GROUP HOSPITALIZATION AND MEDICAL SERVICES, INC.'S FURTHER RESPONSE TO QUESTIONS IN THE THIRD SCHEDULING ORDER AND STATEMENT REGARDING ATTRIBUTION

Group Hospitalization and Medical Services, Inc. ("GMHSI") provides the following statement regarding attribution of GHMSI's surplus, in response to the question posed by the Department of Insurance Securities and Banking ("DISB") in its Third Scheduling Order and in response to the statements by Rector & Associates ("Rector") and D.C. Appleseed ("Appleseed").

Question 1 – Please provide your recommendations regarding how the Commissioner should determine the amount of GHMSI's surplus that is attributable to the District in accordance with 26A DCMR § 4699.2.

GHMSI recommends that the Commissioner not address the attribution of GHMSI's surplus at this time. The Commissioner is not required to address attribution unless he concludes that GHMSI's surplus, as a whole, is excessive. Both Rector and Milliman have determined that GHMSI's year-end 2011 surplus was not excessive as a whole, based upon detailed analyses that follow sound actuarial practice. The Commissioner should make the same finding for all the reasons set forth in GHMSI's testimony, Pre-Hearing Report, and other filings. With that finding, these proceedings may conclude.

If the Commissioner is not required to address attribution at this time, then he should not do so. Attribution of reserves by jurisdiction is inconsistent with sound actuarial practice no matter what approach is used. Surplus simply cannot be subdivided by jurisdiction. *See* Attachment G to GHMSI's 2009 Pre-Hearing Report, at 31-32, attached hereto as **Exhibit 1**. Outside of these proceedings, there is no accounting standard or requirement in the industry that would justify such separate accountings, let alone require them.

A. Attribution should be based on the residency of GHMSI's subscribers.

If the Commissioner does reach the question of attribution, GHMSI's surplus should be attributed on the basis of the residency of GHMSI's subscribers. "Subscribers" are the individuals who select coverage from GHMSI on behalf of themselves and their dependents, and include policy holders in the individual market and certificate holders in the group market.[1] GHMSI's Congressional Charter instructs GHMSI that it must conduct business on behalf of its subscribers, GHMSI's surplus was built from premiums paid by or on behalf of its subscribers, and GHMSI's surplus exists solely for the benefit of its subscribers. It is the subscriber and his or her family to whom coverage is directly provided, and for whom provider networks are built in GHMSI's various jurisdictions. The subscribers utilize covered services primarily in their home jurisdictions, no matter where the policy is issued.

In its 2009 filings, GHMSI explained in detail why the MIEAA requires that attribution be based on subscriber residency. That analysis was provided in Attachment G to GHMSI's 2009 Pre-Hearing Report, attached hereto as **Exhibit 1**. GHMSI incorporates it here.

There are two particularly significant reasons why attribution should be based on subscriber residency:

- First, GHMSI's Congressional Charter makes clear that it is the subscribers, not group policyholders, who are the real beneficiaries of GHMSI's services and for whom surplus is maintained. Under the Charter, GHMSI must conduct business on behalf of its subscribers, and Congress' instruction that GHMSI must "issue to *such individuals* appropriate certificates

[1] The term "subscriber" refers to individuals who select coverage for themselves and eligible dependents. In the group market, a covered employee who selects coverage under an employer's plan would receive a "Certificate of Coverage" for him- or herself and dependents, and may be called both a subscriber and a "certificate holder." In the individual market, the person who purchases a policy is both the policy holder and the subscriber. The term "members" is used to refer to all persons covered under a policy (including both subscribers and covered dependents).

evidencing such contracts" demonstrates a direct link between individual certificate holders and GHMSI's premium income. (emphasis added). Surplus also should be attributable "*to such individuals*," where those individuals live, because any premiums and benefits are paid on behalf of those individuals.

- Second, the MIEAA itself demonstrates that attribution should be based on the residency of GHMSI's subscribers. Under the MIEAA, only "the portion of the surplus . . . that is attributable to the District" may be considered excessive. D.C. Code § 31-3506(e). The term "attributable" connotes both ownership (*i.e.* "belonging to") and causation (*i.e.* "caused by"). The surplus is "owned" by the subscribers in the sense that GHMSI holds the surplus for its subscribers' benefit, to pay future medical claims for the subscribers and their dependents. The surplus was "caused by" the subscribers because it consists of premium dollars paid by the subscribers or on behalf of the subscribers. *All* of the non-Federal Employee Health Benefit Program ("FEHBP") premiums received by GHMSI or BlueChoice are (1) paid by subscribers directly for individual insurance, (2) paid by subscribers through their own contributions to an employer plan, or (3) paid by employers on behalf of subscribers, and provided as compensation to the subscribers as part of their employment. *See NEA-Coffeyville v. Unified School District No. 445*, 996 P.2d 821 (Kan. 2000).

The MIEAA recognizes the subscribers' key role when it provides that if GHMSI's surplus were to be deemed excessive, GHMSI could draw down the excess "entirely [by] expenditures for the benefit of [its] current subscribers." D.C. Code § 31-3506(g)(2)(d). Given that GHMSI's subscribers are its individual certificate holders, *see* GHMSI Charter § 2, the

MIEAA plainly contemplates a direct link between GHMSI's surplus and payments made by individuals.[2]

B. If the Commissioner does consider employer situs, it should be blended with the residency of the subscribers.

As noted above, premium dollars paid by employers are provided as compensation to subscribers, and therefore should be attributed to subscribers for purposes of apportioning surplus. However, if the Commissioner intends to consider the location of employers who purchase a group policy, the residency of the subscribers in that policy still should be given at least equal weight. Both the subscribers and the employer contribute to premiums, and the subscribers will primarily seek and obtain medical care where they and their dependents live.

For example, consider how surplus should be attributed for a DC-based company that purchases coverage from GHMSI and has 1,000 employees, of whom 800 live in Maryland and Virginia. The 800 subscribers and their covered dependents are residents of Maryland and Virginia, contribute to GHMSI premiums out of their Maryland and Virginia income, and use healthcare services—for which GHMSI pays—primarily in Maryland and Virginia. It would make no sense to attribute all surplus arising out of that relationship to the District. At a minimum, the Commissioner should adopt a blended approach that attributes group insurance equally between the situs of the employer and the jurisdictions in which the subscribers reside.

C. Surplus attributable to the Federal Employee Health Benefit Program must be attributed on the basis of the residence of the members in that plan.

Both GHMSI and BlueChoice participate in the FEHBP. FEHBP members should be attributed on the basis of their residence.

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[2] The analysis at **Exhibit 1** sets forth additional reasons why the residency of GHMSI's subscribers should be the basis for any attribution of surplus.

