEP or non-FEP future growth rates will be as low as the highest annual premium growth rate (5.5%) over the preceding five calendar years (2008–2012).” Shaw Report 20. It is impossible to square this assumption with Rector’s testimony at the June 25 hearing that its assumptions were “right down the middle of the fairway” and “exactly what we thought was actually going to happen with the degrees of probabilities.” Tr. 75. Again, the discrepancy underscores the legal impossibility of relying on Rector’s conclusions without full explanation.

The Commissioner asked Rector at least two questions that are essential to understanding how Rector used the premium growth factor in the Modified Milliman Model and determining whether that use accorded with MIEAA. Questions 4 and 6 asked Rector to explain its probability distribution for this factor, its basis for the midpoint (12.5%) used in the Modified Milliman Model, how its “premium growth assumptions were right down the middle of the fairway given GHMSI’s actual historical premium growth,” and how Rector’s assumptions in the model compared with actual results post-2011. Third Scheduling Order, Exhibit A, 2–3.

Again, Rector’s answers to the Commissioner’s question did not meet either the Court’s standards or MIEAA’s requirements. Rector’s answers demonstrate that it has not and cannot justify its treatment of this factor in the model—nor the huge increase in surplus resulting from its use of a 12.5% premium growth projection. Instead, Rector explained that, if one looks back 10 years, the average growth was 7.5%. Rector Aug. 27, 2014, Response, at 15.

Even assuming it is appropriate to look back 10 years and equally weight all years, a history of 7.5% average annual growth does not begin to explain or justify using a most likely outcome of 12.5% in the model. Simply declaring that “the future may be quite different from the past,” *id.* at 16, can hardly meet the Court’s requirement to fully explain what Rector has done and to justify an assumption that so far departs from the historical record. Further underscoring the inappropriateness of Rector’s 12.5 % premium growth assumption is the fact that, as Rector acknowledged in answering the Commissioner’s questions, “GHMSI’s actual post-2011 non-FEP premium levels [which] *decreased* by 5% during 2012 and by 6% during 2013.” *Id.* at 18 (emphasis added).

In summary, Rector, Milliman, and the other actuarial studies all fail each of the three requirements of the Court of Appeals: none calibrated the confidence level as required by the

Court; none properly took into account the “efficiency” standard; and none fully and clearly explained their assumptions under MIEAA. Accordingly, as a matter of law the Commissioner cannot rely on any of the resulting surplus recommendations from these actuarial studies.¹⁴

In Section II, we identify the calibration of a confidence level and the realistic probability distributions that generate a surplus in compliance with MIEAA. Before doing so, we examine the assertions put forward by Mr. Burrell.

C. Mr. Burrell’s Testimony Is Legally and Factually Insufficient To Support GHMSI’s Surplus.

In addition to relying on Rector to justify its surplus, GHMSI also relies on the testimony of Mr. Chet Burrell at the June 25 hearing. But similar to the nine previous actuarial studies, Mr. Burrell’s testimony only underscores that GHMSI has not calculated its permissible surplus in compliance with MIEAA or the Court of Appeals’ decision. Moreover, because his testimony is largely anecdotal rather than a systematic analysis explaining why the company’s specific surplus as of the end of 2011 is permissible, it cannot provide a legal basis for analyzing and upholding that surplus. Furthermore, the anecdotal points Mr. Burrell does offer are substantially overstated. We address these issues below.

1. *As with the nine actuarial analyses, Mr. Burrell’s analysis of GHMSI’s surplus is legally insufficient on its face; it is inconsistent with MIEAA and the Court of Appeals’ decision.*

Mr. Burrell made clear in his June 25 testimony that he did not apply the “in tandem” test established by the Court. He argues his view of reasonableness without regard to GHMSI’s community reinvestment obligation. Accordingly, he fails to “calibrate” an appropriate confidence level in light of that obligation and thereby simultaneously consider the “maximum feasible” and “financial soundness” requirements in order to “balance” the two. Mr. Burrell approached the surplus issue the same way that GHMSI, Rector, and Milliman have done in this and the earlier proceedings.

That is, all of them—Mr. Burrell included—first determined the target surplus for the company *without regard to either community reinvestment or efficiency*, and only then did they determine whether the resulting target allowed any dollars to be available for community reinvestment. As earlier explained, that is *not* what the Court required and it does not meet the in-tandem test.

Yet that is how Mr. Burrell approached and attempted to justify the current high surplus of the company. As he said several times at the hearing, *see, e. g.*, Tr. 153–54, 157–58, the

¹⁴ Ms. Doran indicated that she was satisfied that Milliman had disclosed all information pertinent to its assumptions because Mr. Shaw “was able to, for the most part, replicate our model.” Tr. 151. Mr. Toole made a similar point on behalf of Rector. Tr. 25. But the fact that Mr. Shaw was able to replicate the model by *using* Milliman’s and Rector’s probability distributions has nothing to do with the requirement that Milliman and Rector *explain how* they derived those distributions. It also has nothing to do with the Court’s requirement that the Commissioner be able to fully explain how those distributions comply with MIEAA.

company's community reinvestment was determined by the extent to which the company is above or below its pre-determined target surplus; but that target surplus is not itself determined by taking into account the community reinvestment obligation.

Thus, as Mr. Burrell specifically testified: "The way we view the law is that the *first* thing you do is you look at whether or not you understand what financial efficiency and soundness really means . . . and *then* you determine whether or not the amount of community health reinvestment you've made is consistent with it." Tr. 298 (emphasis added).

This of course is exactly how GHMSI approached community reinvestment in the last hearing, and it is the very reason the Court reversed. Maximizing community reinvestment was the primary purpose of MIEAA; the statute, as the Court explained, requires the target surplus to be determined *in light of that purpose*; and the purpose cannot be met by *first* calculating target surplus *without regard to community reinvestment* and *only then* looking to see whether anything is left over for community reinvestment. Nevertheless, Mr. Burrell said that is what the company did; and he actually testified that GHMSI's approach meets the Court's in tandem test. As he testified: "If the cost of the giving drives our surplus down below a sound level . . . then premiums would have to be increased to bring it back to a sound level. We're trying to balance that, and that is, I think, the tandem test." Tr. 164.

But this is *not* the in tandem test; that test requires GHMSI to compute the requisite "sound level" of its surplus in light of the need to maximize community reinvestment. That is plainly not what GHMSI did.

This was made clear when the Commissioner asked Mr. Burrell at the hearing: "Do you believe you are up to the maximum level feasible for financial soundness or is there any room at all?" Mr. Burrell said: "We believe we are, because we are below the target levels that have been identified in terms of RBC." Tr. 157–58. So again, as was the case with Rector, Mr. Burrell and GHMSI determined a target surplus that did not take into account the company's community reinvestment obligation, and then assumed GHMSI had met that obligation because it met the target surplus. The Court said this approach is insufficient as a matter of law.

The Court further said that the requisite approach to computing the target surplus in light of the community reinvestment obligation is through "calibrating" the confidence level in light of that obligation—which GHMSI clearly did not do, as demonstrated by Mr. Chaney's response to questions posed by Associate Commissioner Barlow.

Associate Commissioner Barlow asked Mr. Chaney, in light of the fact that GHMSI's own experts had recommended a confidence level of 95% to 98%, "why you think 98 is the proper number?" Tr. 135. Mr. Chaney answered that "we want to be as conservative as we possibly can. So *we took the upper end of the confidence level range*. And as was said earlier by Mr. Rector and others, that's a judgment. And that was the judgment of management and that was the judgment of our board." Tr. 136 (emphasis added).

But it was a judgment made without regard to MIEAA as interpreted by the Court. As we have shown, selecting a confidence level at "the upper end of the range"—a selection that takes

no account of the impact on community reinvestment—violates the Court’s decision and drives down the dollars available for community reinvestment by many millions of dollars.

Mr. Burrell’s testimony also makes clear that GHMSI did not take proper account of MIEAA’s “efficiency” requirement in determining the company’s permissible surplus. At the hearing, Mr. Burrell said “I would argue to you two points about efficiency.” Tr. 294. His first point was that it would not be “efficient” to reduce premiums due to excess surplus since that would require subscribers to “experience cuts and then steep increases to come back to adequacy.” His second point was that “once your RBC goes down, do you have a reasonable chance to get it back in the foreseeable future?” *Id.* We understand this second point to refer to Mr. Burrell’s argument that because of the minimum MLR requirement, insurance companies might have greater difficulty accumulating surplus in the future. *See* Tr. 99:15–19.

But neither of these points has anything to do with MIEAA’s “efficiency” requirement. As we have explained, that requirement relates to the nature of the contingencies that should be included in the probability distributions, which should be reasonably probable and not extreme and remote.

The idea that “efficiency” should preclude reducing otherwise excessive surplus under MIEAA because, hypothetically, at a later time higher rates might be needed or the company might need to rebuild surplus, is a frivolous point. Not only does this completely misapprehend the meaning of “efficiency,” but it suggests that the Commissioner could decline to require spend-down of excessive surplus in the current or any three-year review based on Mr. Burrell’s speculation that at a later time the company might show a need for a higher surplus and might be limited by the MLR requirements from raising additional surplus. Under that view excessive surplus could *never* be spent down because it could *always* be argued that at a later date premiums and surplus might need to be increased. MIEAA cannot reasonably be read to require or authorize its own evisceration.¹⁵

In sum, as is true of the nine actuarial analyses, Mr. Burrell’s testimony shows that to date GHMSI has not yet fairly applied MIEAA’s requirements.

2. *Mr. Burrell’s testimony offers no evidentiary basis for upholding GHMSI’s specific surplus*

Apart from the fact that Mr. Burrell offered no analysis of GHMSI’s surplus in terms of MIEAA’s requirements, his testimony is flawed in that it offers no factual predicate the Commissioner can rely on for upholding GHMSI’s specific surplus. Instead, Mr. Burrell simply offered generalities and speculations that bear no relationship to the particular surplus ranges he asks the Commissioner to approve.¹⁶

¹⁵ Having shown that Mr. Burrell’s argument is on its face legally insufficient, we show below why its various elements are also wrong in fact.

¹⁶ Mr. Burrell has offered the very same generalities since before the Council even adopted MIEAA. For example, he consistently cited GHMSI’s “low margin” as a reason for not passing MIEAA, as a reason why the previous

In its June 10 filing GHMSI asked the Commissioner, to adopt Milliman’s proposed range of 1050% to 1300% RBC as presented in Milliman’s June 29, 2011, report (Exhibit 12 at 5). GHMSI Pre-Hearing Brief at 1. But in his June 25 testimony, Mr. Burrell endorsed the range recommended by Rector: 875% to 1040% RBC. Tr. 88:20–21; *id.* at 116:25–117:2. Specifically, Mr. Burrell testified regarding Rector that “we would want to convey to you that we think that the basic overall conclusion that they came to is sound and that the range around the target that they established is also sound.” *Id.* at 117.

Yet Mr. Burrell offered no analysis or evidence that would allow the Commissioner to determine that either the Milliman or Rector range is in fact “sound” under the Court’s standards. Instead, in the end Mr. Burrell made only three substantive assertions in his testimony: (1) GHMSI operates with thin margins, and its surplus has recently declined; (2) the company faces downside risks under ACA; and (3) if the company were required by MIEAA to reduce its surplus, it might have difficulty increasing the surplus if it were determined that, at a later date, a higher level was appropriate.

All three of Mr. Burrell’s assertions. are legally and/or factually insufficient:

First, his own testimony makes clear that GHMSI’s thin margins and the recent modest decline in its surplus are not the result of under-estimations of revenue needs but of intentional choices. *See e.g.*, Tr. 109:19–20 (“ We ...largely seek only to break even with a small margin”); *id.* 156:25–157:2 (“We give essentially as much as our . . . operating gain”); *id.* at 174 (“We used surplus dollars to bring our premiums down”); GHMSI, *Report to the D.C. Department of Insurance, Securities and Banking Regarding GHMSI’s Surplus at Year-End 2012* 5 (July 1, 2013) (“CareFirst opted to set rates at the extreme lower end”).

Thin margins or a decline in surplus from intentional choices do not present an argument that justifies a 998% RBC under MIEAA. Neither do thin margins or a decline in surplus that are due to administrative inefficiency.¹⁷ And, in any case, the alleged risk from thin margins is itself factually suspect: it is clear that the company substantially increased its surplus in prior years notwithstanding having thin margins (see further discussion of this point *infra*, at 36). Mr. Burrell himself noted in response to a question of the Commissioner that one of the advantages of GHMSI’s nonprofit status is that it can be “financially sound” when it “break[s] even with a small margin.” Tr. 109:19–20; *see also id.* at 110 (Nonprofit status “enables us operate with incredibly small [margins], very close to cost, with only a fraction of a percent above that on average over a multi-year period”).

Commissioner should not have found excess surplus in 2009, and now as a reason the current Commissioner should not find excess surplus in this proceeding, Tr. 109 (“[We]largely seek only to break even with a small margin that would keep us financially sound.”); 2009 Tr. 111 (“In the last decade, we have averaged a percent to 2 percent. We operate on extremely skinny margins.”); Testimony of Chet Burrell, Hearing Before the D.C. Dep’t of Ins., Secs. & Banking 2 (Sept. 10, 2009) (“GHMSI . . . has operated at an extremely small operating/underwriting margin . . . averaging . . . between 1 and 2 percent over the entire last decade . . .”)

¹⁷ Mr. Shaw has expanded and rerun his analysis of GHMSI’s administrative inefficiency, in response to Ms. Doran’s criticism. His conclusion remains that GHMSI is administratively inefficient. *See Shaw Rebuttal 22–27*

Second, while it is true that the ACA poses the possibility of downside risks, (a) Mr. Burrell greatly overstates those risks; (b) as Mr. Shaw’s testimony showed, the downside risks for the company are actually smaller now than before ACA; and (c) Mr. Burrell entirely ignores both the upside potentials and the loss-limitation provisions of ACA (the three Rs).

Finally, *third*, not only is the possibility that GHMSI would ever need substantial additional surplus of surplus purely speculative and legally insufficient, but the constraint that would be posed by the MLR in that eventuality is greatly overstated by Burrell and contradicted by Milliman. And in any case, nowhere does Mr. Burrell relate any of his claims to the proposition that GHMSI’s specific surplus at the end of 2011 was justified under MIEAA.

Our second and third points above bear elaboration. As to the second—the many ways in which Mr. Burrell explicitly or by omission overstates risks under the ACA:

(1) Insofar as the ACA may create risks, those risks relate to the individual and small group markets. But the individual market historically has been a small share of GHMSI’s business. Even with a substantial near-term rate of growth, it would remain a small share.

(2) The ACA does not materially change the risk associated with the small group market beyond what it has been since the early 1990s: guaranteed issue and community rating. Shaw Report 49. And, “the ACA does not change insurers’ abilities to underwrite large groups at all. *Id.*”

(3) GHMSI has offered no reason to anticipate a gain or loss in GHMSI’s small group business so large that it creates a material adverse selection problem. There is no such plausible reason.

(4) Mr. Burrell claims that GHMSI has lost bargaining “leverage” vis-a-vis Accountable Care organizations, and that the loss adds to the uncertainties created by the ACA (including illogical claim that ACOs are “oligopolies”). Tr. 149:15–150:12 GHMSI has offered no evidence for these claims, nor does it even address whether the net effect of such organizations will be to increase medical costs after taking into account savings that they are generating. In fact, ACOs are designed to and in fact are reducing costs by reducing the volume and intensity of medical care.¹⁸ In any event, the issue with respect to surplus is not whether bargaining power has shifted

¹⁸ An ACO is a network of doctors and hospitals that shares financial and medical responsibility for providing coordinated care to patients. Medicare operates three ACO payment incentive programs which are intended to discourage unnecessary spending, encourage better care quality, and reduce overall spending. CMS recently announced substantial savings associated with its most ambitious Pioneer ACO program, *see* Press Release, Pioneer Accountable Care Organizations succeed in improving care, lowering costs (July 26, 2013), *available at* <http://www.cms.gov/newsroom/mediareleasedatabase/press-releases/2013-press-releases-items/2013-07-16.html>, and will release information about the results of its Shared Savings program later this year. As of January 2014, five ACOs operating under Medicare’s Shared Savings program served the national capital area. Medicare Shared Savings Program, Accountable Care Organizations (Jan. 1, 2014) *available at* <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/2014-ACO-Contacts-Directory.pdf>.

but *whether the shift has materially increased uncertainty* and, therefore, the likelihood that GHMSI will underestimate provider compensation. GHMSI has offered no reason, and there is no logical reason, why a recognized shift in bargaining power would increase the likelihood that GHMSI will underestimate the costs of provider compensation when it seeks rate approvals, which is the only relevant issue with respect to surplus.

