Statement of
Group Hospitalization and Medical Services, Inc.
In Support of its March 16, 2015 Plan

April 6, 2015

Group Hospitalization and Medical Services, Inc. ("GHMSI") submits this statement in response to the letter by D.C. Appleseed filed with the Commissioner on March 25, 2015. DC Appleseed's complaints are wrong on the law and misstate the facts detailed in GHMSI's Plan.

GHMSI has already complied with the December 30 Order. GHMSI's Plan does not "disregard" the December 30 Order. Rather, the Plan explains in detail how GHMSI has already complied with the Order. Since 2011, GHMSI already has reduced the surplus attributable to the District by more than the December 30 Order requires. Between 2012 and 2014, GHMSI made more than $70 million in community health reinvestments in the District. GHMSI expects that, by the end of 2015, the surplus attributable to the District will have fallen by $61 million since year-end 2011. The risk based capital (RBC) level for the surplus attributable to the District is already far below the 721% RBC.

No further reduction in GHMSI surplus attributable to the District is appropriate – not because GHMSI "disregarded" the December 30 Order, but because the requirements of that Order have already been fully met.

The Plan Addresses the Attribution of Surplus on a Going-Forward Basis for the First Time. GHMSI's Plan also does not re-argue the findings in the December 30 Order. It is true that GHMSI does not agree with those findings, and has filed an appeal. The Plan, however, still uses the December 30 Order and its determination of the surplus attributable to the District as its starting point. The Plan *begins* with the amount of surplus apportioned to the District in the December 30 Order ($202 million) and the target level of surplus determined by the Commissioner in the December 30 Order (721% RBC-ACL).

Now that the Commissioner has determined a specific surplus amount attributed to the District as of year-end 2011, the plan builds upon that determination and addresses the surplus attributable to the District going forward:

1. As the DISB's regulations state, the surplus attributable to the District must be "derived from the Company's operations in the District of Columbia." 26A DCMR 4699.2; Order at 50-51. GHMSI has very clear data from 2011 forward showing the revenues, community reinvestments, and expenses from "the Company's operations" in each jurisdiction. From 2011 forward, the DISB should attribute surplus based on the results of the Company's operations, as its own regulation requires.

2. Using this data, as presented in Exhibit 1 of the Plan, it is plain that GHMSI has already engaged in the community health reinvestment required by the Order, as defined by the statute:

a. GHMSI has made more than $70 million[1] in community health reinvestment between 2012 and 2014, including:

    1. Over $20 million in premium rate reductions and moderation in the District in 2012 and 2013 (in addition to $10 million in reductions and moderation in 2011), resulting from a deliberate decision by the Company to reduce its 2010 year-end surplus; and

    2. $11 million in direct community giving to nearly 150 not-for-profit organizations to help address the unmet health care needs of vulnerable populations who reside in the District. This giving supported those in the community who otherwise would not receive the services of these community-based organizations; and

    3. $24 million in losses for an open enrollment program in the District that served District residents who had been turned down as adverse risks by other carriers and who were otherwise unable to obtain coverage except through GHMSI and its affiliate, BlueChoice; and

    4. $15 million in program funding for the D.C. HealthCare Alliance Program used by the District government to improve the healthcare of District residents in any way the District saw fit.

b. As a consequence of these investments, GHMSI expects that the surplus attributable to the District will have fallen by $61 million by the end of 2015.

c. GHMSI's overall surplus has only fallen by $30 million because GHMSI's business in Maryland and Virginia has contributed to surplus, while the business operations in DC have incurred overall losses. Contrary to DC Appleseed's claims, there are no errors in GHMSI's analysis related to the contributions of Maryland and Virginia.

d. The MIEAA makes clear that the surplus attributable to the District should not fall below the level required to ensure financial soundness. The Commissioner determined that this level was 721% RBC for GHMSI's whole surplus. In denying GHMSI's motion for reconsideration, the Commissioner appears to have applied this same threshold to the surplus attributable to the District. The risk based capital attributable to the District is now far below 721% RBC.

[1] DC Appleseed refers to $80 million in community reinvestment in its letter. This is an error. GHMSI states on page 4 of its Plan that the total community reinvestment was $70 million. Between 2011 and 2013, GHMSI did engage in $30 million in rate reductions and moderation, but the first $10 million occurred in 2011. GHMSI has only included the $20 million in rate reductions that occurred in 2012 and 2013 in its Plan and in the discussion above.

The MIEAA was never intended to be a means for the District to siphon off surplus generated in Maryland and Virginia for the benefit of District residents. The only way to avoid that result is to look at that actual financial results for each jurisdiction, and appropriately to credit the surplus generated or lost in that jurisdiction.

DC Appleseed's Arguments are Incorrect. DC Appleseed's letter contains numerous mischaracterizations of the law and factual misstatements. For example, DC Appleseed asserts that GHMSI did not, in fact, make $70 million in community health reinvestments between 2012 and 2014. This is not true.

With respect to the rate reductions, DC Appleseed opts to simply ignore the language of the MIEAA. DC Appleseed argues on Page 7 that "rate reductions are not community reinvestments within the meaning of the statute." DC Code § 31-3501(1A), however, defines "community health reinvestment" as "expenditures that promote and safeguard the public health or that benefit current or future subscribers, *including premium rate reductions*." (emphasis added).

For these and other reasons, while GHMSI disagrees with the findings in the December 30 Order, it has already satisfied them.