Approximately 365,000 GHMSI members obtain coverage through the Federal Employee Program ("FEP"), a national FEHBP offering coordinated by the Blue Cross and Blue Shield Association ("the Association"). *See generally Group Hospitalization and Medical Services, Inc.'s Responses to Questions in the Third Scheduling Order*, at 9-10, 20-21. The Association operates FEP under a contract between it and the Office of Personnel Management ("OPM"), and FEP covers government employees throughout the United States. FEP is governed by federal, not state, law, and GHMSI does not issue a single policy for the FEP program. Instead, GHMSI signed a contract with the Association (headquartered in Chicago, Illinois) to administer the FEP program in a defined service territory, and GHMSI issues individual certificates to subscribers within that territory. *See id.* at 20-21 & Attachment D. Blue Plans participating in FEP attribute FEP membership according to the residency of the subscriber for purposes of MLR and other reporting. It would be absurd for the Blue Plans across the country to attribute all FEP membership to Washington D.C., because that is the location of OPM, or to Chicago, Illinois, because that is the location of the Association.

BlueChoice operates its own FEHBP plan, with approximately 56,000 members. *Id.* Like the FEP program, BlueChoice provides individual certificates to subscribers in the program, and any surplus attributable to the BlueChoice FEHBP should be apportioned on the basis of where the FEHBP subscribers actually live.

D. The Commissioner should separately apportion surplus attributable to GHMSI and surplus attributable to BlueChoice.

A significant fraction of the surplus held by GHMSI is attributable to BlueChoice. GHMSI and CareFirst of Maryland, Inc. each retain surplus funds on account of their 50% ownership interests in BlueChoice, and BlueChoice has a large impact on GHMSI's financial

results. The Milliman and Rector surplus models for GHMSI include 50% of the actual and projected results of BlueChoice for each relevant factor that is modeled.

For purposes of attribution, GHMSI and BlueChoice have very different service areas. BlueChoice provides coverage throughout all of Maryland, DC, and Northern Virginia, not merely the National Capital Area. Under any approach to apportionment, BlueChoice's share of GHMSI's surplus should be analyzed separately, in light of where BlueChoice's subscribers live.

In 2009, Milliman analyzed BlueChoice's share of GHMSI's surplus. Milliman's 2009 analysis is included in **Exhibit 1**, but it would need to be updated before it could be applied. GHMSI now has a 50% ownership in BlueChoice, while it had only a 40% ownership interest in 2008.

E. Comments on the analyses by Rector and DC Appleseed.

The Rector Approach. Rector suggests an approach under which the Commissioner would (1) undertake two separate multi-factor analyses, one focusing on the location of the policyholder ("situs" approach) and another on the location of the enrollees/certificateholders/ providers; (2) calculate the percentage attributable to the District for each sub-group; and then (3) average the figures. For the reasons stated above, GHMSI believes that both its Charter and the MIEAA require a focus on the subscribers, rather than the multiple factors cited by Rector, and that Rector's approach is therefore not fully consistent with the governing statute. In addition, FEP and FEHBP members should be attributed to the jurisdictions in which they reside, regardless of the approach that is adopted for commercial business, and GHMSI and BlueChoice should be analyzed separately for purposes of apportionment.

However, Rector's approach certainly is superior to that taken by Appleseed, because it does give some (although insufficient) weight to the residence of GHMSI's subscribers and

enrollees in Rector's calculations, whereas Appleseed wholly ignores this legally required consideration.

The Appleseed Approach. Appleseed's approach has three significant flaws. First, Appleseed ignores the language of the MIEAA and the Congressional mandate that GHMSI must serve its subscribers, and instead concocts a test of its own design to "attribute" as much surplus to DC as possible. Appleseed urges the Commissioner to focus solely on the jurisdiction where insurance policies are written, arguing that the "situs" of the contracts should control. This is legally incorrect, for all of the reasons stated above. The MIEAA and the GHMSI charter show that apportionment should be based on the subscribers.

Second, Appleseed misapplies its analysis to FEP, and attempts to attribute all FEP members to the District regardless of where they live. It would be absurd to attribute all FEP and FEHBP members to Washington solely because the OPM signs FEHBP contracts, as Appleseed proposes.

Third, Appleseed simply ignores BlueChoice altogether, and makes no provision at all for the differences between BlueChoice and GHMSI business. For these reasons, the Commissioner should reject Appleseed's analysis in its entirety.

EXHIBIT 1

Group Hospitalization and Medical Services, Inc.

PRE-HEARING REPORT

DISB Review of GHMSI Surplus Pursuant to the Medical Insurance Empowerment Amendment Act of 2008, D.C. Code § 31-3501 *et seq.*

August 31, 2009

Attachment G

"Attributable to the District"

PORTION OF RESERVES "ATTRIBUTABLE TO THE DISTRICT" IS THAT SHARE BUILT FROM PREMIUMS PAID BY DISTRICT RESIDENTS

If, despite all the evidence to the contrary, the Commissioner finds that GHMSI's reserves in whole are excessive, the Commissioner then must oversee a determination of how "the excess" should be disbursed. D.C. Code § 31-3506(g)(1). "The excess" referred to in the statute, however, is not to be measured as a percentage of GHMSI's entire, company-wide reserves. It is, instead, a percentage of the "portion of the surplus . . . attributable to the District." D.C. Code § 31-3506(e)(1). To explain by way of example, if GHMSI's company-wide reserves totaled $10 million, the portion attributable to the District was $1.2 million, and the Commissioner determined that the reserves needed to be reduced by 10 percent, the "excess" in question would be $120,000, not $1 million.

This complication of the Act means that if the Commissioner finds reserves are "unreasonably large," he must delve into a nearly unanswerable question: What portion of GHMSI's reserves is "attributable to the District?" As we explain below, this inquiry makes very little sense as an actuarial matter. Reserves are an undifferentiated whole, and they may be used to pay unexpected claims and other costs as they arise anywhere in an insurer's service area. But, to the extent the analysis is even possible, reserves "attributable to the District" must mean the portion of the reserves that stems from, and would be used to pay the claims of, GHMSI certificate holders who are District residents.

A. Attribution of Reserves By Jurisdiction Is Inconsistent With Sound Actuarial Practice

In light of the manner in which GHMSI's reserves are used and invested, the lack of industry precedent, and the consequences of attribution by jurisdiction, sound actuarial practice counsels against attempting to attribute a portion of GHMSI's reserves to the District. First, all of GHMSI's reserves, like those of any multi-jurisdictional insurer, are used to protect and cover subscribers in all jurisdictions, as needs arise. Specifically, as noted in the supplemental Milliman report filed in conjunction with this Pre-Hearing Report, "All members are protected by the *same* surplus, without regard to their line of business, type of product, age, gender, *geographic location*, or other classification." Milliman Inc., *Evaluation of GHMSI Surplus Attributable to D.C.* 3 (Aug. 28, 2009) (emphasis added). Thus, any attempt to attribute reserves by jurisdiction would be, at best, "artificial," ignoring the actual nature and purpose of the reserves. *Id.* at 4. Moreover, as indicated above, GHMSI's reserves are invested on behalf of all subscribers, and the assets used for those investments are not jurisdictionally separable.

In fact, according to the supplemental Milliman report, there is no precedent anywhere in the nation for the jurisdictional allocation of reserves; the concept of "attribution" in this context is inconsistent with any traditional insurance methodology. *Id.* at 3, 6 ("The concept of attributing accumulated surplus to geographic jurisdictions within the same company is not one that we have seen employed in the health insurance industry and we are aware of no precedent for this process.").