(5) Mr. Burrell makes no reference at all to the cost-reduction initiatives that are accompanying the ACA, including initiatives that CareFirst itself is pursuing and that so far are very promising. CareFirst has a Patient Centered Medical Homes initiative involving one million CareFirst subscribers that reduced expected health care costs in 2012 by 2.7% for PCMH-covered members.¹⁹ A recent *Washington Post* article reports that “CareFirst credits its medical home for helping keep total patient expense growth at 3.5 percent last year, the lowest rate in memory.”²⁰ The article continues: “The program is saving ‘hundreds of millions of dollars in accumulated avoided costs,’ said CareFirst chief executive Chet Burrell. ‘If somebody had said to me three and a half years ago, ‘What would you have hoped for?’ I would not have said anything close to what emerged.”²¹

GHMSI’s overstatement of ACA risks is accompanied by its understatement of ACA risk-mitigation, as we have discussed. *See* DC Appleaseed Pre-Hearing Report 31–34; Shaw

¹⁹ BCBSA, *Blue Perspective: Blue Plans improving Healthcare and Affordability Through innovative partnerships with Clinicians* 1–2 (Feb. 13, 2014), available at <http://www.bcbs.com/healthcare-news/press-center/BP-and-Quality-and-Plan-Innovations.pdf>.

²⁰ Jay Hancock, “Insurer shifting balance in health care,” WASH. POST, July 10, 2014, at B1, available at http://www.washingtonpost.com/national/health-science/will-health-reform-bring-new-role-respect-to-primary-care-physicians/2014/07/10/0116f760-0816-11e4-8615-4eddc1f1cffa_story.html.

²¹ Milliman similarly overstates ACA risks. It asserts that the extensions provided by HHS to non-compliant plans “are likely to exacerbate . . . adverse selection.” Milliman, *CareFirst, Inc., Group Hospitalization and Medical Services, Inc.: Development of Optimal Surplus Target Range* 4, June 27, 2014 [hereinafter “Milliman June 27, 2014 Report”]. These extensions had not been announced as of the end of 2011. In any case, the claim here is that purchasers on HealthLink are heavier users of medical services than are subscribers under grandfathered non-compliant individual and small group plans. *See* Tr. 93:23-25; 94:1-3 (Burrell). If that is true, it means that, when the grandfathered period ends, and subscribers under non-compliant plans begin to purchase through HealthLink, there will be *less* adverse selection on HealthLink plans. Thus, GHMSI has now seen the greatest amount of adverse selection due to the extensions; the problem only diminishes from here on. More broadly, the latest Milliman report now undercuts the whole broad proposition, central to Mr. Burrell’s testimony (though wholly unquantified), that ACA currently presents massive risks that should drive the analysis of needed surplus. Milliman now has dropped its previous claim that a surplus increase of 100 to 150 points is needed for the portions of the ACA that were unimplemented as of its 2011 report. Tr. 12419–22 (Chaney); and *cf.* Milliman June 27, 2014 Report, at 4–5 (absence of 100% to 150% increase), *with* Milliman May 31, 2011 Report, at 5, 7, 24 (estimate of 100% to 150% increase). Apparently, those ACA provisions are proving far less risky in actuality than they appeared in prospect. Moreover, Milliman is now recommending the *same* surplus target for the period beginning in 2017, “when most of the ACA provisions have been fully implemented and the temporary risk mitigation programs have been eliminated,” Milliman June 27, 2014 Report, at 5, as it is recommending for what it calls the ACA “transition period” between now and then, *id.* This conclusion, however Milliman may choose to explain it, can only mean that whatever material uncertainties were initially presented by the ACA have by now been largely eliminated.

Report 13–18. To the three statutory mitigation factors that GHMSI ignores we would add a further, non-statutory, source of risk-mitigation: GHMSI has long enjoyed market power in the individual and small group markets. As Mr. Burrell testified: with respect to the individual and small group markets, “we are the dominant carrier and always have been.” Tr., 128:17-18. Accordingly, GHMSI’s practice has been to reduce *or increase* rates as needed to achieve its surplus targets. *See* GHMSI, Report on GHMSI Surplus 7 (June 1, 2012); Tr. 294:22-25; 295:1-2. GHMSI’s has not suggested, nor could it, that Health Link will lead to its displacement as the dominant carrier. GHMSI claims only that the MLR provisions will constrain its ability to rebuild surplus should the need arise. *Id.* at 129:12–19 (We show immediately below that the MLR is nowhere near the constraint that GHMSI claims it is.) GHMSI’s dominant position confers pricing power that provides a further measure of protection in the event that it ever faces risks that require it to increase rates—likely the same risks that its competitors on Health Link also would face.²²

Our third point above is that Mr. Burrell overstates factually the constraint that would be represented by the MLR, in the unlikely event that GHMSI ever needed to accomplish a major “rebuilding” of its surplus. (We earlier showed how this argument would eviscerate MIEAA, and is therefore legally misconceived on its face.). There would be no rate-regulatory constraint on such rebuilding. Milliman itself, in its latest evaluation of the company’s surplus, correctly notes that, if the company ever needed to increase surplus at a later date, it could build a premium into its rates for that purpose.²³ Moreover, Mr. Burrell himself testified that GHMSI is and intends to continue managing its loss ratio so as to have a cushion above the MLR minimum. Such a cushion means that, if GHMSI ever needed to rebuild surplus, it could reduce its MLR without violating the ACA MLR requirement. It could, for example, increase premium revenues so long as it remained within the MLR bounds. The resulting increase could then be added to surplus.²⁴

²² The ACA does not displace major sources of GHMSI’s market power, such as its dominance in the individual and small group markets, the breadth of its provider network; its uniquely powerful brand; and its territorial exclusivity for use of the brand conferred by the BCBSA license agreement.

²³ Milliman June 27, 2014 Report, at 8. In determining whether to approve premium rates the Commissioner is directed to give “due consideration” to a “reasonable margin for surplus needs,” and to “all other relevant factors.” D.C. CODE § 31-3508(e)(3). The District’s general statutory insurance ratemaking principles require that “due consideration” be given to “[p]ast and prospective loss experience;” “catastrophe hazards,” and “contingencies.” *Id.*, § 31-3311.01(b)(1)–(2); (5). Rates for individual subscribers are deemed approved if not disapproved within 60 days of filing. *Id.* §31-3508(b). The insurer may apply for an expedited effective date for individual rates reviewed and approved by the Commissioner. *Id.* Group rates may be effective on filing, subject to retroactive disapproval. As with individual rates, group rates are deemed approved if not disapproved within 60 days of filing. *Id.* § 31-3508(c).

²⁴ Mr. Burrell testified that GHMSI’s “current – the loss ratio overall for business as a whole is in the 83 to 84 percent range, well above the 80 percent minimum. Over time, we’re headed towards an 85 to 86 percent level we think, but that, in turn, depends on underwriting results and a whole string of other things. We don’t want to be constantly scurrying along the edge” of the 80% requirement. Tr. 132:9–17. GHMSI’s current MLR, and its management goal, mean that, if it ever needed to rebuild surplus, it would have from 3–6% of its individual and small-group premium revenues with which to do that, without violating the ACA’s MLR minimum. Three to six percent of GHMSI’s 2013 premium earned on individual and small group policies would equal \$42 million to \$84 million, estimated as, respectively, 0.03 and 0.06 times \$1.4 billion, GHMSI’s reported earned premiums in 2013.

Further, GHMSI completely ignores the ACA provisions that authorize (a) deferral and (b) adjustment of the MLR requirement. The deferral provision, 45 C.F.R. § 158.270, which is available for both the individual and small group markets, was adopted as a direct response to the concern of the NAIC that the MLR might cause an insurer's RBC ratio to drop below the Company Action Level (200%). *See* Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 74864, 74885 (Dec. 1, 2010). The adjustment provision, 45 C.F.R. §§ 158.310–311; *id.* § 158.330, authorizes adjustments to the MLR for as long as three years for all carriers in a state if its application would “destabilize” the individual market. [Code citation to section 2718(b)(1)(A)(ii) of the Public Health Service Act]. If GHMSI, the dominant carrier by far in the District, were approaching 200% RBC, the Commissioner and the Secretary of HHS might well find that an adjustment was warranted.

We do not contend that relief under the deferral or adjustment provision is a certainty. But surplus review is about probabilities. Mr. Burrell presented the MLR constraint as a driving consideration with respect to surplus. It is in light of that position that the MLR deferral and adjustment provisions become relevant. Mr. Burrell cannot have it both ways. He cannot present MLR as a major risk factor yet assign a zero probability to the risk-mitigation represented by the provisions for deferral and adjustment of the MLR. This distorted approach is no more acceptable than is the failure of GHMSI and Rector to take into account the three Rs. The ACA must be considered in its entirety in order to identify reasonably probable outcomes and the “maximum feasible” amount of community reinvestment consistent with “financial soundness.”

(6) Finally, a key underpinning of Mr. Burrell's testimony seems to be his unexplained, unsubstantiated speculation that DISB will not approve appropriate rates for the company. Tr. 196:9–11. We strongly disagree that this is a legitimate basis for increasing the company's surplus. Rector shares our view and presumably did not base its assumptions in the model on that view. *See* Rector Report 23 (“[W]e do not believe it is appropriate to assume that regulators will restrict needed premium rate increases, . . . especially in scenarios where GHMSI is in a financially difficult situation.”²⁵)

Thus, Mr. Burrell's three contentions are legally insufficient, and factually wrong or unsupported. And none of the contentions ultimately addresses the question before the Commissioner: whether GHMSI's 998% RBC as of December 31, 2011 is excessive under MIEAA. Nor do the actuarial analyses that GHMSI relies on rectify these shortcomings. In the end, neither Rector, nor Milliman, nor Mr. Burrell has offered evidence justifying GHMSI's surplus at that date under the applicable legal standards.

²⁵ Further indication that surplus should not be increased on the assumption DISB will not approve adequate rates is the level of rates DISB just approved for GHMSI and BlueChoice's individual and small group plans. Over strong objection from the DC Health Benefit Exchange Authority, and in contradiction to the actuarial study the Authority submitted, DISB approved significantly higher increases for GHMSI and BlueChoice than the Exchange proposed, and did so even though GHMSI and BlueChoice's competitors all decreased their rates for individual and small group.

We therefore turn now to the proper calibration of the confidence level and to the adjustments that must be made to the probability distributions used in the Modified Milliman Model to allow the model to be used in determining an appropriate surplus for GHMSI under MIEAA.

II. THE COMMISSIONER SHOULD CORRECT RECTOR'S USE OF THE MODIFIED MILLIMAN MODEL BY CALIBRATING THE CONFIDENCE LEVEL AND USING MIDDLE-OF-THE-FAIRWAY ASSUMPTIONS FOR THE COMPANY.

To demonstrate how the Modified Milliman Model should be adapted to comply with MIEAA and the Court of Appeals' decision, we address two points: (1) how to "calibrate" the confidence level to meet the Court's in-tandem requirement; and (2) how to formulate the model's assumptions to meet MIEAA's "efficiency" standard.

A. Calibrating the Confidence Level

As we showed in our June 10 pre-hearing submission, GHMSI and DISB are required to calibrate the confidence level selected for the Milliman model in order to meet the "maximum feasible" test as elaborated. DC Appleaseed Pre-Hearing Report 9–10, 13–15. That is, the confidence level must be used to balance ever greater and more costly degrees of "financial soundness" against the requirement to meet the community reinvestment obligation. As we have discussed, neither GHMSI, nor Milliman, nor Rector has ever performed this balancing. Instead, even at the June 25 hearing, each continued to take the same approach as at the last hearing, before the Court made clear that a different approach is required. That is, they once again simply chose a number representing their views of a "conservative" confidence level *without regard to MIEAA*. They then assume that this conservative confidence level automatically meets the requirement to make the maximum feasible amount available for community reinvestment. As we have shown, this does not comply with the Court's requirements.

We showed in our June 10 pre-hearing report, and discussed at the June 25 hearing, how the Commissioner should "calibrate" the confidence level in order to meet the Court's legal standard. Specifically, the Commissioner should determine whether a lower confidence level than 98% would be sufficient to protect the company's financial soundness and would at the same time maximize community reinvestment.²⁶

²⁶ GHMSI has unfairly characterized DC Appleaseed's position and the process to date. In its answers to the Commissioner's recent questions, in its Sept 5 filing GHMSI says that "Throughout this review process . . . Appleaseed appeared to agree . . . with Rector's development of a fair actuarial analysis utilizing a 98% confidence level . . ." GHMSI Sept. 5, 2014 Response, at 2–3. However, GHMSI says, "once it became clear that this fair and unbiased analysis was going to support GHMSI's current surplus level, Appleaseed changed its tune..." *Id.* at 3. As support for this description of DC Appleaseed's position GHMSI cites our January 18, 2013, letter to Sarah Schroeder, which in turn attached a letter from Mark Shaw. *Id.* at 2–3. As GHMSI knows, early in the process the previous Commissioner' brought Rector and the parties together in settlement discussions to see if a compromise agreement could be reached concerning how to use the model, partly in hopes of avoiding a hearing and potential further litigation. In that context, Mark Shaw's January 18, 2013, letter specifically stated that he would "concur as to the reasonability of that threshold [98%] as long as the 'loss cycle' that determines 98% is appropriately

One element in the proper calibration is to consider the trade-offs between increasingly costly increments in the confidence level and the community reinvestment of excess surplus that is the primary objective of MIEAA.²⁷ Based on calculations made by Mr. Shaw, we showed in our pre-hearing brief and at the June 25 hearing that even if no other changes were made to Rector’s use of the Milliman model, a 90% confidence level, in comparison with a 98% confidence level, would reduce permissible surplus by \$283 million; even a three-point reduction to 95% would reduce surplus by \$149 million. These reductions would become available for community reinvestment—instead of the zero amount available under Rector’s continued use of the 98% confidence level.

These estimates illustrate the correctness of Judge Ruiz’s observation that “one or two percentage points [of confidence] could make a big difference in terms of millions of dollars going to address that immediate [community reinvestment] need.” Compact disc: Oral Argument in D.C. Appleaseed Center for Law and Justice v. D.C. Department of Insurance, Securities, and Banking, No. MIE-007-09, before the D.C. Court of Appeals at 12:23:31 PM (June 9, 2011) (on file with D.C. Court of Appeals). GHMSI has not disputed our calculations of the “big difference” a slight reduction in the confidence level makes with regard to surplus of dollars becoming available for community reinvestment, nor does it dispute our contention that such a calibration of that impact is *required* under the Court’s decision.

The issue before the Commissioner is how to perform the necessary balancing and calibration of the confidence level under the in-tandem test. We submit that once that test is applied, the Commissioner should conclude that a 90% confidence level best complies with MIEAA. We make the case for 90% in two steps. First, we show that in no event can a 98% level be justified. Second, we show that the most appropriate level lower than 98% is 90%.

1. A 98% Confidence Level Cannot Be Justified under MIEAA

The record before the Commissioner demonstrates that the 98% confidence level proposed by GHMSI, Rector, and Milliman cannot be justified under MIEAA and the Court of Appeals’ decision. We say that for several reasons.

constructed.” Letter from Mark Shaw, Senior Consulting Actuary, United Health Actuarial Servs., to Walter Smith, Exec. Dir., DC Appleaseed Ctr. for Law & Justice 4 (Jan. 18, 2013). And, as made clear in DC Appleaseed’s own January 18, 2013 cover letter, Mark Shaw’s suggestions concerning the assumptions to be used to measure the 98% level needed to be based on what we understood Rector would do—premise those assumptions on middle-of-the-fairway probability distributions about what would actually happen in the real world based on GHMSI’s historical results. As we have made clear, that is *not* what Rector did. Moreover, contrary to our understanding of the intended process, no proposal was ever made about a set of assumptions and confidence levels on which the parties might agree. This entire issue is moot unless the Commissioner adopts each and every one of DC Appleaseed’s corrections to the probability distributions used in the Modified Milliman Model. In any event, while we once were open to a compromise agreement that would include a 98% confidence level *and* middle-of-the-fairway assumptions, no such agreement was ever proposed. It would be legal error now to consider DC Appleaseed’s prior willingness in settlement discussions to accept a 98% confidence level as an admission or other evidence that such a level is the correct one. This matter is now in litigation. Accordingly, we now identify, and the Commissioner is obligated to adopt, the assumptions and confidence levels that best implement MIEAA and the Court of Appeals’ requirements.

²⁷ We discuss below, the second element in proper calibration—a realistic assessment of the consequences of falling to 200% RBC.