Finally, because reserves are not divisible, the taking of reserves by any single jurisdiction would come at the derogation of subscribers in the other jurisdictions served by GHMSI. The subscribers in the benefiting jurisdiction would be "double dipping"; they would have exclusive access to a portion of the reserves attributed to them, while also enjoying the benefit of the protection derived from the balance remaining in the reserves. At the same time, subscribers in the other jurisdictions would bear the burden, having less protection available to meet their needs. As explained in the supplemental Milliman report,

> If the portion determined to be attributable to D.C. were found to be excessive and therefore used for other purposes, the protection afforded to all policyholders, including those in Maryland and Virginia, would be diminished. Likewise, if the regulators in Maryland or Virginia were to determine that the surplus attributable to their respective jurisdictions was to

be expended for a designated purpose, the protection of all policyholders, including those in the District, would be affected.

Id. at 3. Therefore, if GHMSI is placed at risk by such taking, it would be required to seek financial support from GHMSI's reserves attributable to other jurisdictions, or seek financial support from CareFirst of Maryland, Inc. under the terms of the CareFirst intercompany agreement. Accordingly, CFMI subscribers in Maryland and Virginia would, in this way too, effectively be forced to subsidize the cost of coverage for GHMSI subscribers in D.C.

For these reasons, evaluation of the appropriateness of reserves should always be done at an entity-wide level.

B. To the Extent Attribution of Reserves Ever Need Be Attempted, It Should Be Driven By the Residence of GHMSI's Certificate Holders

Background

While we firmly believe that it is inappropriate to "attribute" reserves by jurisdiction, if such "attribution" of reserves nevertheless is attempted, we would argue that one must look to whom the reserves belong or who built them – in other words, the subscriber. As discussed earlier, it is the subscriber whose premiums contributed to the reserves and therefore any attribution must be done on the basis of the residency of the subscriber. Both now and historically, the subscriber (or, as specified in GHMSI's Congressional Charter, the "certificate holder" on whose behalf GHMSI is mandated by Congress to conduct its business) is the individual or family that is provided health insurance coverage and on whose behalf GHMSI is organized. Reserves exist solely for the benefit of subscribers. They were built over time from the premiums paid by or on behalf of the subscriber minus medical claims filed and administrative costs incurred. They are held principally to cover the insurance risks associated with current subscribers. This position is clear in the context of Section 2(d) of the MIEAA, codified at D.C. Code § 31-3506(e), that provides that the District's Insurance Commissioner shall review only "the portion of the surplus of [GHMSI] that is attributable to the District and shall issue a determination as to whether the surplus is excessive."

As explained below, the phrase's plain meaning, the statutory context, the applicable cases and the MIEAA's legislative history all point in the same direction: Surplus is "attributable to the District" if it stems from, and is being held in reserves to pay the claims of, GHMSI certificate holders who are District residents.

The law specifies that the calculation of reserves must be tied as precisely as possible to those who built those reserves – i.e., the individual subscribers whose premium payments and claims experience contributed to producing the reserves GHMSI holds today. Thus, "attribution" of reserves to the District must be focused on who built the reserves.

Congressional Charter Supports – Indeed Requires – Residency as Basis for Attribution

The need to determine attribution based upon residency would hold for any insurer. But, it is especially compelling as it applies to GHMSI, which not only is the only insurer covered by the MIEAA's unique provisions but which also operates under a Congressional Charter that explicitly creates obligations running from the Company to the *individual certificate holder* – not to the employer groups that facilitate coverage.

The Charter provides that GHMSI is "empowered…to enter into contracts with *individuals or groups* of individuals," but as mentioned above, the "groups" are not the certificate holders. Instead, the Charter expressly instructs GHMSI to "issue *to such individuals* appropriate certificates evidencing such contracts."[28] This verbiage is important for two reasons. First, it strongly suggests that Congress contemplated a direct link between individual certificate holders and GHMSI's premium income, such that any surplus would necessarily be "attributable" to a jurisdiction based on the premiums the individuals in that jurisdiction had paid. To the extent that is so, the doctrine of federal preemption forecloses any attempt to calculate surplus "attributable to the District" on a *situs* basis. *In Armstrong* v. *Accrediting Council for Continuing Educ. and Training, Inc.*, [29] the court held that state law is preempted when it "actually conflicts" with federal law;

[28] Charter § 2 (emphasis added).
[29] 168 F.3d 1362, 1369 (D.C. Cir. 1999).

similarly in *California Fed. Sav. & Loan Assoc.* v. *Guerra*,[30] the court held that state law "must give way" to federal law when "the state law stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress."

But, aside from the preemption argument, the Charter further supports the notion that the phrase "attributable to the District" mandates an analysis based on residency. The Charter, of course, is part of the statutory context that informs the interpretation.[31] Section 2 of the Charter only underscores what the words "attributable to" already provide by their terms: that GHMSI's surplus is generated by, and exists to provide for, the individual certificate holder, and that accordingly it is the legal residence of those individual certificate holders that provides an appropriate methodology for apportioning the Company's surplus.

The Relevant Case Law Mandates a Residency-Based Approach

In the District, "[t]he text of an enactment is the primary source for determining its drafters' intent,"32 but context is also crucial to the inquiry: "Statutory construction is a holistic endeavor, and, at a minimum, must account for a statute's full text, language . . . , structure, and subject matter."[33] Here, both text and context mandate that surplus be "attributed" based on residency, not technical *situs* of the group contract.

Beginning with the text, the MIEAA requires that only "the portion of the surplus…that is attributable to the District" be considered.[34]. The word "attribute," in turn, is defined to mean "regard as *belonging to* or *being caused by*."[35] Courts interpreting the word "attributable" have emphasized the notion of ownership as "belonging to" and causation as "caused by". In *Braunstein* v. *Commissioner*,[36] for example, the Supreme Court interpreted "attributable to" in the phrase "gain attributable to such property" as "merely confin[ing] consideration to that gain caused or generated by the property in question."[37] Likewise, the Federal Circuit understands "attributed to" to mean "due to, caused by, or generated by."[38] The Second Circuit put the matter starkly: In *Benedek* v. *Commissioner*, [39] the court was asked to determine whether gain was "attributable to" certain property.[40] The court wrote, "There appears to us to be no special mystery about the word 'attributable' as it is used in the statute. The question to be answered is 'where did the money come from?' The answer will ordinarily be the source to which the gain is 'attributable.' "[41]

Applying these definitions of "attributable to" in the unique context of the MIEAA leads to the clear conclusion that attribution should be calculated based on the residency of the certificate holder. After all, an insurer's surplus is "caused by" premiums paid by, or on behalf of, certificate holders. Likewise, to the extent an insurer's surplus "belongs to" anyone, it belongs to the subscribers, in the sense that it is held to pay for future claims made by those subscribers. *In Maryland Casualty Co.* v. *United States*,[42] the court describes reserves as "a fund with which to mature or liquidate…future unaccrued and contingent claims" and *Jones* v. *United States*, [43] the court observes that insurers must "maintain high levels of cash capital and surplus so that the insurers' 'creditors,' the policyholders, would be adequately protected." The MIEAA's proponents in the D.C. Council certainly thought as much. As discussed below, they clearly believed (i) that the surplus was "caused by" and "belongs to" GHMSI's certificate holders and (ii) that those very premises under-girded the legislation. *See infra* at 35, which discusses comments of Councilmember Catania.

Importantly, the only court of which we are aware that has reached the question presented here – who "causes" insurance surplus, and to whom does it "belong"? – squarely held that it is caused by and belongs

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[30] 479 U.S. 272, 280-281 (1987).
[31] *See District of Columbia* v. *Beretta, U.S.A., Corp.,* 872 A.2d 633, 652 (D.C. 2005).
[32] *Stevenson* v. *District of Columbia Bd. of Elections & Ethics*, 683 A.2d 1371, 1376 (D.C. 1996).
[33] *Beretta*, 872 A.2d at 652 (quoting *United States Nat'l Bank of Oregon* v. *Independent Ins. Agents of Am.*, 508 U.S. 439, 455 (1993)) (alteration in *Beretta*).
[34] D.C. Code § 31-3506(e).
[35] Compact Oxford English Dictionary of Current English (3d ed. 2005) (emphasis added).
[36] 374 U.S. 65 (1963).
[37] *Id.* at 70.
[38] *Electrolux Holdings, Inc.* v. *United States*, 491 F.3d 1327, 1330-31 (Fed. Cir. 2007) (citations omitted) (construing 26 U.S.C. § 6511(d)(2)(A)).
[39] 429 F.2d 41 (2d Cir. 1970).
[40] *Id.* at 43.
[41] *Id.*
[42] 251 U.S. 342, 350 (1920).
[43] 659 F.2d 618, 620 (5th Cir. 1981).

to individual subscribers. In *NEA-Coffeyville* v. *Unified School District No. 445*,[44] a school district's group health insurer held a surplus stemming from the school district's premium payments and was contractually obligated to refund it. The Court was asked to decide to whom the refundable surplus belonged – the district, which had created the group plan, or the teachers, who were the individual subscribers. The Court held that, "as a matter of community standards of fairness and decency," the surplus belonged to the individual subscribers because it had been caused by them:

> "Regardless of whether the teachers or the District actually paid for the group health insurance, there is no dispute that the divisible surplus was created by the actions of the subscriber-teachers in filing fewer and/or smaller claims than were anticipated when BCBS set the premiums. The divisible surplus is wholly a product of their actions rather than anything that may be attributed to the District…We conclude that in the absence of a contract provision addressing the rights of the parties in this situation, those whose conduct generated the refund, the teachers, are entitled to the refund."[45]

The same principle applies here. There is a direct link between an insurer's surplus and the payments made by its certificate holders. The surplus "is wholly a product of their actions,"[46] and its *raison d'etre* is to pay their medical bills. Since "the money come[s] from" the certificate holders, *Benedek*,[47] it rightfully is attributable to each jurisdiction in a proportion that reflects the payments made by the certificate holders in that jurisdiction.

Similarly, the D.C. Circuit construed a District law with nearly identical "attributable to" language and held that the law *required attribution based on subscribers' place of residence* in cases where the company's business revolved around income from and services to subscribers. Those holdings compel the same result here.

The cases in question addressed a D.C. statute that imposed a 5 percent franchise tax on corporations doing business in the District. The statute provided that the income on which the 5 percent tax should be imposed was "that portion of the net income of the corporation . . . as is *fairly attributable to any trade or business carried on or engaged in within the District* and such other net income as is derived from sources within the District."[48] In *District of Columbia* v. *Evening Star Newspaper Co.*,[49] the D.C. Circuit considered what portion of the *Evening Star*'s income was "fairly attributable" to its business within the District—and he settled squarely on a calculation based on the residency of the newspaper's customers. Writing for a unanimous panel, he explained that "[i]t is apparent that all revenues" of the newspaper "rest ultimately upon circulation and readership."[50] He therefore concluded that net income had to be "apportioned between District and non-District sources" and that that should be accomplished by the location of subscribers, such that if "20% of the newspaper's circulation is outside the District and the balance within the District, then 80% of the 'operating net income' would be the amount attributable to the District and subject to the tax."[51]

Three years later, the Circuit had occasion to elaborate on *Evening Star*. In *Broadcasting Publications, Inc.* v. *District of Columbia*,[52] again writing for a unanimous panel, Judge Burger explained that *Evening Star* stood for the proposition that, in order to determine what portion of income is "fairly attributable" to District operations, one had to "examine [the] Taxpayer's total activity and select that function which fairly reflects the geographical sources of income."[53] "In that case," he wrote, "we concluded that the essence of the newspaper business, for franchise tax purposes, is the dissemination of news, *i.e.*, the distribution of newspapers."[54] "Allocation of income" therefore had to be made "according to the situs of subscribers."[55]

These decisions point the way to a residency-based approach here. The "essence" of GHMSI's insurance business is the collection of premiums from, and the eventual payment of claims to, its subscribers (*i.e.* its

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[44] 996 P.2d 821 (Kan. 2000).
[45] *Id.* at 832.
[46] *Id.*
[47] 429 F.2d at 43.
[48] D.C. Code § 47-1580 (1951) (emphasis added).
[49] 273 F.2d 95 (D.C. Cir. 1959).
[50] *Id.* at 102.
[51] *Id.* at 103.
[52] 313 F.2d 554 (D.C. Cir. 1962).
[53] *Id.* at 559.
[54] *Id.*
[55] *Id.*

certificate holders).[56] Just as in *Broadcasting Publications*, then, it is the "situs of *subscribers*" – not the situs of contracts entered into by those subscribers' employers – that best describes the source, and the eventual destination, of GHMSI's surplus.[57] It is at their legal residence that the certificate holders subtract from their net worth to make premium payments; it is at their legal residence that they eventually will be benefited by claims payments. Because the residency of GHMSI's certificate holders most "fairly reflects the geographical sources" of the surplus,[58] it is that measure that should be employed to calculate the portion of the surplus attributable to the District.[59]

A Plain Reading of the Statute Requires That Attribution be Based upon Residency

Statutory context requires the same result.[60] Section 2(d) of the MIEAA, codified at D.C. Code § 31-3506(g)(2), provides that if GHMSI's surplus were to be deemed excessive and unreasonably large, GHMSI could draw down the excess "entirely [by] expenditures *for the benefit of current subscribers* of the corporation." (emphasis added). GHMSI's "subscribers" are its individual certificate holders.[61] Section 31-3506(g)(2) therefore contemplates a direct link between GHMSI's surplus and payments made by individuals. Read together with the text of Section 31-3506(e) – as it must be under well-settled principles of statutory construction – the provision makes clear that the calculation of surplus "attributable to the District" must focus on the individuals who pay their premiums, and receive the benefits of any surplus, where they live.