First, the Court of Appeals expects the Commissioner to select a confidence level lower than 98% as a result of the calibration the Court directed. As Judge Ruiz said, “millions of dollars hang in the balance, and you’re right you can get a little extra security [with a higher confidence level], but there is always an opportunity cost.” *Id.* at 12:23:09. And as Judge Fisher said in responding to the proposed use of a 95% confidence level, “I don’t think I’ve ever acted on any contingency in life with 95% certitude. Why is [GHMSI] allowed that luxury?” *Id.* at 12:21:36. Moreover, a 98% confidence level is extremely difficult to justify when—as we have shown—the opportunity cost of Rector using that level in its application of the Modified Milliman Model is that *no dollars* would be available from surplus to meet what Judge Ruiz called the “immediate need” to invest in the health of the community.²⁸

Second, as Mr. Shaw explains in his attached statement, both Rector and Milliman demonstrated at the hearing that they misunderstood the effect of using a given confidence level, whether 98% or 90%, when, as is the case here, the modeling is based not on 1-year periods but on 3-year periods. Rector and Milliman testified that their intent in using a 98% level was to protect against a one-in 50 year possibility of GHMSI falling to 200% RBC. Tr. 39, 136–37. As Mr. Shaw shows, however, Rector and Milliman both overlooked the fact that the Modified Milliman Model was using the 98% confidence level to protect GHMSI *during a three-year period*, not a one-year period. The difference between a confidence level used for a one-year period and a three-year period is substantial.

Thus, as Mr. Shaw shows in his attached statement, Shaw Rebuttal 15, to achieve Rector’s and Milliman’s intent of protecting against a one-in-50 year event, the correct confidence level is 94%. A 98% confidence level applied to a three-year period actually protects not against a one-in-50-year event but against a *one-in-150-year* event—a level that would obviously be irrational and violative of MIEAA, and that no party has urged. This further confirms that in no event is a 98% confidence level appropriate. A 90% confidence level would mean that there is a 10% likelihood of reaching 200% once in every ten 3-year periods, or once in every 30 years, and not once in every 10 years as Rector asserted.

This analysis means that the only genuine issue remaining with respect to the confidence level is the difference between 94% (the level that would achieve the Milliman-Rector goal of reaching 200% once in every 50 years) and 90% (the level that we contend is the proper one under MIEAA and that would protect against reaching 200% once in every 30 years).

²⁸ At the June 25 hearing, counsel to GHMSI (Mr. Perella) argued that we are incorrect to say that under Rector’s analysis GHMSI “will not be spending a single dollar of community reinvestment.” Tr. 155. Mr. Perella points out that “GHMSI has always given millions of dollars a year to the community.” *Id.* But this misunderstands our position and also misconstrues the purpose of this proceeding. This proceeding is designed to determine whether GHMSI has excessive surplus under MIEAA and, if it does, to require a spend-down of that excess on community reinvestment. The fact that in the past GHMSI has spent funds *from its operating budget* on community reinvestment is irrelevant to whether funds ought also now be spent for that purpose from surplus. The issue is not whether GHMSI has engaged to some extent in community reinvestment; the issue is its capacity to do so as defined by the MIEAA standards. As we have shown, that capacity is vastly greater than what it is spending.

Third, wholly apart from their failure to calibrate the recommended confidence levels in light of the community reinvestment requirement, neither Rector nor Milliman nor GHMSI has ever justified *the particular confidence levels* they chose. In the last hearing—and again in this hearing—both contended that the consequences of falling below 200% RBC or 375% RBC would be severe and therefore very high confidence levels should be chosen. Granting—as we do—that avoiding 200% is an important objective, it simply does not follow that 98% is the right confidence level to be used in the model.

In the last proceeding, the Commissioner stated that

If GHMSI falls to [the] 200% level, GHMSI would lose its trademark rights associated with the Blue Cross and Blue Shield Association. Additionally, falling below the Blue Cross Blue Shield “Early warning Monitoring” threshold (375% RBC-ACL ratio) triggers restrictions on GHMSI’s operations and oversight by the Blue Cross and Blue Shield Association.

Final Decision and Order 10, *In the Matter of Surplus Review and Determination Regarding Group Hospitalization and Medical Services, Inc.*, Order No. 09-MIE-007 (D.C. Dep’t of Ins., Secs. & Banking Oct. 29, 2010).

However, the Court found this determination insufficient as a matter of law to justify the particular confidence levels recommended in the actuarial studies (Rector, Milliman, Lewin, and Invotex) on which the Commissioner relied. The Court stated: “There is no explanation why the Commissioner thought it was necessary to have such high confidence levels for these thresholds, or why a 4% spread in confidence levels was appropriate in light of their different sources and consequences.”²⁹ *D.C. Appleseed*, 54 A.3d at 1218.

While fully accepting the importance of not falling to 200% RBC, the Court’s point was not only the need to justify the high confidence levels, but the need to explain the particular levels selected and the spread between the level for 200% RBC and 375% RBC. None of these requirements has ever been met.³⁰

Nor could they be met. We addressed in our Pre-Hearing Report the consequences to GHMSI in the extremely unlikely event that its surplus dropped to 200% RBC. DC Appleseed Pre-Hearing Report 12–13. As we pointed out, under D.C. law and the NAIC structure, a surplus of less than 200% RBC is a Company Action Level Event. For such an event, the statute prescribes in detail remedial measures to be taken by the Commissioner and the Company, designed to ensure financial soundness. Even if the Commissioner believed that GHMSI falling

²⁹ The “spread” refers to the suggested use by Rector of 99% at the 200% RBC level, and 95% at the 375% RBC level.

³⁰ In the last proceeding Rector’s “spread” between confidence levels for 200% and 375% was, as the Court said, 4 percentage points; in this proceeding the “spread” is 13 percentage points—85% confidence for 375% RBC and 98% for 200% RBC. But again, not only is there no explanation for this spread; there is no explanation for the particular levels selected, much less an explanation for how those levels balance financial soundness and community reinvestment.

to 200% RBC were a realistic prospect, if that occurred there is every reason to expect that GHMSI and the Commissioner would fashion a Company Action Level plan that would provide good prospects of recovery, especially in light of GHMSI's inherent strengths—its uniquely powerful brand, its territorial exclusivity, the breadth of its provider network,³¹ and its dominance. That is the appropriate, reasonably probable, assumption under MIEAA. GHMSI's suggestion that a 200% RBC would entail a complete collapse of the company is simply not well-founded.

The day before the June 25 hearing, the BCBSA weighed in, claiming that, if a Blues plan's ratio "were to fall below 200 percent, BCBSA's Board of Directors (composed of the CEOs of all 37 Plans and BCBSA) would immediately commence actions to terminate that company's license to use the Blue Brands." Letter from Scott P. Serota to The Hon. Chester A. McPherson 1 (June 24, 2014).

Termination of the marks would, if the consequences are as severe as GHMSI claims, constitute a de facto repeal of D.C.'s statutory provision for a Company Action Level Event, and would short-circuit the NAIC's entire structure of graduated safeguards. There would be little point in the DISB proceeding with a detailed remedial plan if the outcome was already foreordained because the marks had been withdrawn. Thus, the carefully drawn statutory remedial provisions would be rendered nugatory.

Of course that de facto repeal is never going to happen. Nor in our view is the Commissioner—or GHMSI itself—ever going to permit GHMSI's surplus to fall anywhere near to the 200% RBC level. And even if it did fall to that level, the Commissioner could stop a termination of the license simply by requesting BCBSA to defer action to withdraw the marks, in order to provide opportunity for a remedial plan to be developed and implemented over a reasonable period of time. It is virtually inconceivable that the BCBSA Board would ignore such a request, or that, if it did, supermajorities of Blues plans in both number and interest would vote to withdraw. In the interest of avoiding disruption that could turn out to have been unnecessary, both common sense and comity would support honoring such a request.³²

³¹ "We have the broadest networks, provider networks typically" Tr. 110:8-9 (Burrell).

³² The rush-to-judgment scenario that GHMSI, Milliman, and Rector press is extremely implausible for yet another reason. BCBSA and its licensees are under heavy antitrust attack in multidistrict litigation involving dozens of complaints initially filed by subscribers and providers in jurisdictions across the country and now consolidated in federal district court for the Northern District of Alabama. *See In re Blue Cross Blue Shield Antitrust Litig.* (MDL No. 2406) (N.D. Ala.), Class Action Complaint (filed June 12, 2014); Consolidated Second Amended Provider Complaint (filed Sept. 30, 2014). The allegations focus on the territorial exclusivity provisions of the Blues license agreements. Discovery has just begun. The consolidated complaints specifically cite the procedures for termination of the Blues marks as one of the elements in the alleged per se violation and anticompetitive conspiracy. Class Action Complaint ¶ 343; Provider Complaint ¶ 161. Termination of GHMSI's marks would involve joint action by potential competitors to remove an incumbent and create an opportunity to substitute as the exclusive Blues licensee for one of the potential competitors voting for termination. Such action might or might not constitute an antitrust violation. But it would assuredly constitute a disruptive, destructive, and controversial joint action affecting the Nation's capital through a mechanism and by an Association that is under large-scale antitrust attack. A prudent

The time for GHMSI's prospect of recovery to be assessed would be after the remedial plan had been in effect for a reasonable time, and not before the Commissioner and the Company had even developed such a plan. An RBC ratio of 200% is an event that all concerned should seek to avoid. There is no dispute about that. But a surplus at that level would not, contrary to the claims by GHMSI and Rector, make withdrawal of the Blues marks inevitable.³³

In his Third Scheduling Order, the Commissioner directed GHMSI to "explain with specificity the consequence to GHMSI . . . if its surplus falls below either 200% RBC-ACL or 375% RBC-ACL, distinguishing in each case between discretionary and mandatory actions on the part of the Association."³⁴ As part of its response, GHMSI claims that the Association "has acted forcefully in the past to enforce its brand standards and financial requirements."³⁵ For that assertion it cites, as its sole example, the Association's Complaint in *Blue Cross & Blue Shield Association v. CareFirst, Inc., et al.*, Case No. 1:03-cv-03422 (N.D. Ill. May 21, 2003) ("Complaint"). This supposed example does not bear even remotely on the issue whether supermajorities in separate votes by number and interest of Blues licensees would take the counter-productive action of automatically withdrawing the Blues marks from GHMSI even if it appeared that GHMSI had a reasonable prospect of regaining its footing, pursuant to the cooperative remedial plan worked out with the Commissioner under the Company Action Level provisions of the NAIC capital management structure and the D.C. Code.

GHMSI does not reveal in its answer to the Commissioner's question anything about what that suit was about; it says only that it involved legislation that "applied to GHMSI." GHMSI Sept. 5, 2014 Response, at 10–11. In fact, the suit involved provisions in the license agreement that are entirely different from the 200% and 375% standards. It involved provisions providing for "automatic termination" of the license agreements if "the Department of Insurance or other regulatory agency assumes control of the Plan" or a "trustee, interim trustee, receiver or other custodian for any of the Plan's property or business is appointed."³⁶ Complaint ¶ 28. No special meeting, no vote, and no supermajorities, were involved.

BCBSA board would avoid such action unless and until it was clear that there was no other course. That point could not be reached until the Company Action Level remediation plan had been developed, implemented, and given appropriate opportunity to succeed.

³³ A close reading of the BCBSA's submission to the Commissioner does not contradict this view. The statement by the BCBSA's President that its Board "would commence actions to terminate" is artfully ambiguous. If it simply means that the Board would be required by BCBSA's by-laws to put the matter to a vote of the licensees, then it says nothing about what that vote would be. If, instead, it is a prediction of the vote, it remains without foundation and is implausible; it assumes precipitate action that is self-destructive, sabotages both the NAIC structure and DC law, and would ignore a direct request by the Commissioner that we are confident would have been made.

³⁴ Third Scheduling Order, Exhibit A, at 4.

³⁵ GHMSI Sept. 5, 2014 Response, at 10.

³⁶ According to the Complaint, the relevant provisions were in Paragraph 15(a) of the License Agreement. The comparable provision in the current version of the license agreement is in ¶ 7.E.(3)(v)-(vi). See GHMSI Sept. 5, 2014 Response, Attachment A, Controlled Affiliate License Agreement. It states that, in the event of the assumption

After the unsuccessful WellPoint bid, the state of Maryland enacted legislation that would have resulted in the State “assuming control over CareFirst.” *Id.* ¶ 5. The legislation:

- “mandated the complete removal of CareFirst’s existing board of directors and banned them for life from returning to the board;”
- “vested in the Maryland Insurance Commissioner effective control over the board’s most important operational decisions, including executive compensation;”
- “established a Joint Nonprofit Health Service Plan Oversight Committee . . . consisting of legislators and others selected by the Governor and the leaders of the Maryland Senate and House and serving at their pleasure, granting it virtually plenary powers of review over CareFirst’s business and operations.”

Id. ¶ 31.

Of course in these circumstances the licenses would terminate. The licensee, while it still existed in form as a corporate entity, no longer existed in substance as an independent business entity run by its own board. This supposed “example” is irrelevant. And it ignores the Commissioner’s request in his question to “explain with specificity the consequences” of falling below 200%, “distinguishing in each case between discretionary and mandatory actions on the part of the Association.” The example involved mandatory action, whereas the 200% question involves discretionary action; and, far from illustrating anything with specificity, involved entirely different provisions from the 200% provision.

None of this is to say GHMSI’s surplus falling to 200% RBC is not a serious matter and is not one to be avoided. Our point is that the consequences of falling to that level do not warrant a 98% confidence level that results in the withdrawal of hundreds of millions of dollars from being available for community reinvestment—an availability that was the primary purpose of MIEAA.

Fourth, the excessiveness of the 98% confidence level was further demonstrated by the rationale that Rector itself gave for selecting that level. At the June 25 hearing Rector testified:

[T]he scenario we’re seeking to protect against . . . would be one where GHMSI were to lose approximately \$700 million in surplus in just three years. You might think that it’s impossible for GHMSI to lose that much money that fast, but remember, that we’re talking about something that has a 2 percent chance of happening, something that would happen statistically twice every 100 years. . . . For example, just before the Great Recession hit, no one thought that we would ever again have a financial catastrophe even approaching that of the Great Depression. But we’ve now had two such financial catastrophes in less than 100 years, roughly the same probability as we measured relative to GHMSI.

Tr. 38:25–39:17.

of control by government or a trustee the licenses “*immediately terminate without any further action* by any party.” *Id.* ¶ 7.E (emphasis added).

In the first place, the Commissioner should plainly not adopt a confidence level designed to protect against a loss that Rector itself said seems impossible—that the company could lose \$700 million in three years; this is particularly so given that the most extreme event Rector could conceive of that might precipitate such a loss—the Great Recession— was one in which GHMSI actually *increased* its surplus.

Moreover, the idea that GHMSI would lose \$700 million in three years is not just remote; it is completely implausible based on the track record of the company. The fact is that the company has never lost \$100 million over any 3-year period, never mind more than \$200 million a year three years in a row. Shaw Rebuttal 11. As Mr. Shaw shows in his attached statement, based on GHMSI’s actual performance over the last 19 years, (1995–2013) and standard statistical calculations. GHMSI has only a 2% chance of losing even \$50 million over a three-year period, which is once in every 102 years (once in every 34 three-year periods); less than a 1% chance of losing \$300 million over a three-year period, which is once in every 2,187 years; and a virtually non-existent chance of losing \$700 million over a three-year period. As Mr. Shaw demonstrates, the probability of GHMSI losing \$700 million in surplus in three years—based on its actual historical record—would be once in every 2.5 million years. *Id.* at 13.

We recognize that modeling, in contrast to this historical examination, attempts to account for events that might occur, and that are possible and (when properly done) reasonably probable. While this 19-year analysis is, therefore, not a substitute for modeling, it should bear on the judgments to be made with respect to the modeling, including the confidence level. The 19-year analysis covers the entire relevant historical period (subsequent to the adoption of the RBC structure, and to the replacement of the GHMSI management group that had egregiously misbehaved in the early 1990s). Instead of using constructed probability distributions, it shows actual, all-in effects: “The year-to-year surplus changes reflect the impact of all items that impact surplus on a year by year basis – changes in non-admitted assets, investment gains or losses, underwriting losses or gains, company strategies, management interventions and market pressures.” Shaw Rebuttal 12. The results are strikingly consistent, throughout this period of economic and technological change.