Location or *Situs* of Employer Contracts Is Irrelevant to Determining Attribution

For the same reasons of text and context, the phrase "attributable to the District" cannot be properly read to mean "attributable to *contracts that have their legal situs in* the District." As an initial matter, that construction involves adding words to the statute – a fundamental statutory-interpretation taboo.[62] But, in any event, the surplus generated by premium payments made by (or on behalf of) Maryland and Virginia residents who happen to work in the District cannot be said to "belong to" the District.[63] As discussed above, the surplus is held to pay the medical claims of *certificate holders*, not of their employers. The money paid out as claims effectively enriches those certificate holders – at their legal residences – by assuming their obligation to pay medical or related bills. It would be the merest legal fiction to say that money held for a Maryland resident, and eventually paid to settle medical bills that otherwise would draw down his or her personal wealth in Maryland, and overwhelmingly paid to Maryland providers, "belongs to" the District just because that Maryland resident works in the District. The law is to the contrary.[64]

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[56] *See* Black's Law Dictionary 802 (7th ed. 1999) (defining insurance as an agreement by which the insurer "commits to do something of value" for the insured "in return for a premium payment").
[57] 313 F.3d at 559 (emphasis added).
[58] *Id.*
[59] To be sure, tax law has evolved in the half century since *Evening Star* was decided, and courts now employ a multi-factored test to determine how much tax a corporation should pay in a given jurisdiction. But that evolution of tax doctrine does not undermine the persuasive force of Judge Burger's decisions in this case. *Evening Star* and its progeny are relevant here not as cases reflecting modern tax law, but as the leading cases in the District on what it means to say funds should be "attributed to" a given jurisdiction.
[60] *See Gondelman* v. *DCRA,* 789 A.2d 1239, 1245 (D.C. 2002) ("[W]e construe statutory provisions 'not in isolation, but together with other related provisions.' ") (quoting *Olden* v. *United States*, 781 A.2d 740, 743 (D.C. 2001)).
[61] *See* GHMSI Charter § 2 (directing GHMSI to "issue to such individuals appropriate certificates" evidencing their contracts of insurance).
[62] *See United States* v. *Curtis,* 755 A.2d 1011, 1017 (D.C. 2000).
[63] *See* Oxford English Dictionary of Current English, *supra*.
[64] This is so even though a certificate holder's employer may pay a portion of his premium as part of the employee's ancillary benefits. The *NEA-Coffeyville* court faced identical facts and dismissed the employer's payments as irrelevant, holding that to the extent the insurer ends up holding a surplus, it is because the employees have not made claims seeking disbursement of the money. *See NEA-Coffeyville*, 996 P.2d at 832.

Legislative History Makes Clear the Intent to Consider Residency

Because the language of the MIEAA is clear, and is only reaffirmed by case law construing a closely analogous provision, there is no need to consult the legislative history.[65] But, in any event, the legislative history further supports GHMSI's position. On December 2, 2008, Councilmember Cheh explained the newly added "attributable to the District" language as follows:

> [T]he committee print for the bill initially required the Mayor to review the company's entire surplus and determine what percentage of premium revenues must be devoted to community health reinvestment.
>
> Under the amendment, the Commissioner of DISB…instead of looking at CareFirst's entire surplus, will review only that portion of the surplus, quote/unquote, "attributable to the District." *This addresses concerns raised by the Maryland congressional delegation about the fairness of the bill* and actually captures our intent in any event from the original bill.[66]

Members of the "Maryland congressional delegation," in turn, had expressed their belief that "reserves belong solely to CareFirst subscribers" and that "any excess reserves should be required to be given directly back to the…individuals who have paid into CareFirst." *See*, Letter from Sens. Barbara A. Mikulski and Benjamin L. Cardin, *et al.*, to Hon. Vincent C. Gray at 1 (Dec. 15, 2008). The Maryland legislators had further expressed concern that aspects of the MIEAA would "tak[e] money away from the Marylanders, Virginians, and Federal Employees who are CareFirst beneficiaries." *Id.* The "concerns raised by the Maryland congressional delegation about…fairness," in short, centered on ensuring that GHMSI certificate holders resident in Maryland did not subsidize, through their premium payments, the mandates of the MIEAA. Given that Councilmember Cheh explicitly identified this concern as the driving force behind the "attributable to the District" amendment, the "attributable" language is best interpreted to require apportionment of surplus based on the residency of GHMSI's certificate holders.

The comments of other MIEAA proponents underscore this interpretation. Throughout the hearings, for example, Councilmember Catania linked his concerns about the surplus to District "citizens," observing that the surplus came from "70 years of citizens contributing" premium payments and asserting that "[t]his money belongs to the citizens of the District of Columbia if and when this company is ever sold." *Bill 17-934: Medical Insurance Empowerment Amendment Act of 2008*, Committee on Public Services & Consumer Affairs, at 74-75 (Oct. 10, 2008) (comments of Hon. David A. Catania). Given this focus, it would betray the purposes of the MIEAA – not to mention be unjust – if moneys contributed for decades by *Maryland* and *Virginia* citizens were to become subject to the MIEAA's dictates. The legislative history, in short, points in the same direction as the MIEAA's plain text and the relevant case law. Surplus "attributable to the District" equates to surplus generated from (and payable to) certificate holders who reside in the District.

Ability to Attribute Does Not Negate the Reality That Reserves are Indivisible

In spite of the theoretical ability to attribute reserves and the inherent logic and case law that underlies it, the ability to analytically attribute reserves to a jurisdiction does not change the fact that by virtue of their purpose and nature reserves are indivisible. In fact, the very Charter under which GHMSI operates, the insurance regulatory framework, accepted actuarial practice and the legal framework within which GHMSI operates, dictate that the amount of reserves attributable to D.C. is nothing but an analytical artifact. Nor does this theoretical exercise change the nature of GHMSI's duty to meet all of its obligations to all of its subscribers from the same reserve, regardless of where they live.

Residence-Based Attribution Data For GHMSI

For all of these reasons, "the portion of the surplus of [GHMSI] that is attributable to the District," D.C. Code § 31-3506(e), is the portion generated by premium payments from District residents. As Milliman calculated in their residency-based analysis, the portion of GHMSI's surplus attributable to the District at year end 2008 is 11.6% or $79.5 million.

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[65] *See Ratzlaf* v. *United States*, 510 U.S. 135, 147-148 (1994) ("[W]e do not resort to legislative history to cloud a statutory text that is clear.").

[66] *Bill 17-934: Medical Insurance Empowerment Amendment Act of 2008*, Transcript of Thirty-Seventh Legislative Meeting of the D.C. City Council at 5 (Dec. 2, 2008), which details comments of Hon. Mary M. Cheh (emphasis added).

Exhibit A

Milliman Report Dated August 28, 2009

CareFirst, Inc.
Group Hospitalization and Medical Services, Inc.
Evaluation of GHMSI Surplus Attributable to D.C.

August 28, 2009

Prepared by:

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Evaluation of GHMSI Surplus Attributable to D.C.

I. Introduction

At the request of CareFirst, Inc., Milliman has carried out an analysis of the surplus accumulation of Group Hospitalization and Medical Services, Inc. (GHMSI). This analysis addresses the estimated portion of the accumulated Statutory surplus that is attributable to the District of Columbia (D.C.).

In December 2008 the D.C. Council enacted an amendment to the Hospital and Medical Services Corporation Regulatory Act of 1996, known as the "Medical Insurance Empowerment Amendment Act of 2008". This Amendment Act included a provision that requires the Commissioner of Insurance to determine whether the portion of the surplus of GHMSI that is attributable to D.C. is excessive. We were asked by CareFirst to evaluate what portion of the GHMSI surplus could be considered attributable to D.C.

We have estimated that 11.6% of GHMSI's surplus as of December 31, 2008 is attributable to D.C. This report describes our approach to this evaluation. We believe that the assumptions and methods underlying our analysis are reasonable and appropriate based on the data and other information available and the purpose for which it has been developed.

Limitations

In developing these estimates, Milliman has relied on various descriptions, data, and sources of information provided by CareFirst. We did not audit any of the information we received, although we did review it for general reasonableness. If there should be any inaccuracies in this information, then the results shown may be affected accordingly.

The results presented in this report represent estimates, and are based on the methodology described. Other methods could be expected to produce different results. Further, application of this methodology in future years may produce different results.

Use of Work Product

This material has been prepared for the use of and is only to be relied upon by the management of CareFirst. We understand that CareFirst may wish to share this report with regulators in the District of Columbia and

other jurisdictions in which they are licensed. We hereby grant permission, so long as the document is provided in its entirety. Milliman does not intend to benefit any third party either through this analysis or by granting permission for this report to be shared with other parties.

This report represents the opinions of the authors and does not necessarily reflect the opinions of other Milliman consultants. The authors are Members of the American Academy of Actuaries and meet its qualification standards for performing this type of analysis.

Judgments as to the conclusions contained in our report should be made only after studying the report in its entirety. Furthermore, conclusions reached by review of a section or sections on an isolated basis may be incorrect. The results in this report are technical in nature and are dependent upon specific assumptions and methods. No party should rely upon these results without a thorough understanding of those assumptions and methods. Such an understanding may require consultation with qualified professionals.

II. Background and Role of Surplus

The Medical Insurance Empowerment Amendment Act of 2008 provides that, initially and then on an annual basis, "…*the Commissioner shall review the portion of the surplus of the corporation that is attributable to the District and shall issue a determination as to whether the surplus is excessive*." In view of this legislation, CareFirst management asked for Milliman's assistance in evaluating the portion of GHMSI surplus that could be considered attributable to the District.

Adequate surplus is central to the viability and sound operation of any insuring organization. It is needed to enable a company like GHMSI to ensure that the promises and commitments to its customers, as well as to hospitals, physicians, and other providers, can be met. In addition to providing for the many and varied risks assumed by an insuring organization, surplus is needed to develop new products, maintain service capabilities, respond to regulatory requirements, build infrastructure, and generally operate effectively as a viable ongoing business entity over time.

The surplus is available for the protection of all policyholders and for the sound business operations of the entity as a whole. GHMSI management must continually evaluate and monitor surplus requirements, and make decisions regarding the products and services offered by the company in order to ensure its ability to provide sufficient protection from risks (known and unknown) and contingencies. These decisions are made based on the conditions and operations of the entire company. All members are protected by the same surplus, without regard to their line of business, type of product, age, gender, geographic location, or other classification.

The concept of attributing accumulated surplus to geographic jurisdictions within the same company is not one that we have seen employed in the health insurance industry and we are aware of no precedent for this process. While the attribution of existing surplus arises in the demutualization of an insurance company, in that situation a portion of the surplus is allocated to policyholders as consideration for relinquishing membership rights. Geographic jurisdiction is generally not a direct factor in this allocation process. In any case, the demutualization process represents a unique circumstance where surplus is being allocated over the policyholders / owners of the company for the purpose of reorganizing the company. This is decidedly different from attempting to allocate the surplus of a not-for-profit corporation where surplus is maintained for the ongoing protection of the policyholders.

Given these considerations, we believe that any attribution of GHMSI surplus by jurisdiction is artificial. The surplus is intended to benefit all policyholders. If the portion determined to be attributable to D.C. were found to be excessive and therefore used for other purposes, the protection afforded to all policyholders, including those in Maryland and Virginia, would be diminished. Likewise, if the regulators in Maryland or Virginia were to determine that the surplus attributable to their respective jurisdictions was to be expended for a designated purpose, the protection of all policyholders, including those in the District, would be affected.

Note that our analysis is limited to the surplus of GHMSI and does not include any consideration of the relationship of GHMSI to the holding company CareFirst, because the law applies only to hospital and medical service corporations.

III. Development of Estimated Surplus Attributable to D.C.

We have developed an estimate of the portion of GHMSI surplus as of December 31, 2008 that is attributable to D.C., as summarized in the following table.

Summary of Estimated Surplus Attributable to D.C.
(Values in Millions)

	GHMSI December 31, 2008 Reported Statutory Surplus	Estimated % Attributable to D.C.	Estimated Surplus Attributable to D.C.
Parent Excluding Value of CFBC	$524.1	13.9%	$72.8
CFBC Value	162.7*	4.2%**	6.8
Total GHMSI	$686.8	11.6%	$79.5

*** Full value**

**** Reflects GHMSI 40% ownership share**

Note that we have developed separate estimates for the portion of GHMSI surplus that excludes the value of CareFirst BlueChoice (CFBC), a partially-owned affiliate, vs. the portion that represents the value of CFBC. This and other facets of our development are discussed below.

Considerations in Development of Methodology

As mentioned previously, we are unaware of any precedent for the development of surplus attributable to geographic jurisdictions within the same company. In defining the approach that we have utilized, we considered the purpose for which this development is to be used, the characteristics of GHMSI's business, and the limitations of the available historical data. Our objective was to develop a methodology within these parameters that is equitable, and at the same time relatively straightforward and replicable. We believe that the assumptions and methodology we have employed meet this objective, and that they are reasonable and appropriate from both an actuarial and a general financial perspective.

Following is a brief discussion of some of the major considerations in the development of our approach, and the manner in which they have been addressed in our evaluation.

Purpose – The development of estimated surplus attributable to the District has been prepared in response to recent legislation that requires the Commissioner of Insurance to determine whether the portion of the surplus of GHMSI that is attributable to D.C. is excessive. This legislation also states that *"If the Commissioner determines that the surplus of the corporation is excessive, the Commissioner shall order the corporation to submit a plan for dedication of the excess to community health reinvestment in a fair and equitable manner."*

Determination of Jurisdiction – We considered two alternative approaches to the determination of how membership, premium, and other financial measures would be attributed by jurisdiction. These were: (a) attribution of values to the jurisdiction in which a given subscriber resides (the "residence" approach), or (b) attribution to the jurisdiction of the situs of the associated contract, meaning the residence of an individual subscriber or the situs of the employer of a group subscriber (the "situs" approach).

While we are not attorneys and cannot offer legal interpretations, it appears to us that the intent of the legislation is to have any distribution of surplus that results from the application of the requirements of the law benefit residents of the District of Columbia. It was our conclusion based on this understanding,that the residence method is the appropriate alternative. If the funds are to be used to benefit only D.C. residents, then it would seem that they should be comprised of amounts that are attributable to only D.C. residents. The situs approach, if used instead, could have the effect of causing surplus that was attributable in part to residents of Maryland and Virginia to be expended on behalf of residents of D.C. only. This would not be equitable, and we concluded that the situs approach would therefore not be appropriate.