Fifth and finally, the record in this proceeding shows that GHMSI’s own experts do not uniformly support a 98% level. For example,

Milliman, in its report recommending GHMSI’s surplus level as of the end of 2010, stated that in developing its recommendations it considered “a range of multi-year loss cycle amounts for which there is a high likelihood (i.e., *exceeding levels of 90% to 98%*) that such a loss will not be exceeded, even under significant or severe unforeseen adverse circumstances” Milliman May 31, 2011 Report, at 18 (emphasis added)

Milliman then shows what the percentage losses would be for GHMSI at each of those high confidence levels—at 90%, 95%, and 98%. *Id.* at 17. It then selected 95% confidence level for avoiding 375% RBC, and 98% for avoiding 200% RBC—98% being what Milliman called “virtual certainty.” *Id.* at 13, 15. However, without explanation, in its most recent report (regarding recommended surplus as of the end on 2013) Milliman *lowered its confidence level* for avoiding 375% *from 95% to 90%*. Moreover:

- Lewin, in its 2009 report, also had recommended the lower 90% confidence for avoiding 375%, and 95% (rather than Milliman’s 98%) for avoiding 200% RBC. The Lewin Group, *Recommended Surplus Range for GHMSI: Approach and Considerations for Determining the Appropriate Range of Surplus 23* (Oct. 29, 2009).
- And Rector, differing from Lewin, stands by Milliman’s 98% for avoiding 200% RBC (in disagreement with Lewin), yet has now lowered its recommended level for avoiding 375% RBC by a full 10 percentage points—from 95 % to 85% confidence (differing from both Milliman and Lewin).

This variation among GHMSI’s own actuaries and with Rector is not a surprise. It demonstrates that there is simply no clear case even among GHMSI’s own experts that 98% is “the right” level to select, and even when those experts selected that high level, it is clear they should have selected a lower level given their expressed purpose in selecting 98%.

The selection of the confidence level is in the end *a legal judgment, not an actuarial judgment*, and one to be made through application of the calibration and balancing required by the Court of Appeals. As Mr. Rector said at the June 25 hearing: “It’s a matter of judgment, and ultimately, it’s a matter of the Commissioner’s judgment.” Tr. 35:9.³⁷ To that we would add, as previously noted, that a proper judgment must integrate the MIEAA directive for “maximum feasible” community reinvestment. Moreover, the fact that GHMSI’s own actuaries acknowledged that 95% or 90% would protect against “particularly or severely adverse outcomes,” Milliman May 31, 2011 Report, at 18, confirms our view that one of those lower levels should be considered—especially since GHMSI’s own actuaries selected lower levels *without regard to the need to maximize community reinvestment*.

2. A 90% Confidence Level Best Implements MIEAA

Given that a 98% confidence level cannot be justified, the question before the Commissioner is: what is the lower level that should be selected in light of MIEAA and the Court of Appeals’ decision? For several reasons, the Commissioner should select a 90% confidence level.

First, the Commissioner should start with the fact that the level Milliman and Rector intended to use was one they thought would protect against a one-in-50 year event. And as we have explained, that number is 94% not 98%. This necessarily shows that the correct number

³⁷ Even though Rector agreed the selection of the confidence level is a matter of judgment for the Commissioner, Rector initially did not provide the Commissioner any data from which he could effectively choose a different level from the one they recommended. Mr. Shaw’s statement and tables do provide that data. The Commissioner subsequently asked Rector what the target surplus would be at confidence levels of 90%, 93%, and 95%. Third Scheduling Order, Exhibit A, at 1 (question 2). Rector suggested that the Commissioner ask the question of GHMSI/Milliman. Rector Aug. 27, 2014, Response, at 3. The Commissioner did so in his Order With Supplemental Information Requests (Oct. 3, 2014). The information Rector provided based on Milliman’s calculations confirms Mr. Shaw’s contentions that small changes in the confidence level and/or premium growth assumptions produce dramatic reductions in GHMSI’s need for surplus.

under MIEAA should be lower than 94%, because that number was effectively endorsed by Rector and Milliman *without applying the in-tandem test* as required by the Court.

Second, as Mr. Shaw's work shows, lowering the confidence level by only 8 points (from 98% to 90%) creates significant dollars for community reinvestment. At the same time, as a practical matter a 90% confidence level is consistent with the company's financial soundness. Milliman itself considered 90% as a "high" confidence level that would protect against reaching 200% even in "significant or severe unforeseen adverse circumstances." Milliman 2011 Report, 18. That level protects against reaching 200% even once in every 30 years.

Third, 90% is only 5 percentage points below the number Lewin recommended *without regard to the in tandem requirement*. Moreover, as we earlier discussed, Judge Fisher was skeptical that a confidence level as high as 95% confidence could be justified under MIEAA, much less 98%. Oral Argument at 12:21:36. Taken together, these considerations indicate that if the "calibration" for community reinvestment is to have real meaning under the Court of Appeals' decision, a figure several points lower than 95% is appropriate.

Finally, in addition to the calibration required by the Court, the "efficiency" standard should inform the Commissioner's selection of the confidence level. Under the "efficiency" standard, as we have explained, GHMSI's surplus should be calculated to protect GHMSI from all reasonably probable outcomes, but not from outcomes modeled from probability distributions skewed toward remote and extreme events. Protecting GHMSI from 90% of the outcomes generated by realistic probability distributions comes closest to fulfilling the "efficiency" requirement, and a level higher than 90% would therefore depart from reasonably probable outcomes.

Taken together, these considerations confirm that a 90% confidence level comes closest to meeting MIEAA and the Court of Appeals' requirements: at that level, the Commissioner can be confident that the company is well-protected against reasonably probable contingencies and has also maximized the dollars it is making available for community reinvestment. We therefore urge that the 90% confidence level be selected.

B. Selecting Middle-of-the-Fairway Assumptions

Other than the selection of the confidence level, three factors used in the Modified Milliman Model have the biggest impact on the estimate of GHMSI's need for surplus: (1) rating adequacy and fluctuation; (2) equity portfolio asset values; and (3) premium growth. Tr. 72–73. Shaw's June 10 Pre-Hearing Statement, at 10 (confirming these are important). Shaw Report 3–4.

As a consequence, Mr. Shaw focused his analysis on the reasonableness of Rector's and Milliman's assumptions regarding those three factors. Mr. Shaw then went on to show how the assumptions for those three factors should be computed. And in doing so, Mr. Shaw did what Rector and Milliman did not do: he explained exactly *what* data he relied on to derive his assumptions, *how* he used those data to derive those assumptions, and *why* those assumptions constitute a reasonably probable estimate of GHMSI's likely future performance.

We think the explanation Mr. Shaw offered is required *as a matter of law by the Court's decision*. Furthermore, his corrected assumptions comply with MIEAA's "efficiency" standard, while, those used in the Modified Milliman Model do not. Below, we show that Mr. Shaw's assumptions for the three key factors that drive the model's results meet MIEAA's efficiency standard. We then answer Ms. Doran's criticism of Mr. Shaw's work as presented in her written testimony of June 25. *Public Hearing to Review the Surplus and Community Health Re-Investment of GHMSI Before the D.C. Dep't of Ins., Sec. & Banking* (June 25, 2014) (Testimony of Phyllis Doran, F.S.A., M.A.A.A.) [hereinafter "Doran Testimony"]. Finally, in Section III we show why the results of Mr. Shaw's correction to the model, together with other factors the Commissioner should consider, strongly indicate that the surplus that best complies with MIEAA is a point between \$400 and \$500 million.

1. *Rating Adequacy and Fluctuation*

Mr. Shaw explained in his June 10 pre-hearing statement, Shaw Report 6–18, how he computed the appropriate RAAF probability distributions to determine the most likely middle-of-the-fairway outcomes. *Id.* at 6–18. He analyzed the historical experience of the 10 most comparable Blues during 2002–2013 and GHMSI's experience during 1999–2013. He used the underwriting gains and losses for these companies as a proxy for rating adequacy, measuring the probability of negative results based on actual historical performance. The results show that the probability distributions for RAAF used by Milliman and Rector in the Milliman model bear no resemblance to the historical record and greatly inflate the probability of severe negative losses based on the RAAF factor. *Id.* at 12.

Mr. Shaw also adjusted historical results for the ACA, *id.* at 13–17, and specifically considered whether the ACA would increase the risk of *large losses*. He shows that once the risk mitigation measures of the ACA are taken into account—which neither Milliman nor Rector did—the ACA will have little impact on the risk of large losses and that, if anything, that risk will be *decreased* under the ACA. *Id.* at 17.

Based on these observations Mr. Shaw developed a revised probability distribution for the RAAF factor used in the Milliman model and explained why he chose the numbers that he did, based on the historical record and the likely impact of the ACA. The result was that, using the corrected probability distribution for this factor and holding everything else equal, Mr. Shaw projected a loss of 16.6% at the 98th percentile—not the 23.2% loss that Rector calculated. Although this still allows for substantial loss at the 98% level due to rating adequacy, the loss is smaller than the loss that Rector assumes but did not explain. *See* Section I, *supra*. Given the way the model works, a 16.6% loss factor rather than a 23.2% loss factor translates into a surplus need that is \$193 million lower. Shaw Report 17, 18.

In her June 25 written testimony, Ms. Doran objected to Mr. Shaw's RAAF calculations. In the attached Rebuttal Report, Mr. Shaw responds to Ms. Doran.

Before addressing Ms. Doran's objections to how and why he adjusted Rector's probability distributions for the RAAF, we note that still, to this day, Milliman has not offered *any* explanation for *its* probability distributions. *See* Section I, *supra*. Nevertheless, Mr. Shaw

responds to Ms. Doran’s criticisms of his approach even though she has not provided the required explanation of her own approach.

Ms. Doran says in her June 25 testimony that Mr. Shaw’s analysis of the rating adequacy and fluctuation factor used in the Modified Milliman Model “should be disregarded” because it is “based on an approach that is indirect, potentially biased, and of limited (if any) applicability to GHMSI.” Doran Testimony 3, 5.

Ms. Doran’s criticism is very hard to understand since what Mr. Shaw analyzed is the *actual results of GHMSI itself* and 10 Blues comparable to GHMSI in size over the entire period of time during which current RBC standards have been in place (2002–2013). This allowed Mr. Shaw to base predictions about rating adequacy based on real-world results for GHMSI and its peers during the most relevant time period.

In contrast, Ms. Doran says in her testimony that Milliman’s approach to predicting GHMSI’s future need for surplus due to potential rate inadequacy is preferable because it “*simulates* GHMSI’s rating processes using a large universe of healthcare costs . . . measured over an extended period of time (from 1986 through 2010).” Doran Testimony at 5 (emphasis added). Ms. Doran never explains her basis for believing that she can simulate GHMSI’s responses, why simulated results are better than real ones, what she means by a “large universe of healthcare costs,” why she thinks that a “large universe” is a better indicator than the actual costs of companies most comparable to GHMSI, and why going back to 1986 is better than analyzing the years most indicative of future performance—the years when the current RBC regulatory regime has been in place.

Further, and contrary to the requirements of the Court of Appeals, Ms. Doran never gives the details of her approach. As a result, we do not know how Milliman went about “simulating” GHMSI’s “rating processes” based on a “large universe of healthcare costs” during the years 1986–2010. Ms. Doran simply asserts—without analysis or justification that could meet the Court’s standards—that “Milliman’s approach to simulating rate adequacy and fluctuations directly for GHMSI is robust, sound, and superior.” Doran Testimony at 5. Saying it will not make it so, and conclusory statements cannot provide the necessary reasoned explanation that is required for the Commissioner’s decision.

Ms. Doran was also critical of Mr. Shaw for leaving certain companies out of the ten he used for his analysis. In response, Mr. Shaw added an additional five comparable companies to his analysis and shows in the attached statement that there is no material impact on his recalculation of the rating and adequacy factor that should be used in the Modified Milliman Model. Shaw Rebuttal 17–18.

In the end, Mr. Shaw’s analysis estimates reasonably probable outcomes for the company—including possible downturns—based on historical performance and adjusting for the ACA. This approach is consistent with MIEAA’s efficiency requirement. And, as noted, although his recalculation allows for the possibility of a significant 16% loss due to this factor at the 98% confidence level, this still requires a reduction in needed surplus of \$193 million, in contrast to Rector’s unexplained results using the Modified Milliman Model.

2. *Equity Portfolio Asset Value*

As Mr. Shaw explained in his June 10 statement, predicted losses associated with GHMSI's equity portfolio were the second biggest driver of Rector's increase in projected surplus compared with its 2009 report. Shaw Report 30. But as we have shown, *supra*, neither Rector nor Milliman has met MIEAA's requirements, as established by the Court, for developing and explaining their use of this factor. Indeed, not only did Rector and Milliman fail to explain why they used a negative 3% return as the most likely middle-of-the road outcome for equities, but they also misunderstood that the use of this negative return rather than the previous 50-year positive return of 7.3% resulted in a significant deduction for non-FEP premium revenue in the pro forma model and a huge increase in needed surplus.

As a consequence, Mr. Shaw did his own analysis to determine an appropriate probability distribution for this factor based on historical performance. As a basis for his analysis, Mr. Shaw studied the returns on the Dow Jones Industrial Average as the basis for determining the risk of loss in GHMSI's equity portfolio for the period 2012–2014.

Based on this analysis, Mr. Shaw developed a revised probability distribution for this factor, reducing the probability of the loss to GHMSI from Milliman's -23.2% to a more reasonably probable -15.8%. Shaw Report 21. This distribution showed a lower risk to GHMSI's equity portfolio than the distribution Rector used and, as a result, a significantly lower need for surplus. This was not a surprise: the most likely outcome for the portfolio based on past performance would be *a significant gain*. In contrast, Rector relied on the Milliman distribution, which assumed the most likely outcome would be a negative 3 percentage points. Mr. Shaw's adjustment to the equity portfolio factor, leaving everything else in the model unchanged (including the 98% confidence level), decreases the estimated surplus target by \$216 million. Shaw Report 32.

In her June 25 written testimony, Ms. Doran says Mr. Shaw's analysis "is completely wrong based on a number of analytical errors." Doran Testimony, at 6. She appears to suggest four such errors, which we address below:

First, Ms. Doran explained that Milliman's approach to this factor (which Rector adopted without change) was first to project annual investment income "based on an expected average rate of return" and then to use the model "to reflect the risk that the actual rate of return deviates from this average rate. . . ." *Id.* But the problem with this is that Mr. Shaw explained how he developed the expected average rate of return based on the Dow's past performance and how he developed probability distributions to reflect the risk that the average historical rate of return might not be obtained in 2012–2014. Neither Milliman nor Rector explained the probability distributions they used. But in any case, their probability distributions are plainly wrong because they bear no relationship to either the levels or variations in actual equity returns since 1975. Milliman does not explain why the most likely deviation for the equity portfolio would be a negative 3 percentage points loss for the period 2012–2014 when, as Mr. Shaw showed, over the period 1975–2013, "a gain for the a 3-year period is more than four times as likely as a loss." Shaw Report 30.

Second, Ms. Doran asserts that Mr. Shaw was wrong to develop distributions reflecting “three-year full rates of return, rather than deviations from an expected rate of return.” Doran Testimony 6.

As Rector explained, its surplus recommendation using the Modified Milliman Model is based on a “three-year pro forma income statement for 2012–2014.” Memorandum from Sarah Schroeder, Rector & Assocs., to Philip Barlow, Assoc. Comm’r, DISB 4 (May 12, 2014) (“Rector May 12, 2104 Memo”) (attached to May 13, 2014 Letter from Commissioner McPherson). The probability distributions that Milliman developed, Rector accepted, and Mr. Shaw modified were all designed to do what Ms. Doran says—estimate the risk that the actual equity rate of return during 2012–2014 would deviate from the expected average rate of return. That is what Mr. Shaw calculated. Again, the difference is that Mr. Shaw explained what he did and why, and his probability distributions reflect reasonably probable future outcomes based on historical performance. The distributions developed by Milliman and adopted by Rector are unexplained, and they do not reflect historical performance.

It could be that Ms. Doran’s point is the one we addressed earlier in commenting on Rector’s responses to the Commissioner’s questions. There, we noted, Rector seemed to justify its treatment of the equity portfolio factor by saying that while it is true that it projected a loss on equities as the most likely outcome, it somehow netted that loss against the 3.75% gain expected for the total portfolio. But as we explained earlier, that is not how the model works: Rector’s projected loss on equities causes a substantial reduction in GHMSI’s projected non-FEP premium revenue, not a netting against its portfolio income. And as result, the negative projected equity return requires a huge increase in surplus—\$215 million at the 98% confidence level. *See* Section I, *supra*; Shaw Rebuttal 2.

Third, Ms. Doran says Mr. Shaw should not have included returns on pension assets in assessing expected future returns. Doran Testimony at 7. But Milliman appears to have done just that. As Mr. Toole explained in his March 6, 2014 memo, Milliman made changes to this factor by “including the impact of pension [] [assets]”—producing a 70-point increase in Milliman’s estimate of GHMSI’s need for surplus.³⁸ As Mr. Shaw simply accepted and adopted Mr. Toole’s statement of what Rector and Milliman did, in order to replicate the model, Ms. Doran is also contradicting Mr. Toole. Further, she is contradicting what Rector said in response to the Commissioner’s recent questions. Rector has specifically told the Commissioner that in response to Milliman’s 2009 analysis, Milliman *did include pension assets in its 2011 analysis*.

In fact, GHMSI fully integrates its pension assets and liabilities (as well as liabilities for other post-retirement benefits such as retiree health insurance) into its capital and surplus statement, in large part as adjustments to admitted assets. In addition, GHMSI sponsors a nonqualified supplemental retirement plan (which provides benefits to “certain officers” that exceed IRS limits on tax-qualified contributions) and contributes to these benefits as they are

³⁸ Memorandum from Jim Toole, FTI Consulting, to Rector & Assocs. (Mar. 6, 2014), *available at* <http://disb.dc.gov/sites/default/files/dc/sites/disb/publication/attachments/QuantificationofAssumptionChanges.pdf>.

paid, in effect drawing from surplus or potential surplus annually.³⁹ In 2013, GHMSI recognized \$37.7 million in “net periodic benefit cost” for pension and other post-retirement benefits as a charge against capital and surplus. Health Annual Statement for Year Ended Dec. 31, 2013 of GHMSI, Notes to Financial Statement, Section 12.

Fourth, Ms. Doran says that Mr. Shaw erroneously omitted consideration of Blue Choice in assessing the impact of the equity portfolio on surplus needs. In his rebuttal Mr. Shaw has recast his EPAV factors to reflect this additional element and the change in the EPAV factor impact is modest – the EPAV factor remains second to RAAF in its impact and continues to have greater impact than all other non-RAAF factors combined.

In the end, we think it is quite clear that Rector and Milliman’s use of the equity portfolio factor in the model is not based on middle of the road assumptions and is nowhere near being what Rector said it was trying to accomplish—projecting through the model what it thought was actually going to happen. Rector acknowledged that actual equity returns over the last 50 years were 7.3%. Yet in the model it projected that the most likely outcome for 2012-2014 was a loss of 3% on equity in GHMSI’s portfolio. The Commissioner in his questions to Rector asked what the actual equity returns were to GHMSI’s portfolio in 2012 and 2013. Although Rector did not answer the question, Mr. Shaw shows in his attached statement that the actual equity returns to the portfolio were 16.6% in 2012 and 12.7% in 2013.

In these circumstances, DC Appleaseed submits that even if the Commissioner changes nothing else in Rector’s use of the model—in addition to calibrating the confidence level and changing the premium growth assumptions—he should also change the equity factor assumptions in order to bring use of the model into compliance with MIEAA. This is particularly needed given, as Mr. Shaw has shown, the dramatic increase in surplus need produced by Rector’s use of an equity portfolio factor so out of keeping with historical performance. As Mr. Shaw shows in his attached statement, making only the changes to premium growth (non-FEP growth rate centered at 8%) already calculated by Rector, along with using an equity portfolio factor that projects returns based on actual historical performance, produces a need for surplus of 394% RBC at the 90% confidence level, 461% RBC at the 93% level, and 523% RBC at the 95% level. Shaw Rebuttal 35 ch.20.

³⁹ GHMSI’s 2011 annual statement language clearly explains that these payments are taken from capital and surplus; a relatively small share is backed by nonadmitted assets: “The estimated transition asset, prior service cost and net actuarial loss for the defined benefit pension plans that will be amortized in 2012 *from capital and surplus* into net periodic benefit costs are \$(2,650,000), \$190,000, and \$11,715,000, respectively. The estimated transition liability for other postretirement benefit plans that will be amortized in 2012 *from capital and surplus* into net periodic benefit costs is \$283,000. An additional pension liability is required when the actuarial present value of accumulated benefits obligation exceeds plan assets and accrued pension liabilities. As of December 31, 2011 and 2010, additional liabilities of \$23,650,000 and \$8,656,000, respectively were recorded. In connection with the additional liabilities, intangible pension assets of \$140,000 and \$152,000, respectively, were *recorded and nonadmitted.*” (emphasis added) Health Annual Statement for Year Ended Dec. 31, 2011 of GHMSI, at 25.11 (emphasis added).

3. Premium Growth Assumptions

Rector used a 12.5% growth rate for non-FEP as the most likely outcome for the years 2012-2104—even though during the most recent five years the average growth was 2.8%, and the highest growth for any one year was 5.5%. Mr. Shaw modified Rector’s probability distribution for premium growth based on the most recent five years’ actual experience while allowing for the possibility of reasonably probable departures from past experience due to ACA and other market factors. Specifically, he assumed 3.8% non-FEP weighted average premium growth (1 percentage point higher than the historical weighted average), rather than the 12.5% used by Rector. Shaw Report 26. This change reduced the estimated need for surplus by \$207 million, leaving all other assumptions in the Modified Milliman Model and the 98% confidence level unchanged. *Id.* at 27.

Ms. Doran criticizes this adjustment in her June 25 written testimony. She says that the previous five years were “atypically low” for premium growth and therefore Mr. Shaw’s use of 3.8% is inappropriate. She proposes 7% and 11%, and does not say what number Milliman would propose; nor does she endorse or attempt to justify Rector’s use of 12.5%.

She does cite a study saying that aggregate employment-based premiums decreased by 6% from 2008 to 2011, in part due to consumers downgrading benefits to offset increased medical costs. Doran Testimony at 7. Her implicit point, presumably, is that this was attributable to the recession and that now greater growth can be expected. But facts belie that supposition. There are no facts that could justify a finding that 7%, 11% or 12.5% growth in 2012-2014 is reasonably probable when GHMSI’s membership declined in three of the last five years, including 2013. Moreover, she offers no evidence to suggest that consumers will cease downgrading benefits, or when that will occur, or why it will occur given that it has not yet occurred.

In addition, Ms. Doran points out, *id.* at 7, that “GHMSI’s growth rates have varied substantially over time”—which is true. But she nowhere explains why a dramatic change from the last five years should be expected, or why the change would warrant a prediction of 7%, 11%, or 12.5% growth as the most likely outcome versus the actual 2.8% experience of the last five years.

In the end, as with the other key assumptions used in the Modified Milliman Model, neither Rector nor Milliman has explained the basis for their assumptions in a way that would meet the requirements of the Court of Appeals’ decision. Mr. Shaw’s data-driven analysis shows the error in those assumptions, and develops corrected assumptions that do meet those requirements. His analysis provides the appropriate modeling component for the Commissioner’s ultimate judgment as to the appropriate surplus for GHMSI under that decision.

Before turning to that judgment, we wish to address the new data Rector has provided in response to the Commissioner’s supplemental questions. In those questions the Commissioner asked Rector to compute a revised surplus estimate based on lower confidence levels and lower premium growth assumptions.

The much lower need for surplus resulting from slight reductions in the confidence level, particularly taken together with the premium growth assumptions suggested by the Commissioner, confirm the reliability of the calculations provided by Mr. Shaw in his June 10 statement. Shaw Report 58 ch.25. Rector's revised premium growth assumptions, in contrast, still are not based on middle-of-the-fairway projections and do not fairly implement MIEAA's requirement that the surplus be based on reasonably probable outcomes. As Mr. Shaw says in his attached statement, even accounting for the one time surge in enrollment that was expected in 2014 due to removal of individual underwriting and the exchange subsidies, GHMSI's 3-year average annual non-FEP growth rate including the surge year of 2014 is only 5.4%. Shaw Rebuttal 6–7. This confirms that the growth rates Rector used were neither reasonably probable nor middle of the fairway. It also suggests that the alternative non-FEP premium growth rates suggested by the commissioner in order number 14-MIE-008 are also too high as those rates have 8% as the most likely result, with the possible range being 4.5% to 12.2%.

Accordingly, in Mr. Shaw's attached statement, he shows the results the Commissioner would produce at the 95%, 93%, and 90% confidence levels if he changed nothing else except (1) adjusted the premium growth assumptions as the Commissioner has already suggested, or (2) also changed the equity portfolio projections as Mr. Shaw suggests; or (3) made a further change in the premium growth assumption to the recent 5.4% 3-year growth rate and also changed the equity portfolio assumption as Mr. Shaw suggests. These changes produce the following outcomes: 1) 721%, 653% and 575% RBC at 95%, 93% and 90% confidence, respectively; 2) 523%, 461% and 394% RBC at 95%, 93% and 90% confidence, respectively; and 3) 506%, 445% and 380% RBC at 95%, 93% and 90% confidence, respectively. Shaw Report 35 ch.20.

III. BASED ON THE MODIFIED MILLIMAN MODEL WITH CORRECTED ASSUMPTIONS AND A FAIR IMPLEMENTATION OF MIEAA, THE COMMISSIONER SHOULD APPROVE A SURPLUS FOR GHMSI AT A POINT BETWEEN \$400 AND \$500 MILLION.

While we have not agreed with using the Milliman model for this proceeding, we understood that the Commissioner might wish to rely on it at least in part for his determination. Accordingly, we recommended adjustments that we think must be made to the model so that the numbers it produces will be calculated in compliance with MIEAA and the Court of Appeals, see discussion in Section II, *supra*.

These adjustments were initially set out in Figure 7 of our June 10 Pre-Hearing report and are based on Chart 25 of the Shaw Report. *See* DC Appleseed Pre-Hearing Report 43 fig.7. Chart 20 in Mr. Shaw's Rebuttal Report contains revised numbers with respect to the EPAV factor, and Premium Growth; including, for the latter, results using the 8% growth assumption as to which the Commissioner inquired of Rector and Milliman. The revisions are explained in Mr. Shaw's Rebuttal. Shaw Rebuttal 6–7, 20–21, 35.

Chart 25 shows the surplus levels (as a percent of RBC) that the Modified Milliman Model would produce, depending on the confidence level selected (90 %, 95%, or 98%) and the assumptions made for the three key factors that largely drive the model's results (namely, the RAAF, the Equity Portfolio Asset Value factor, and the Premium Growth factor). *Id.* With corrected assumptions in hand, the Commissioner can properly take into account the modeled

results. In addition, as just noticed, we have provided an additional chart in Mr. Shaw’s rebuttal showing more limited adjustments the Commissioner might make to Rector’s use of the model.

At the same time, however, the Commissioner needs to go beyond the model in reaching his ultimate conclusion under MIEAA. Modeling has figured heavily in this proceeding, but we are now at the final stage where an ultimate determination under MIEAA is necessary. That ultimate determination requires both taking into account and going beyond model results. Estimating a reasonable surplus under MIEAA requires a broader assessment than can be provided by computer output that was never intended to reflect actual real-world events, and that, like any model, does not capture all relevant factors. As we noted in response to the Commissioner’s question 4.a. in the Third Scheduling Order, “[s]ophisticated as it may be, a model is only a theoretical construct that does not fully capture reality; instead, the very purpose of a model is to simplify reality.”⁴⁰ The probability distributions inputted to the Modified Milliman Model were by design once-removed from reality: they related to various potential negative impacts on GHMSI’s surplus but not to underlying real-world events that might bring about those impacts. As Rector testified: “We don’t place probabilistic probabilities [sic] on specific events such as a pandemic or a terrorist attack. Instead, we just demonstrate the potential impact of events of a certain probability of magnitude on surplus levels no matter what caused it.” Tr. 70:1–6. Thus, “we didn’t look at—we weren’t saying, well, let’s see what can happen with this potential event or that potential event or what happened if we had five of these specific potential events. We didn’t look at potential events like that at all.” *Id.* at 70:23–71:3.

The Commissioner thus should supplement the model results to ensure that his ultimate determination bears a reasonable relationship to reality and as a practical matter faithfully implements the intent of MIEAA. Indeed, it is a basic principle of administrative law that the “ultimate responsibility for the policy decision remains with the agency rather than the computer.” *Sierra Club v. Costle*, 657 F.2d 298, 334 (D.C. Cir. 1981), and that “models, despite their complex design and aura of scientific validity, are at best imperfect and subject to manipulation The accuracy of the model’s predictions also hinges on whether the underlying assumptions reflect reality, which is no small feat in this volatile world.” *Id.* at 332; *see also Chem. Mfrs. Ass’n v. EPA*, 28 F.3d 1259, 1265 (D.C. Cir. 1994) (“we must reverse the agency’s application of the . . . model as arbitrary and capricious if there is simply no rational relationship between the model and the known behavior . . . to which it is applied”).

The Pennsylvania decision recognized the necessity of judgment as well. As that decision states, RBC is a “valuable tool” to be used “to evaluate and express surplus adequacy or excess.” But it is “not used by the Department in isolation or as an absolute criterion for an efficient operating range.” *In re: Applications of Capital BlueCross, et al.*, Misc. Dkt. No. MS05-02-006, slip op. at 19, 22, 23 (Ins. Dep’t of Commonwealth of Pa. Feb. 9, 2005). Moreover, the decision states, it must be recognized that models should not be relied on to assess surplus without close scrutiny since “a ‘model’ is an abstraction of reality” and “[a]ll models represent a simplification.” *Id.* at 28.

⁴⁰ DC Appleseed’s Response to Questions/Information Requested 3, Surplus Review and Determination for Group Hospitalization and Medical Services, Inc. (D.C. Dep’t of Ins., Sec. & Banking Aug. 27, 2014).

Thus, in our view the Commissioner should not rely on the Modified Milliman Model alone—or any model—without also making “a conscientious effort to take into account what is known as to past experience and what is reasonably predictable about the future.” *Am. Pub. Gas Ass’n v. Fed. Power Comm’n*, 567 F.2d 1016, 1037 (D.C. Cir. 1977).

In contrast to Rector, the Commissioner *does* have to think about whether potential events in the real world might realistically cause the enormous losses that Rector’s use of the model produces. And when he does so, we think he should conclude that Rector’s predicted losses are not reasonably probable and, therefore, should not determine GHMSI’s surplus under MIEAA. Instead, several other factors should be given weight by the Commissioner along with the model results. The number that takes account of those factors and best effectuates MIEAA is one between \$400 and \$500 million.

A. The Surplus Levels Recommended by Rector and Milliman are Unreasonable and Implausible on Their Face.

Once the Commissioner makes the appropriate adjustments to the Modified Milliman Model, the Commissioner should then test the model’s results against reality. The surplus levels recommended by Rector and Milliman cannot meet such a test. Below we explain five reasons why that is so.

First, neither Milliman nor Rector explain how their assumptions are tied to specific, real-world risks, and Rector specifically disavows any such link.

Second, it is not reasonably probable that GHMSI could lose \$700 million in a three-year period, which is what Rector’s use of the model assumes. In fact, GHMSI has never even lost \$100 million of surplus over any three-year period, much less the staggering amounts produced by Rector’s use of the model. Moreover, GHMSI management and the DISB would intervene well before the company even approached such sustained losses. In addition, as earlier noted, Mr. Shaw has shown that based on GHMSI’s actual performance for the last 19 years the statistical probability that it could lose \$700 million in three years is virtually nil.

Third, Rector’s and Milliman’s target surpluses each increased 400 percentage points from the 2008 surplus review to the current proceeding, without sufficient justification, casting further doubt on their recommendations.

Fourth, recent actual experience flatly contradicts a key premise of the model—that an enormous economic downturn could bring huge surplus reductions. In fact, GHMSI’s surplus actually *increased* during the most catastrophic potential risk event during the past 50 years, the Great Recession

Fifth, GHMSI’s own recent actions make clear that the company itself does not believe and apply the high surplus recommendations made by Rector and Milliman.

Although these five points are related, we address them separately below. Together they should inform the judgment that the Commissioner superimposes on the model results, in light of the MIEAA standards.

1. *Rector's Use of the Model is not Based on Specific, Real-World Risks.*

The Commissioner cannot reasonably rely exclusively on the results from Rector's use of the Modified Milliman Model because, in general, they reflect probability distributions that are detached from the specific, real-world risk events from which the surplus is designed to provide protection. In fact, as we discussed, *supra*, Rector was explicit that the outputs from the model were by design not keyed to actual real-world events.

Moreover, such exclusive reliance on a model does not, as explained earlier, comport with the legal requirements governing use of a statistical model in an agency proceeding. Rather, an agency is required to take "into account what is known as to past experience and what is reasonably predictable about the future." *Am. Pub. Gas Ass'n*, 567 F.2d at 1037. In addition, under the Court of Appeals' decision, the Commissioner cannot rely on the assumptions in the Rector model unless these assumptions have been explained and the Commissioner determines that these assumptions are sufficiently realistic.

However, in this proceeding, Rector never disclosed the factual bases for those assumptions. And as we have said, as a matter of law this failure to disclose should preclude the Commissioner from relying on the output from the model.