Time Period of Evaluation – The estimation methodology that we have employed in developing surplus attributable to D.C. involves the analysis of historical annual changes in surplus values as reported in GHMSI's Statutory blank. Each year's change in surplus, due to operating results and other factors, was evaluated in order to attribute an appropriate portion to each jurisdiction. In order to carry out this evaluation it was necessary to supplement the information reported in the Statutory blank with additional data tabulations drawn from GHMSI's internal reporting and information systems. The approach we have selected is designed to be relatively straightforward, allowing future replication and updating with a reasonable level of effort.

We worked with GHMSI staff to identify the types of information that were required, and the availability of such information by year. While the data available for the most recent five years was fairly comprehensive, for earlier periods the level of detail that could be obtained was more limited. In general, we found that the degree of detail of the information and its level of quality both tended to decline with each additional year, working backward in time.

After analysis and discussions with GHMSI management, we determined that a ten-year period of historical information would be studied, and that this would produce equitable results by offering a reasonable compromise between the desire to incorporate a sufficient historical period of time and the importance of utilizing reliable information.

Therefore our methodology involves the analysis of the reported change in surplus values by year for the period of 1999 through 2008, in order to evaluate which portion of each year's amount is attributable to D.C. The Statutory surplus value as of December 31, 1998 was then assumed to be attributed by jurisdiction in the same proportions as the surplus accumulated from 1999 through 2008.

Treatment of Affiliates and Subsidiaries – GHMSI owns a 40% share of CareFirst BlueChoice (CFBC), and holds a 100% share in a number of materially smaller subsidiaries, none of which are insuring entities. Given the significant size of CFBC and the materiality of its contribution to GHMSI's surplus, we carried out a parallel evaluation of the reported annual change in surplus of CFBC and its predecessor (Capital Care, Inc.) for the period of 1999 through 2008. Based on this analysis, we estimated the portion of GHMSI surplus contributed by CFBC and its predecessor that can be considered attributable to D.C. residents.

The annual changes in value associated with other GHMSI subsidiaries were treated as investment returns in our evaluation, and were therefore attributed to jurisdiction based in part on premium income and in part on the attribution of the prior year's ending surplus value. The subsidiaries of CFBC were treated in a parallel manner in our evaluation of CFBC and its predecessor.

Surplus Target - We have not done an evaluation of optimal surplus levels for GHMSI at the jurisdictional level (and there would be many technical problems with trying to do so). However, we can state that any range that is appropriate for the District of Columbia portion of GHMSI would be higher, when expressed as a percentage of the applicable benchmark, than the optimal surplus target range that we recommended for GHMSI as a whole.

Brief Description of Methodology

The general approach that we employed in our evaluation was to first attribute each year's Statutory underwriting gain/loss (UGL) by jurisdiction in proportion to estimated premium or fee income by jurisdiction of residence. This attribution was made separately for the UGL of each of the three major risk categories – i.e., Risk (excluding FEP[67]), FEP, and Non-Risk. Each of these was considered separately in view of their unique underwriting and risk characteristics, which have resulted in materially differing financial objectives and underwriting results.

The evaluation of premium or fee income by residence necessarily involved an estimation process, because this information is not directly tabulated. Therefore, premium was first attributed to jurisdiction of situs, based on information in the Statutory blank for the Risk segment[68], and using the distribution of membership by residence for FEP. For the Non-Risk segment the fee income by situs from internal jurisdictional tabulations was utilized. The premium or fee income for each situs jurisdiction was then attributed to jurisdiction of residence based on available membership data, which was cross-tabulated by situs and residence for periods in 2005 through 2008.

After attributing each year's underwriting gain/loss by jurisdiction of residence, the other components of the change in surplus were attributed in proportion to premium and fee income, with the exception of investment returns. Attribution of the annual investment return was based in part on premium income (in recognition of the float generated by the time lag between premium collection and claims payment) and in part on the attribution of the prior year's ending surplus value.

It must be emphasized that while the process described above involved the direct use of detailed data where possible, it also required a significant degree of judgment and estimation due to the limitations on availability of such data. The earlier years, in particular, required some reliance on incomplete data tabulations, and where no applicable data was available, on patterns observed in subsequent years.

IV. Conclusion

In our opinion, the assumptions and methods employed in our analysis are reasonable and appropriate given the limitations of the data and other information that was available, and in view of the purpose for which it has been developed. Further, we believe that the methodology satisfies the objectives of providing an equitable approach to the attribution of surplus, while being straightforward, replicable and easily updated in future years.

We appreciate the opportunity to present the results of our analysis of GHMSI surplus attributable to the District of Columbia. The authors are available to explain and / or amplify any matter presented herein, and it is assumed that the reader of this report will seek such explanation and / or amplification as to any matter in question.

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[67] By FEP, we mean GHMSI's participation in the BCBSA Federal Employee Program offerings within the Federal Employees Health Benefits Program (FEHBP). This does not include the CFBC offering within FEHBP, which is not part of the BCBSA program.

[68] For 2008 this allocation was based on internal jurisdictional tabulations, because the premium information by jurisdiction in the Statutory blank did not reflect the impact of reinsurance agreements that became effective in 2008 between GHMSI and CareFirst of Maryland, Inc. (CFMI).

Exhibit B

Lewin Group Report Dated August 31, 2009

Background and Methodology

The Lewin Group was retained by CareFirst to perform an independent assessment of the risk based capital range (RBC) suggested by Milliman for CareFirst's subsidiary, Group Hospitalization and Medical Services, Inc. (GHMSI).
This report contains Lewin's findings in response to three key questions addressed as a part of this analysis. Those questions are:

- Question 1: Is RBC an appropriate mechanism for assessing upper limits of insurers' surplus?
- Question 2: Is the approach used and range of RBC set forth by the Milliman report appropriate?
- Question 3: Is the concept of attributing "excess" surplus to a geographic area reasonable? What are potential mechanisms that could be used for attributing surplus in this manner?

Lewin relied on several sources of information to conduct this assessment. First, we relied on our experience in having conducted similar analyses on behalf of states and other health insurers. Second, we used statutory financial statements as the basis for much of our review of GHMSI's financial condition. We have noted instances where our findings were supplemented by interviews and/or information obtained solely through CareFirst. Finally, we used publicly available reports and documents, such as Milliman's December 4, 2008 report to CareFirst executives and the documents publicly available on the DC Department of Insurance, Securities, and Banking (DC DISB) website.