In the end, the probability distributions used by Milliman and Rector are simply numbers on a computer printout; neither we nor the Commissioner knows the underlying assumptions for them. Therefore, there is no factual predicate for assessing whether those numbers—which drive the model's output—constitute reasonable probability distributions for real-world outcomes. As a matter of law, this should preclude the Commissioner's exclusive reliance on the output from the model.

2. *It Is Implausible that GHMSI Could Lose More than \$700 Million in Three Years.*

From its use of the Milliman model, Rector concluded that there is a sufficient likelihood that GHMSI will lose more than \$700 million during any three-year period, including 2012-2014, such that the company must maintain a nearly \$1 billion surplus for protection against that risk. *See* Tr. 38.⁴¹ DC Appleseed believes this \$700 million loss assumption outcome is not remotely probable, let alone reasonably probable, and therefore should not form the basis for the Commissioner's determination in this proceeding. We have already shown that a surplus loss for which the likelihood is 2% (the 98% confidence level) is too remote to satisfy MIEAA. And we have already demonstrated through Mr. Shaw's corrections to the probability distributions that, even at 98%, \$700 million greatly overstates the risk of loss. (With Mr. Shaw's corrections to the distributions for Premium Growth, RAAF, and EPAV, required surplus at the 98% confidence level is 503% RBC, or \$504 million.) Shaw Rebuttal 35 ch.20.

⁴¹ We are now near the end of one such three-year period, which involved both the lingering effects of the Great Recession and the period of maximum uncertainty under the ACA, and GHMSI itself has projected a loss that is only a fraction of Rector's \$700 million—that is \$80 to \$100 million. And even this loss was, as Mr. Burrell testified, after GHMSI intentionally reduced surplus over the last three years.

The company has never come anywhere near approaching a \$700 million loss at any time during the relevant historical period—the past nearly 20 years, which is most predictive of future performance. In fact, it is extremely unlikely that GHMSI has ever lost even \$100 million of surplus over any three-year period. There is no such loss in the period back to 1995. And, at year-end 1995, GHMSI had surplus of \$100 million, so it is unlikely that they had ever lost that amount prior to then, let alone \$700 million Nor has Rector pointed to any real-world occurrences that might produce such losses.

A loss of \$700 million in a three-year period is implausible for a further, fundamental reason: GHMSI management and the DISB would intervene well before that ever happened. Thus, the entire premise of the Modified Milliman Model is itself highly doubtful.

The premise is that there is a realistic prospect that during some three-year period the company's surplus will be engulfed in an unprecedented and unrelenting decline that would take it down through 375% and then to 200% RBC—a rate of \$19 million in losses per month—and that no steps by either GHMSI or DISB would be effective to prevent it. This premise is simply not credible. And yet to adopt the model's output as measured by Rector, the Commissioner would have to find this premise not only credible, but sufficiently persuasive as to justify a \$1 billion surplus that would allow for no community reinvestment from surplus. The Commissioner should reject this outcome as completely implausible.

Oddly, in this proceeding, Rector has added nearly \$200 million to recommended surplus to account for a *lack* of management intervention.⁴² In the 2008 proceeding Rector saw the issue very differently. In that proceeding, Rector criticized Milliman for “assum[ing] that management will not step in and make a ‘course correction’ to prevent GHMSI from getting into financial trouble.” Rector 2010 Rebuttal at 8. Rector rejected Milliman's view, stating that “it appears that GHMSI has active and experienced management, and we do not believe that its management would sit by idly if the company's financial condition were to begin to worsen.” *Id.* Further, Rector stated: “if GHMSI were in danger of crossing an important RBC threshold . . . , management would take steps in an attempt to keep GHMSI above the RBC threshold.” *Id.* We think Rector got it right in 2009. Such steps might include adjusting group premiums (which are not subject to ACA open enrollment constraints) and adjusting provider contracts to the extent that such contracts allow). A loss on average of over \$19 million a month would be quickly noticed, and would result in prompt and vigorous action by GHMSI management.

⁴² As we noted in our Pre-Hearing Brief, Rector has never fully accounted for this difference. DC Applesseed Pre-Hearing Brief 36. In its 2009 report, Rector stated that it considered three types of management intervention: (1) changes to reserve margins, (2) changes to pricing margins and underwriting standards, and (3) deferral of infrastructure investments. In its December 2013 report, Rector said that the DISB instructed it not to consider changes to reserve margins, which accounted for approximately \$70 million. Letter from the Honorable Chester A. McPherson, Interim Comm'r, D.C. Dep't of Ins., Secs. & Banking, to Walter Smith, Exec. Dir., DC Applesseed 6 (Apr. 18, 2014) [hereinafter McPherson Apr. 18, 2014, Letter]. As for the other two forms of intervention, Rector only said that it embedded those in the model. Mr. Shaw analyzed this claim; and found it “logically flawed or questionable.” Shaw Report 48. Further, Rector does not say how or by how much this supposed consideration of management intervention affected its conclusions concerning required surplus. Rector simply has never accounted for \$120 million of additional surplus need attributable to management intervention,

What Rector said about management is also true of the DISB. If GHMSI were ever to begin a serious decline from its current 932% RBC, the DISB would take steps to protect the company and would approve rate increases if need be to aid in that protection. In the unlikely event of a substantial loss sustained for even a few months due to unexpected circumstances, rate increases would almost certainly be cost-justified. As we have already noted, the waiting period for deemed approval under the DC statute is only 60 days; in even less time than that, the Commissioner may provide expedited approval of individual rates; and group rates may be made effective on filing. *See supra*, 27 n.23. As the Commissioner said at the June 25 hearing when Mr. Burrell warned that the company’s surplus might fall dramatically: “I don’t think Mr. Barlow will allow you to get to 200[%] RBC.” Tr. 306. Yet this is exactly what the model contemplates as a sufficiently realistic possibility as to justify a \$1 billion surplus.

For all these reasons, DC Appleseed believes that, wholly apart from the fact that a 98% confidence level does not comply with MIEAA, the result from the model espoused by GHMSI and Rector—a 2 percent likelihood of a \$700 million loss—simply not credible. That the Modified Milliman Model generates this result only underscores the importance of Mr. Shaw’s corrected probability distributions.

3. *Rector’s and Milliman’s Target Surpluses Inexplicably Increased 400 Percentage Points from 2008 to 2011.*

In just three years, Milliman’s and Rector’s targets for avoiding 200% RBC at 98% confidence increased by approximately 400 percentage points (equal to approximately \$400 million). This increase (for Rector, an increase of 74%) is implausible on its face and has never been fully and clearly explained. In the 2008 review, Rector’s target surplus for avoiding 200% RBC with 98% confidence was 553%⁴³ and Milliman’s was 750%. Yet for this proceeding, Rector’s target is 958%, and Milliman’s is 1050%–1150%, plus an additional 100 to 150 percentage points for new ACA provisions.

In response to our initial request for information, we were told that Rector “was in the process of further analyzing the causes” of this significant increase between 2008 and 2011. E-mail from Philip Barlow to Walter Smith, Exec. Dir., DC Appleseed (Feb. 10, 2014 05:18 PM EST). We were then provided information explaining only 250 percentage points of the change. Toole Mar. 6, 2014 Memorandum. Later we learned that Rector had added 190 points that previously had reduced surplus requirements by accounting for the possibility of management intervention. McPherson Apr. 18, 2006 Letter, at 6. Rector claimed that it now had taken this possibility into account through the probability distributions, Letter from Chester A. McPherson, Interim Comm’r, D.C. Dep’t of Ins., Secs. & Banking, to Walter Smith, Exec. Dir., DC Appleseed 10 (May 13, 2014); but how, and to what extent, are undisclosed. Rector also revealed that it had added at least 150 points due to uncertainties surrounding ACA. DC Appleseed Pre-Hearing Report 33 (citing sources).

⁴³ This is our estimate based on Rector’s 2008 target of 600% for avoiding 200% RBC at 99% confidence. Rector stated through the DISB that it considered this estimate to be “reasonable.” Letter from Chester A. McPherson, Interim Comm’r, DISB, to Walter Smith, Exec. Dir., DC Appleseed 5 (Apr. 18, 2014) (“McPherson Apr. 18, 2014 Letter”).

The idea that surplus should rise nearly \$200 million in three years on the assumption that management will not intervene in the event of a downturn is simply not credible. Moreover, the assumption that the company may lose at least \$150 million due to ACA is also unsubstantiated, particularly since Rector took no account of the safeguards established by the Affordable Care Act to stabilize the individual and small group markets (reinsurance, risk adjustment, and risk corridor programs).

4. *GHMSI's Surplus Increased During the Great Recession.*

Rector's proposed 958% RBC is based on the need to protect against an assumed 2% chance of a \$700 million loss. To support the plausibility of GHMSI facing such a risk, Mr. Rector testified that "just before the Great Recession hit, no one thought that we would ever have a financial catastrophe even approaching that of the Great Depression. But we've now had two such financial catastrophes in less than 100 years, roughly the same probability as we measured relative to GHMSI." Tr. 39.

However, Rector's own example illustrates just how unrealistic a \$700 million loss would be for GHMSI. During the Great Recession (the more recent of the two noted "financial catastrophes"), GHMSI's surplus *actually increased by more than 250 percentage points*—from 845% RBC in 2008, to 1098% RBC in 2010. Also during the last review, Rector noted that GHMSI experienced a net gain in income during the recession that was lower than its projections "but still positive results in a very difficult economic environment." Rector & Assocs., Inc., Report to the D.C. Department of Insurance, Securities and Banking: Group Hospitalization and Medical Services, Inc. 15 (undated) [hereinafter Rector 2009 Report].

The substantial increase of GHMSI's surplus during the Great Recession completely undercuts Rector's and Milliman's theory that GHMSI needs nearly \$1 billion in surplus to protect against such twice-in-a-century occurrences.⁴⁴

5. *GHMSI Itself Does Not Adhere to the High Surplus Recommendations Before the Commissioner.*

GHMSI also undercuts its asserted need for high surpluses because it consistently keeps its surplus below the Milliman target. GHMSI argues that its current surplus is permissible because it is consistent with targets approved by its board, outside experts, and regulators for avoiding 200% RBC at a 98% confidence level. According to Mr. Burrell, the company's financial health hinges on meeting these targets. He testified that "[t]o argue that [surplus] should be materially lower than that, we think, puts the company and its subscribers at substantial risk . . ." Tr. 91.

Yet, despite such statements from Mr. Burrell, the record shows that GHMSI itself does not maintain such high surpluses. In fact, Mr. Burrell testified that the board considered the recommendation of its own expert—Milliman—but "did not feel that it was bound to take it literally." Tr. 123. By consistently and purposefully managing its surplus well below Milliman's

⁴⁴ Tr. 236:22–237:1.

recommended targets, GHMSI's board superimposes its judgment on the model results. The Commissioner should do this too; but the Commissioner's judgment must properly reflect MIEAA. That GHMSI's board consistently adopts surplus targets below the modeled recommendations has a further import: it obviously calls the legitimacy of those targets into question.

GHMSI's year-end 2013 surplus was 932% RBC—more than 250 percentage points lower than the target recommended by Milliman (1200%), Milliman June 27, 2014 Report, at 8, and more than 200 percentage points lower than the target established by its board (1150%), which the MIA has ordered the company to “strive to maintain.” MIA Order at 7.⁴⁵ Indeed, as earlier noted, Mr. Burrell endorsed Rector's recommendation in this proceeding—which is 250 points lower than the 1200 recommended by Milliman. And when the company began to approach Milliman's high numbers at the end of 2011 (a 1058% RBC), the company intentionally reduced its surplus over the next three years by 166 percentage points by “engag[ing] in aggressive rate moderation.” GHMSI Pre-Hearing Brief at 7–8.

In fact, Mr. Burrell testified that GHMSI is now below Rector's lower surplus range. As Mr. Burrell testified: “We are below the target that Rector has recommended and we are dropping. We are still giving. And there's nothing that we have curtailed in our giving as a result of where our RBC is right now.”⁴⁶ Tr. 157. It is commendable that GHMSI engages in such giving. However, the fact that it is doing so when its surplus is below the ranges recommended by Rector and Milliman indicates that GHMSI does not in fact think it is at financial risk by falling below those ranges, as Mr. Burrell claimed.

B. A Properly Adjusted Milliman Model, Along with Several Practical Considerations, Strongly Support a Surplus Between \$400 Million and \$500 Million.

For the reasons stated, the surplus proposed by Rector and supported by Milliman is completely implausible and not in keeping with MIEAA's requirements. A properly constructed Milliman model, along with several other practical considerations, all support a surplus between \$400 and \$500 million. Taken together, there are five persuasive reasons the Commissioner should adopt a surplus within that range.

First, as noted, if the Modified Milliman Model is relied on by the Commissioner, he should use a 90% confidence level and should at a minimum adjust the probability distributions

⁴⁵ The CareFirst board, Milliman, and the MIA have recommended even higher target surpluses for CareFirst of Maryland, even though that company maintains a surplus that is nearly 500 percentage points below those recommendations.

⁴⁶ It is important to note that the issue in this proceeding is not whether GHMSI fulfills community reinvestment obligations as part of its annual operating expenditures, as Mr. Burrell was describing, but whether its *surplus* is consistent with that obligation. We also note that not only has GHMSI operated well below Milliman's surplus recommendations, but CareFirst of Maryland (CFMI) has also consistently operated even further below Milliman's target. For example, Milliman's target for CFMI in 2011 was 1050% to 1300%, yet the company's surplus was 679% then and is now 717%.

for the RAAF, the equity portfolio, and premium growth factors. Mr. Shaw shows that changing only the confidence level to 90% and adopting the Commissioner's suggested tested premium growth numbers lowers the surplus to 575% RBC; changing in addition the EPAV and RAAF factors but leaving the confidence level at 98% lowers the surplus to 513% RBC; making those three changes and lowering the confidence level to 95% lowers the surplus to 421% RBC; and making those three changes and lowering the confidence level to 90% reduces the surplus to 334% RBC. Shaw Rebuttal 35 ch.20. Furthermore, according to Milliman's own recent calculations, accepting only the premium growth assumptions reflected in Rector's recent filing changes the need for surplus to 721% RBC at the 95% confidence level and 575% RBC at the 90% level. *Id.*

GHMSI argued at the hearing and in its September 5 answers to the Commissioner's questions that the fact that Mr. Shaw's results produce numbers at the low end that approach 200% RBC casts doubt on these position. GHMSI Sept. 5, 2014 Response at 28. But that is not so.

Instead, Mr. Shaw's work shows the numbers that the model produces when based on with realistic probability distributions. The fact that Mr. Shaw's use of more realistic assumptions produces much lower surpluses than GHMSI espouses does not cast doubt on those results. To the contrary, they demonstrate that when key assumptions are validated by *actual* historical results, much lower estimates of needed surpluses result. Given the sustained historical strength in the company's actual results and therefore the very small risk it faces from huge and sustained losses, a lower estimate of surplus from the model was to be expected. And at a minimum, when Rector's use of the model is properly adjusted with a calibrated confidence level and more realistic assumptions, the model demonstrates that certainly no more than a surplus of \$400–\$500 million is needed.

Second, as already discussed, a surplus loss of even \$100 million over a 3-year period would be unprecedented for GHMSI and is highly unlikely. In the unlikely event of large, sustained losses, GHMSI's management, the BCBSA, and DISB, would develop remedial measures well before GHMSI's surplus approached 200% RBC. For that to occur there must be an interval between the onset of large losses and that ratio of RBC. Setting the surplus above 400% RBC provides that interval. For example, large losses over several months would be noticed; and there would be a decision to initiate remedial measures if such measures were indicated, as presumably they would be. The surplus could be protected more easily than if maximum surplus were, say, at 300% RBC. Moreover, as a practical matter, it is reasonable to avoid a maximum that is below the BCBSA monitoring threshold of 375%. In other words, so long as GHMSI's surplus is between \$400 and \$500 million, the Commissioner can be quite confident that even if extremely adverse events occurred, his action, BCBSA's, and the company's would provide timely intervention to protect the company from ever falling anywhere near to 200 RBC.

Third, given GHMSI's very strong performance during the last 19 years (1995 to 2014)—including, as we have pointed out, during the worst downturn of the last half-century (the Great Recession), when the company's surplus actually increased—a surplus between \$400 and \$500 million is more than adequate as a practical matter to cover any reasonably probable contingencies—including GHMSI's much-mentioned ability to pay claims that might exceed its

\$200-plus million claims reserve. (We note that it is conventional that this claims reserve would contain an additional 10% cushion—equal to more than \$20 million—above the claims that the company expects actually to occur.)

Fourth, only three years ago Rector determined that a \$453 million surplus was sufficient to protect the company with 98% confidence from falling to the 200% RBC level. Rector has not fully and clearly justified the \$500 million increase above this \$453 million that it now recommends, and the earlier recommendation is in the middle of the \$400–\$500 million we now recommend, which is further indication that the proper amount is within that range.

Finally, in 2005 former Insurance Commissioner Larry Mirel expressly determined—as noted by the Court of Appeals—that “GHMSI should be engaging in charitable activity significantly beyond its current activities.” *D.C. Appleaseed*, 54 A.3d at 1194. At that time, GHMSI’s surplus was \$501 million. D.C. Council, *Report on Bill 17-934, the Medical Insurance Empowerment Amendment Act of 2008*, at 5 (Oct. 17, 2008) [hereinafter “Committee Report”]. Although GHMSI apparently responded positively to Commissioner Mirel’s determination at first, that reaction “was short-lived” and after 2005 “its community health investments [had] tapered off.” *Id.* at 6, 8.

For these and other reasons, the Council found a “deep uncertainty surrounding CareFirst’s degree of dedication to its charitable public health mission.” *Id.* at 9. The Council was, as the Court of Appeals said, “dissatisfied with the state of affairs,” *D.C. Appleaseed*, 54 A.3d at 1194. It therefore passed MIEAA, having concluded “that CareFirst’s history of straying from its public health mission, combined with unmet expectations and a lack of clear framework for its accountability to its mission, call for a legislative response.” Committee Report 11. As the Court of Appeals expressly found, this legislative history shows that “the community health reinvestment obligation created by § 31–3505.01, was the primary motivation behind the MIEAA.” *D.C. Appleaseed*, 54 A.3d at 1214. And yet, far from heeding the admonition from Commissioner Mirel and the Council, GHMSI instead grew its surplus by nearly another \$500 million by the end of 2011.

The \$500 million ceiling Commissioner Mirel found appropriate in 2005 is still a useful reference point for this proceeding. While we recognize that surplus is intended to protect the company in the event that several types of reasonably probable adverse situations might materialize, we note that GHMSI’s own assessment of claims risk has not changed. When Commissioner Mirel acted, GHMSI’s claims reserve (as of the end of 2004) was \$231 million; at the end of 2011 it was \$288 million. Adjusted for inflation to make the figures commensurable, the reserve figure for 2005 is \$285 million and for 2011, \$298 million. As one reference point for the Commissioner’s decision, it appears that more surplus it not clearly needed against unanticipated claims: in general, if a \$500 million surplus was the right back-up in 2005 for unanticipated claims that might exhaust a reserve of \$285 million, it remained the right back-up in 2011, when the reserves needed to meet anticipated claims were approximately the same. Of course, assessing an appropriate surplus for GHMSI is more complex than looking to the level of its claim reserves as a sole indicator. But as the Pennsylvania Commissioner observed, while RBC is a valuable basis for estimating needed surplus, it is imperfect: other indicators should be considered as well. Pennsylvania Decision 22–23. And the level of claims reserves is one such indicator.

For all these reasons, and because the results from the Modified Milliman Model when adapted to comply with the Court of Appeals decision show that a number no higher than \$400 to \$500 is appropriate, a surplus in that range strikes a fair balance. It protects the company's soundness; it meets the efficiency requirement; and at the same time it maximizes community reinvestment. Therefore, the Commissioner should select a figure in that range as the appropriate surplus level for GHMSI.

IV. THE COMMISSIONER SHOULD ALLOCATE SURPLUS BASED ON THE JURISDICTION IN WHICH PREMIUMS ORIGINATE.

MIEAA authorizes the Commissioner to "review the portion of the surplus of the corporation that is attributable to the District."⁴⁷ The determination of how to allocate the portion of GHMSI's surplus that is derived from the company's operations in the District of Columbia is a legal question.

For three reasons, DC Appleaseed submits that the Commissioner should allocate surplus among the three jurisdictions based on the proportion of premiums that originate in each jurisdiction. First, as the Court's decision makes clear, the surplus is produced by the premiums paid by individuals and small-group and medium-group employers and their employees. Second, as Rector noted in its August 27 filing, because the individuals and employers who produced the surplus through their premium payments are supported in their activities by the resources and services of the jurisdiction where they are located, the attribution method should reflect the contribution to surplus made by those employers and individuals. And third, allocating surplus on the basis of the situs of the contracts that produced the surplus is also consistent with insurance practices both here and in other jurisdictions.

In the 2009 proceeding, Rector developed data showing that 69% of GHMSI's premiums were derived from District-based contracts. However, in response to the Commissioner's request that GHMSI update Rector's data to the end of 2011, on October 31 GHMSI submitted a table stating that the amount of premiums attributable to the District had fallen to just 19% of GHMSI's total premiums. However, as we will show, GHMSI's new number is inaccurate and Rector's earlier figure remains a fair measure of surplus that should be allocated to the District. Using premiums reported by GHMSI from 1999 to 2011⁴⁸ as the standard for allocating surplus, the Commissioner should attribute 66.9% of GHMSI's excess surplus as of 2011 to the District, and 33.1% to Maryland and Virginia.

⁴⁷ MIEAA § 2(e); D.C. CODE § 31-3506(e).

⁴⁸ Since 2009—and coincident with enactment of MIEAA—GHMSI has reported its FEP business differently than in prior years. Specifically, it appears that GHMSI now no longer reports FEP premiums in the conventional way, by the situs of the contract. However, we have found neither disclosure of the method GHMSI now uses to report FEP business nor evidence that the results of its new method have been audited. Based solely on inspection of annual reports since 1999, it is our understanding that GHMSI's method of reporting non-FEP individual and group premiums—that is, by the situs of the contract—has not changed.

GHMSI's argument that its surplus "simply cannot be subdivided by jurisdiction"⁴⁹ is disingenuous. GHMSI has repeatedly claimed that surplus should be allocated based on residency of subscribers, which presupposes that surplus is allocable.⁵⁰ Moreover, by seeking advice on how to allocate the surplus, the Commissioner implicitly acknowledged (as have his predecessors) that the surplus can in fact be allocated among the three jurisdictions, as have his predecessors. The Maryland Insurance Commissioner has also recognized the divisibility of the surplus.⁵¹ In fact, the requirement that the Commissioner review only the portion of the surplus that is attributable to the District was included in the MIEAA legislation as a direct response to concerns that MIEAA did not protect the interests of Maryland and Virginia.⁵²

A. GHMSI's Surplus Should be Allocated Based on Premiums Paid by Individuals, Employers, and FEP

Under MIEAA, surplus should be attributed based on the jurisdiction in which the insurance policy was written and over which the District has regulatory oversight—in other words, where the master contract (for group coverage) or policyholder (for individual coverage) is located. For most employer-sponsored group insurance policies, the surplus therefore will be attributed to the jurisdiction where the employer's principle place of business is located, and for individual policies, the surplus will be attributed to the jurisdiction in which the insured individual resides (in both cases, the "home state"). Thus location of the policyholder—and specifically the percent of premiums originating in the District—is a good way to determine the surplus attributable to the District.

The primary reason this is the best proxy for attributing surplus is that it is the fairest and most objective way for assessing which jurisdictions actually produced the surplus. As the Court of Appeals determined in its September 2012 decision, "subscribers who are individual members and small group (and perhaps also medium-size) employers . . . are the ones who have contributed the 'bulk' of the surplus." *D.C. Applesseed*, 54 A.3d at 1204. In reaching that determination, the Court relied on Mr. Burrell's own testimony in the prior proceeding, where he stated that GHMSI's surplus comes "directly from individual and small and medium group

⁴⁹ Group Hospitalization and Medical Services, Inc.'s Further Response to Questions in the Third Scheduling Order and Statement Regarding Attribution 1 (Oct. 2014).

⁵⁰ *See, e.g.*, Post-Hearing Brief In Support of Group Hospitalization and Medical Services, Inc.'s Position Regarding the Commissioner's "Surplus" Review 18–23 (Nov. 2, 2009); GHMSI Rebuttal Report Responding to Applesseed's Supplemental Report 7–9 (Sept. 30, 2010) (all arguing that attribution should be based on the residency of subscribers covered by GHMSI's policies).

⁵¹ Letter from Ralph S. Tyler, Comm'r, Md. Ins. Admin., to The Honorable Thomas E. Hampton, Comm'r, Dep't of Ins., Secs. & Banking (Aug. 21, 2009) ("Consistent with Maryland's interest in GHMSI, the Maryland Insurance Administration ('MIA') has retained the Invotex firm to review the surplus of CareFirst of Maryland, Inc. ('CFMI') and GHMSI . . . to get advice on how to approach the question of allocating the surplus if it is determined to be excessive.").

⁵² Letter from Barbara A. Mikulski, Benjamin L. Cardin, Elijah Cummings, Chris Van Hollen, John P. Sarbanes, Jim Moran, and Frank Wolf, to The Honorable Vincent C. Gray, Chairman of the Council of the District of Columbia (Dec. 15, 2008).

policy holders, and only from them.”⁵³ *Id.* at 1203–04. However, from 1999 through 2011, we estimate that 53% of GHMSI’s total premiums flowed from FEP business. Therefore, it follows that (a) the surplus should be attributed to the jurisdictions where the individuals and group employers that entered into the contract and produced the premiums and that built the surplus are located; and (b) FEP is a significant component of GHMSI’s total accumulated surplus derived from its contract in the District. Notwithstanding GHMSI’s unorthodox reporting practices since 2010, the District is the situs of the FEP contract.⁵⁴

Although not directly relevant to the proper legal basis for attribution, it bears mention that the resolution of the attribution issue does not necessarily control who ultimately benefits from a spend-down plan. MIEAA does not require that the excess surplus be spent on initiatives that benefit only District subscribers or residents. MIEAA directs that, when implementing the law, “the Commissioner *shall consider* the interests and needs of the jurisdictions in the corporation’s service area,”⁵⁵ and that GHMSI “submit a plan for dedication of the excess to community health reinvestment in a fair and equitable manner.”⁵⁶ Subject to the approval of the Commissioner, GHMSI could spend down the excess attributable to those states in ways that benefit subscribers and others living in those states.

B. Attribution Based on Situs of the Contract Appropriately Recognizes the Role played by the Supporting Jurisdiction

In addition to being the best proxy for measuring the source of GHMSI’s surplus, allocating that surplus according to the situs of the policyholder also appropriately recognizes

⁵³ Mr. Burrell made a similar point at the June 25, 2014, hearing, stating:

It is that part of the market, individuals and small groups, that have paid into and built the surplus that GHMSI currently has. If it were to be found that GHMSI has accumulated too much surplus, then by rights it should go back to them and would be argued that that is the proper disposition of that excess.

Tr. 90:5–11; *see also* Tr. 86:17–20 (“If there is any excess surplus, *that excess was the result of premiums paid by or on behalf of policyholders* and plainly not the result of anything that the public did.” (emphasis added)) (quoting then Maryland Commissioner Ralph Tyler’s 2009 hearing testimony).

⁵⁴ A DISB regulation provides that the Commissioner “shall” base his attribution determination on the “number of policies by geographic area” and the “number of health care providers under contract with the company by geographic area,” along with “[a]ny other factor that the Commissioner deems to be relevant” based on the record. D.C. Mun. Reg. tit. 26A, § 4699.2. The analysis above strongly demonstrates that premiums are a far more accurate basis than number of policies or number of health care providers for allocation of surplus. The number of policies or health care providers offers no information about amounts that policyholders contributed to surplus. Based on the record, it would be arbitrary to base the allocation determination to any significant degree on either of those two factors, and an agency may decline to apply a rule when application of the rule in the circumstances would lead to an arbitrary result. Similarly, it would be arbitrary to base the allocation determination on an average of factors (as Rector suggested in its August 27 filing), especially when any or all of the factors fail to measure the amounts that policyholders have contributed to surplus.

⁵⁵ MIEAA § 31-3506.01(b) (emphasis added).

⁵⁶ D.C. Code § 31-3506(g)(1).

that the jurisdiction where the policyholders are located directly supported the activities that made payment of the premium possible.⁵⁷

As Rector stated in its August 27 filing with the Commissioner, an argument could be made “that the location of the master group policyholders should be given the most weight since . . . they and their employees consume the District's resources and benefit by being associated with the District; and since the employers (and not the enrollees/certificate holders) typically pay a majority of the premium associated with group health insurance.” Rector Aug. 27, 2014 Response at 2.

In other words, not only should surplus be allocated based on where the premium payer is located, but it should be recognized that the jurisdiction itself is entitled to that allocation due to the services it provided to support the premium payers’ activities.⁵⁸

C. Attribution Based on the Situs of the Contract is Consistent with Industry Practice and Other State and Federal Regulatory Practices

In addition to being the fairest and most practical way to allocate surplus, allocating on the basis of the situs of the contract is also consistent with regulatory and industry practice.

First of all, attribution based on where the policy is issued is consistent with the scope of the Commissioner’s authority to regulate rates in the District and implement the insurance oversight provisions of the Affordable Care Act. The District regulates insurance *policies issued in the District*, as opposed to policies issued to *residents of the District*.⁵⁹ Likewise, the

⁵⁷ Cases in which courts have sought to apportion net income of a corporation for purposes of taxation are instructive in this context. See *Gen. Motors Corp. v. District of Columbia*, 380 U.S. 553, 561 (1965) (“While the Court has refrained from attempting to define any single appropriate method of apportionment, it has sought to ensure that the methods used display a modicum of reasonable relation to corporate activities within the State. The Court has approved formulae based on the geographical distribution of corporate property and those based on the standard three-factor formula [giving equal weight to the geographical distribution of plant, payroll, and sales].”) *id.* (interpreting a D.C. statute that levied a tax on the portion of net income of the corporation that was “fairly attributable to any trade or business carried on or engaged in within the district and other net income as derived from sources within the District”). See also *Container Corp. of Am. v. Franchise Tax Bd.*, 463 U.S. 159, 170 (1983) (As a general matter, a court will invalidate a formula when a taxpayer can prove by “clear and cogent evidence” that the income attributed to it via the formula is “out of all appropriate proportions to the business transacted in that state.” (internal quotation marks and citations omitted)); see also *ASARCO Inc. v. Idaho State Tax Comm’n*, 458 U.S. 307 (1982); *Exxon Corp. v. Wisconsin Dept. of Revenue*, 447 U.S. 207 (1980).

⁵⁸ See *Exxon Corp.*, 447 U.S. at 223 (“The ‘linchpin of apportionability’ for state income taxation of an interstate enterprise is the ‘unitary-business principle.’ [*Mobil Oil Corp. v. Comm’r of Taxes of Vt.*, 445 U.S. 425, 439 (1980)]. If a company is a unitary business, then a State may apply an apportionment formula to the taxpayer’s total income in order to obtain a ‘rough approximation’ of the corporate income that is ‘reasonably related to the activities conducted within the taxing State.’ [*Moorman Mfg. Co. v. Bair*, 437 U.S. 267, 273 (1978)].”).

⁵⁹ See D.C. Appleseed Rebuttal Submission to DISB, Attachment B (Nov. 2, 2009); D.C. CODE § 31-202(b). (Before any such insurance company, association, or order shall be licensed to do business in the District it shall file with the Commissioner a copy of its charter, declaration of organization, or articles of incorporation duly certified in accordance with the law by the Commissioner of Insurance and Securities, Insurance Commissioner, or other proper

Maryland and Virginia insurance commissioners do not have the authority to regulate health insurance sold to employers located in the District and whose policies are issued in the District, regardless of where their employees reside. The attribution method flowing from where an insurance contract is “issued or delivered” should be coterminous with the jurisdictional reach of the insurance commissioners—in other words, based on where the insurance contract is issued.

Attribution to the jurisdiction where the contract was issued is also consistent with both industry practice and federal regulatory practice. Industry practice in issuing premium refunds in the event of low loss ratios or excess profits is to allocate such refunds by the jurisdiction of where the policy was issued, not by the residence of the individual subscriber. Federal implementation of the minimum medical loss ratio provisions of the Affordable Care Act recognized this industry practice. Specifically, federal regulation requires issuers to refund excess premiums to employer entities holding the group contract (with respect to group contracts) or to individual policyholders (with respect to individual contracts).⁶⁰ The Blue Cross Blue Shield Association explicitly endorsed this approach.⁶¹

Finally, attribution of surplus based on where the policy was issued is consistent with Maryland law and with GHMSI’s own past practice. Pursuant to Maryland law, the Maryland Insurance Commissioner is authorized to review and evaluate the effects of any surplus evaluation conducted by another state but *only* with respect to “premiums charged to subscribers under policies issued or delivered” in Maryland.⁶² Although the statute does not define “issued or delivered” for purposes of attribution, its meaning seems plain. Moreover, case law involving group life insurance policies points to the conclusion that the phrase should be defined according to the subscriber’s place of employment—in other words, the jurisdiction in which the contract was issued to the employer providing the coverage or in which an individual policyholder resides.⁶³

We are aware that in its October 10 filing GHMSI contends again that allocation should not be based on the situs of the contract, but rather on the residence of the subscriber or

officers of the state, territory, or nation where the company, association, group, or organization was organized, a certificate setting forth that it is entitled to transact business and assume risks and issue policies of insurance therein and any other information required by the Commissioner”).

⁶⁰ 75 Fed. Reg. 74864, 74870 (Dec. 1, 2010); 45 C.F.R. § 158.120.

⁶¹ See Blue Cross Blue Shield Association Comments on the Interim Final Rule for Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements Under the Patient Protection and Affordable Care Act (Jan. 31, 2011).

⁶² Md. Code Ann., Ins. § 14-124(a)(5).

⁶³ Cases discussing choice of law provisions for group life insurance policies rely on the Restatement (Second) of Conflicts of Laws § 192 (1971) in defining “policies issued or delivered.” The Restatement explains that the rights of an insured should be determined “not by the local law of the state where the employee was domiciled and received his certificate but rather by the law governing the master policy This will usually be the state where the employer has his principal place of business.” Cf. *Guardian Life Ins. Co. of Am. v. Ins. Comm’r of Md.*, 446 A.2d 1140 (Md. 1982) (holding that a policy delivered to a Rhode Island trustee was not “issued or delivered” in Rhode Island but was instead issued or delivered in Maryland, the state in which the employer was located).

alternatively based on an approach that blends the location of employers and residency of subscribers. We are also aware that Rector has suggested this is another arguable way to approach allocation.

The Commissioner should reject both approaches for several reasons.

First, as Rector pointed out, individuals living outside the District who are covered by small group insurance obtained by a District-based employer did not remit the premiums that produced the surplus, and they did not contribute most of the premiums that employers remitted.⁶⁴ Instead, it is group and individual policyholders that enter into contracts with GHMSI, are subject to all of the obligations of the contract, and remit payment for the agreed-upon premium. Although certificate holders (that is, covered employees and their families) benefit from the contract, they are under no obligation to seek or receive health care in their home jurisdiction as GHMSI contends, nor is the location of their residence or site of their care relevant to the amount of compensation their employers withhold as contributions to coverage.⁶⁵ In the absence of the agreement between the policyholder and GHMSI, certificate holders would not have coverage, regardless of their state of residence. Thus, the surplus both “belongs to” and is “caused by” the policyholder—either an employer in the case of a group policy or an individual in the case of an individual policy.

Second, to allocate District-based coverage to another jurisdiction would be to ignore the critical support services provided by the District in making that District-based coverage possible.

Third, basing allocation on the residence of the enrollee rather than the situs of the contract is wholly inconsistent with the standard regulation of contracts by DISB and other insurance commissioners, as well as federal rules implementing provisions of the ACA (as described earlier).

Fourth, and finally, GHMSI’s argument that attribution based on the location of the policyholder does not take into account the FEHBP members living across the country disregards the fact that GHMSI’s surplus arose in part from the FEP contract that is issued in DC, as well as from individual and group subscribers.

⁶⁴ As the Court put it, they are not “the ones who have contributed the ‘bulk’ of the surplus.” *DC Appleseed*, 54 A.3d at 1204.

⁶⁵ Rector suggests in its August 27 filing that “an argument could be made that the location of the enrollees/certificate holders should be given the most weight since they and the providers they frequent have critical impact on GHMSI’s profitability due to their use of medical care and the cost of their medical care.” Rector Aug. 27, 2014, Response, at 2. It is true that the cost of medical care affects profitability. But it is the premiums that produce the surplus; and without the premiums there is no medical care to begin with. As Mr. Burrell said: the surplus comes “directly from individuals and small and medium group policyholders, and only from them.” *D.C. Appleseed*, 54 A.3d at 1204.

D. GHMSI's October 31 Filing Stating that Only 19% of Premiums Are Attributable to the District Is Inaccurate

The Commissioner's Supplemental Information Request asked GHMSI to update the surplus attribution factors Rector listed on page 18 of its July 21, 2010 Report. For the reasons already stated, DC Appleseed believes the key factor included in Rector's Report –and the measurer the Commissioner should rely on – is the factor Rector labeled "Premiums by Jurisdiction." In determining that factor, Rector followed what it called "the Schedule T approach." Rector 2009 Report, at 21. Schedule T is where GHMSI itself reported premiums allocated to each jurisdiction based on the situs of the contract giving rise to the premiums. Relying on GHMSI's Schedule T reporting, Rector determined that based on actual premiums earned in the years 1999-2008, 68.92% of GHMSI's premiums should be allocated to the District.

Surprisingly, in responding to the Commissioner's request to update this information to the end of 2011, GHMSI reports that the comparable "Premiums by Jurisdiction" number has fallen from 69.82% to 19.03%. For several reasons, GHMSI's new number is not reliable.

First, GHMSI does not explain how it computed its dramatically lower number; nor does it acknowledge the huge difference with the earlier Rector number. But it is clear GHMSI did not simply update Rector's Schedule T approach. If it had done so, GHMSI would have shown an allocation of 68.92% of premiums attributable to the District. Significantly, the previous Commissioner found as fact that Rector's 68.92% allocation fairly attributed surplus based on GHMSI's own Schedule T. *In the Matter of Surplus Review and Determination Regarding Group Hospitalization and Medical Services, Inc.*, Decision and Order, Order No. 09-MIE-006 11 (D.C. Dep't of Ins., Secs. & Banking Aug. 6, 2010).

Second, for several reasons, GHMSI's apparent apportionment of FEP premiums outside the District should not be accepted: GHMSI fails to explain the methodology for making that apportionment; the apportionment is inconsistent with industry, regulatory, and GHMSI's own reporting practice prior to enactment of MIEAA; and there is no evidence that its unexplained apportionment has ever been audited.⁶⁶

Third, to the extent GHMSI apportions surplus on the basis of measures related to Blue Choice, it is inappropriate. Blue Choice is an asset, comparable to any other asset, and yields only investment income. Blue Choice surplus is not the subject of this proceeding.

In summary, the earlier analysis by Rector regarding the source of GHMSI's surplus is still controlling and should be used by the Commissioner in this proceeding. Looking over the period 1999-2011, this approach produces an allocation of 66.9% to the District. Moreover, as Mr. Shaw explains in his attached statement, the figure Rector found in the earlier proceeding of a proper allocation to the District based on premiums (69%) remains a valid measure of the source of GHMSI's surplus. This is because all gains to surplus after Rector's earlier analysis

⁶⁶ Prior to 2010, GHMSI allocated all FEP premiums to the District on Schedule T. But beginning in 2010, GHMSI allocates just 17–20% of FEP premiums to the District, with the remainder allocated to Virginia and Maryland.

came from investment income—which was earned on earlier accumulated premiums. Shaw Rebuttal 33–34 & ch.19.

* * * * *

The Commissioner should allocate surplus based on earned premiums, inclusive of FEP, and based on the situs of the contracts that produced GHMSI’s surplus. This approach produces an allocation of 67% to the District based on premiums at the end of 2011, and 69% based on Rector’s earlier analysis.

V. DISTRICT LAW GOVERNS GHMSI’S PERMISSIBLE SURPLUS.

At the June 25 hearing, GHMSI argued that the Maryland Commissioner had agreed to a *consent* order under which the company is to increase its surplus, and that DISB should consider this fact before directing the company to decrease its surplus. Tr. 103. GHMSI also urged the Commissioner to avoid issuing any order regarding GHMSI’s surplus that might conflict with Maryland’s determinations on that issue. *Id.*

Following up on this argument, the Commissioner asked GHMSI what steps it had taken to increase its surplus in response to the Maryland Commissioner’s determinations. Responding to this, GHMSI said in its September 5 filing:

At bottom, the Commissioner’s question underscores the impossible position that GHMSI is in when it must operate under conflicting mandates from various regulators. For example, if DISB were to adopt Rector’s proposed target of 958% RBC-ACL, there would be a 200 point difference between the Maryland and District of Columbia target points. GHMSI obviously can only fully comply with a single target point at any one time. This problem would be made even worse if the Commissioner were to adopt an even lower surplus target that would require GHMSI to reduce its surplus even farther. Such an order could result in action by Maryland to enforce its own consent order, potentially setting off an inter-jurisdictional struggle that would benefit none of the parties and potentially could only be resolved in federal court. It is to prevent such struggles that the MIEAA requires the Commissioner to confer with other jurisdictions before taking action.

GHMSI Sept. 5, 2014 Response at 22–23.

DC Appleseed agrees with GHMSI that the Commissioner should consult with both Maryland and Virginia concerning his plans for assessing whether GHMSI’s surplus complies with MIEAA and the Court of Appeals. We also agree that consultation should be designed to avoid any “inter-jurisdictional struggle” over GHMSI’s permissible surplus.

But we strongly disagree with GHMSI that the Commissioner should do anything other than faithfully apply MIEAA’s and the Court of Appeals’ standards to GHMSI’s surplus. We also strongly disagree with GHMSI that doing so would lead to an “inter-jurisdictional struggle,” even if the Commissioner found a lower surplus than did Maryland. We say this for three reasons.

First, given the District’s stricter standards—which the Commissioner must apply—a lower surplus for GHMSI than that found by Maryland was to be expected.

Second, in the event of differing determinations between the District and Maryland, under GHMSI’s federal charter, which assigns regulatory authority over GHMSI to the District, it is the District’s determination that controls.

And third, as GHMSI’s September 5 response makes clear, the company is not taking steps to meet Maryland’s higher surplus determination.

Moreover, while GHMSI opposes a lower surplus determination than its current level, if the Commissioner finds that MIEAA requires a lower level, he will require a spend-down only of the District’s allocable share of the excess surplus; Maryland and Virginia will determine for themselves whether and how to spend down their respective allocable shares. We address each of these points below.

A. Given MIEAA’s Stricter Requirements, a Lower GHMSI Surplus Would be Expected Under District Law than Under Maryland Law

It would not be surprising—and we believe it would be completely predictable and understandable—if the Commissioner were to find a lower permissible surplus for GHMSI than did Maryland, for the simple reason that MIEAA has a much stricter standard than does Maryland.

As the Court of Appeals noted, Maryland has only the “unreasonably large” requirement; but MIEAA requires in addition that the surplus meet the “in tandem” requirement of maximizing community reinvestment and being efficient. *D.C. Appleseed*, 54 A.3d at 1215. Maryland did not apply those additional requirements; yet the Court of Appeals reversed the previous DISB determination precisely because those additional District requirements had not been fairly applied. And as we have shown, application of those requirements produces a lower surplus than that found by Maryland.

To the extent GHMSI is requesting the Commissioner to defer to the higher surplus found by Maryland in order to avoid a conflict with Maryland, the request misconstrues the effect of MIEAA. The Commissioner must follow MIEAA and the Court of Appeals decision. And he should consult with the other jurisdictions concerning how and why he is doing so. Moreover, we believe that in the course of those consultations he should explain, as next discussed, that while conflicting surplus determinations should be avoided if at all possible, in the end it is the District’s determination of permissible surplus that controls surplus attributable to the District.

B. The District Determines GHMSI’s Permissible Surplus for the Portion of the Surplus Attributable to the District.

GHMSI was established by an act of Congress as a District of Columbia corporation. Pub. L. No. 103-127, 107 Stat. 1336 (1993). The company is “licensed and regulated by the District of Columbia in accordance with the laws and regulations of the District of Columbia.” *Id.* As an Act of Congress, the charter creating GHMSI is federal law, and “as such, the charter is a ‘legislative act[]’ that must be construed and interpreted just like any other federal statute.”

District of Columbia v. Grp. Hospitalization and Med. Servs., Inc., 576 F. Supp. 2d 51, 54 (D.D.C. 2008). Under familiar preemption principles, state law is preempted when it conflicts with federal law. Such conflict can arise when it is not possible to comply with both federal and state law. *Hillman v. Maretta*, 133 S.Ct. 1943, 1950, (2013). As quoted above, GHMSI has claimed that Maryland has directed it to increase its surplus, and that it could not comply with the Maryland order and any order of the Commissioner directing a reduction in surplus. If this claim is correct, and if consultation by the District and Maryland commissioners does not resolve the issue, the answer is simple. A regulatory action by Maryland that negates a regulatory action of the District would conflict with Congress’s grant of regulatory authority to the District.

More broadly, conflict can also occur when state law “stands as an obstacle to the accomplishment and execution of the full purposes and objectives of congress.” *Id.*, (quoting *Hines v. Davidowitz*, 312 U.S. 52, 67 (1941)). Maryland law governing surplus must give way to MIEAA when it stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress in conferring regulatory authority over GHMSI on the District. Even if GHMSI could comply with both the District and Maryland law, Maryland law must give way where it would frustrate the Commissioner’s regulation of GHMSI under MIEAA. That is true whether the Maryland action would be an obstacle to a determination by the Commissioner of excessive surplus; to a determination by the Commissioner of the portion of GHMSI’s surplus that is attributable to the District; or to the terms and operation of a spenddown plan that the Commissioner has approved as “fair and equitable.”⁶⁷

Although we urge the Commissioner to seek a consensus over GHMSI’s permissible surplus with his counterparts in the other jurisdictions, in the end he should apply MIEAA as the D.C. Council intended.

C. The Risk of Conflict with the Other Jurisdictions is Minimal

Although District law controls in the event of conflicts over GHMSI’s surplus, we think the risk of conflict is actually very small. We say that for three reasons.

⁶⁷ Again, the spenddown plan under MIEAA relates to the portion of the excess surplus that is attributable to the District. It does not mandate the spenddown of portions attributable to Maryland or Virginia. The McCarran-Ferguson Act, 15 U.S.C. §§ 1011–1015, does not provide an exception from the application of standard preemption principles. That Act exempts from federal preemption state laws that regulate the “business of insurance,” but the exemption does not extend to an act of Congress that “specifically relates to the business of insurance.” *See id.* § 1012(b). The Supreme Court has construed this language as a matter of “ordinary English.” *Barnett Bank of Marion Cnty. v. Nelson*, 517 U.S. 25, 37–38 1996). And it has noted that the Act “seeks to protect state regulation primarily against *inadvertent* federal intrusion.” *Id.* at 39 (emphasis in original). Congress’s grant to the District of regulatory authority over GHMSI, which includes all aspects of “the relationship between the [insurer and the insured],” *SEC v. National Sec., Inc.*, 393 U.S. 453, 460 (1969), was clearly advertent and, as a matter of ordinary English, relates to the business of insurance.

First, we think the other jurisdictions will understand and agree that conflicting determinations are to be avoided and that under GHMSI's charter that conflict should be avoided by uniformly implementing District law for the portion of surplus attributable to D.C.

Second, as GHMSI's September 5 filing with the Commissioner acknowledged, GHMSI's expressed concern over conflicting orders is not well-founded. The company is plainly not taking steps to increase its surplus to the higher levels recommended by Maryland. To the contrary, as elsewhere discussed in this rebuttal, rather than being under pressure from Maryland to increase its surplus, GHMSI has in practice been deliberately decreasing its surplus and has in this proceeding endorsed a lower surplus than the one determined by Maryland.

And finally, nothing in this proceeding will in any way intrude on the authority of Maryland and Virginia to decide whether and how to spend down excess surplus the Commissioner may find. Under MIEAA, as we have stated above, it is only *the District's* share of the excess surplus that the Commissioner will regulate. Maryland and Virginia will decide for themselves how to deal with those jurisdictions' share of the excess.

For all these reasons, the Commissioner should proceed to determine the District's share of excess surplus according to MIEAA's and the Court of Appeals' standards and should work closely with the other jurisdictions in doing so.

CONCLUSION

The effort by DISB and the D.C. Council to hold GHMSI accountable to its mission has been going on for nearly 10 years. During those 10 years GHMSI has nearly doubled its already large surplus ---from approximately \$500 million to approximately \$ 1 billion. DC Appleseed believes that an appropriate use of the Modified Milliman Model, together with consideration of practical, real-world factors that test the outcome of the model, demonstrate that this doubling of the company's surplus is not justified under the governing legal standards.

DC Appleseed also believes that reducing the surplus back to the \$400-\$500 million range will fully protect the financial soundness of the company and at the same time allow it to meet its duty to use its surplus to the maximum extent feasible to address pressing community healthcare needs. That is the result the Commissioner should reach. Such a result would be fair to the company, to subscribers, to potential subscribers, and to the public. It would also bring the company into compliance with MIEAA and the decision of the Court of Appeals.

DC Appleseed appreciates the opportunity the Commissioner has afforded us to participate in these proceedings. And we hope to participate in the Commissioner's review of a plan to implement GHMSI's responsibilities under the statute.