Question 1: Is RBC an appropriate mechanism for assessing upper limits of insurers' surplus?
To answer this question, it is important to define both surplus and RBC. Surplus is generally defined as an insurer's retained earnings or funds on hand to protect the company and its customers against adverse business conditions and support investment needs. Since surplus amounts do not provide perspective on a health plan's risk profile and organizational structure, state regulators commonly use RBC to assess an insurer's level of risk.
RBC is a measure generally used by regulators to establish the minimum amount of capital appropriate for a health plan to support its overall business operations during a period of adverse conditions. In DC, if RBC drops below 200% an insurer is required to present a plan to the DC DISB for improving its surplus. Blue Cross Blue Shield plans have similar, but more stringent RBC requirements imposed by the Blue Cross Blue Shield Association (BCBSA). The BCBSA requirements generally call for a licensee to maintain an RBC ratio of at least 375% as a threshold below which additional reporting and monitoring with regard to surplus levels is required .[69]

Appropriate use of RBC

RBC was designed by NAIC to help regulators "distinguish adequately capitalized companies from inadequately capitalized companies."[70] Several reports and commentaries point to RBC's use as a mechanism for monitoring minimum levels of capital required to remain solvent, and not for setting upper limits of surplus. This is due to several reasons, but notably:

1) RBC does not measure the "appropriate" level of surplus for an insurer. The NAIC's RBC formula projects a regulatory minimum amount of capital that is based on a standardized set of RBC factors

[69] A description of minimum solvency requirements and capital thresholds is contained on pages 17 through 21 of the GHMSI Milliman report, as available on the DC DISB website at http://disb.dc.gov/disr/cwp/view,a,1299,q,644199.asp

[70] Statement on Use of RBC Data from the NAIC. Accessed on August 26, 2009. Mike Barth, "Ranking Insurers by RBC Measures: Still Not Such a Smart Move," NAIC Research Quarterly, April 1995.

applied to specific financial statement values of each company. However, the amount produced is a bare-bones minimum, and most companies carry well in excess of the statutory minimum.[71] How much surplus is required in excess of the minimum is not addressed by the formula and is largely a matter of a plan's unique circumstances rather than a standardized calculation. Surplus management for a health insurance carrier must include consideration of both the *solvency* and *vitality* of the company.

Solvency is addressed, in part, by RBC measurement and other benchmarks. As we note elsewhere, however, RBC measures of solvency are point-in-time calculations. Surplus management and targets set by companies must, in fact, reflect a longer-term perspective to ensure that the point-in-time RBC measures are achieved.

Vitality objectives for companies address changes demanded by the marketplace, regulators, and members in response to an evolving healthcare environment. The history of the U.S. healthcare industry has been marked by continuous change in both the nature of available treatments and the manner in which services are provided by carriers. Companies require capital to react to these changes and develop or modify products and services to best serve its membership. Examples may be market driven (e.g. new and improved claims payment systems) or regulatory (e.g., ICD10 requirements), but typically are required to keep the company competitive and retain vitality in the marketplace.

BCBS plans are uniquely challenged because they lack the ability to sell stock to raise money, an option that is available to their for-profit competitors. Non-profit BCBS plans must fund large capital expenditures for innovation and vitality through either accumulated surplus or certain forms of new debt. Perversely, demands for capital are often likely to occur in a business environment which represents the worst time to incur additional debt. Appropriate levels of surplus must therefore address both solvency and an exercise in anticipating funding for necessary capital expenditures.

2) RBC is extremely volatile and can fluctuate between years for both consequential and inconsequential reasons. The RBC calculation is extremely sensitive to several variables, including underwriting performance, investment income, changes in non-admitted assets and internal accounting mechanisms. For example, the average BCBS companies' RBC ratio plummeted by 104 percentage points last year, primarily driven by the recent economic downturn and the loss of investments in the capital markets. GHMSI also experienced such a loss, in excess of 70 percentage points, as investment income fell by 42% from 2007 to 2008.

3) RBC is generated by a finite set of entries available in NAIC reporting formats and, as such, does not take into account all risks that insurers may face. As a generic formula, every single risk exposure of a company is not necessarily captured in the formula. The formula focuses on the material risks that are common for the particular insurance type.[72] Examples of risks not included are: pandemics/epidemics (e.g., H1N1 influenza), natural disasters (e.g., Hurricane Katrina) and the implications of broad health reform efforts (e.g., such as those currently being considered by the Obama administration).

4) RBC is a point in time measurement and does not take into account issues associated with surplus planning across a multi-year period. Historical results for health insurance carriers reflect successive years of gains and losses across multi-year periods. These are so common as to be industry-referenced as the "underwriting cycle." Such cycles are not coincidental but are actually cause and effect outcomes created by events which trigger an initial loss and the subsequent business dynamics by which companies react to losses and re-establish appropriate rate levels across their entire book of business.

Such loss cycles are therefore not uniform in length or depth of losses. There are unique characteristics in each company's block of business with regard to the regulatory, competitive, and contractual limitations which might be placed on re-establishing appropriate rate levels. Loss cycles also vary based on the nature of the trigger for initial losses and the overall business and economic environment at that point in time.

Surplus management must focus on levels of surplus required to weather the cumulative impact of the multi-year loss cycles. The RBC measure becomes one test as a surplus floor against which solvency needs to

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[71] Ibid.

[72] Risk-Based Capital, General Overview, July 15, 2009.

be measured at each year-end in modeling the impact of a projected loss cycle. As discussed above, it is also only one factor in such surplus assessments. Additionally, the RBC formula does not necessarily reflect the unique characteristics of the block of business of any given company when considering target surplus under the various loss scenarios.

Therefore, the appropriate use for the RBC is to help regulators provide an "early detection" system to monitor the solvency of an insurer.

The use of the RBC ratio by both health insurers and regulators

In recent years regulators and insurers alike have used RBC beyond its original intent as a measure of minimum financial solvency. Most insurers seem to contend, as GHMSI has done, that an insurer wants to provide an adequate margin of safety so that the company can endure periods of adverse experience without triggering any form of regulatory intervention while maintaining operational vitality and the ability to nimbly respond to unfolding market conditions. As noted above, it is most common for health plans to target surplus levels to cushion against a downturn in the underwriting cycle.[73]

The use of RBC as a mechanism for regulating the upper limits of an insurer's surplus is much more controversial. For the reasons listed above, the RBC calculation was never designed to regulate the upper limits for insurer surplus.

Regulating the maximum levels of surplus for an individual insurer can lead to several unintended consequences within the market place. If an insurer perceives that it may be accumulating surplus at a faster rate than a regulatory threshold permits, the insurer is incentivized to spend the "excess" surplus before regulatory intervention. For example, all insurers need to have the ability to plan for capital investments (e.g., IT investments) that need to be made in future years. This is particularly true for non-profit insurers, such as GHMSI, since they must either borrow the money or rely on surplus to fund such investments. Capping surplus accumulation makes it difficult for insurers to plan for long-term, future capital investments that are required so the company can remain competitive in the market place.

Additionally, an insurer seeking to avoid the trigger of a maximum regulatory threshold may not be maintaining surplus at an adequate level to remain solvent across several years of poor financial returns, low underwriting cycles, and other conditions mentioned previously.
Only two states actively apply an RBC-type formula to monitor insurers' upper surplus limits.[74]

- *Pennsylvania.* In 2005, the Pennsylvania Insurance Department stipulated RBC ratio ranges for all BCBS insurers operating within Pennsylvania. If a BCBS insurer goes above that range, they are required "to provide a plan to the Department illustrating how it will reduce its surplus level back to within its sufficient surplus operating range over a reasonable period of time."[75]

- *Michigan.* In 2003, Michigan enacted a provision stipulating that the BCBS insurer operating in that state shall not maintain an RBC ratio greater than 1000%.[76]

All other states have either not addressed placing a limit on insurer surplus or have simply chosen not to do so. Based on Lewin's experience in conducting research on this topic, most regulators tend to deal with the

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[73] James Drennan, "How Much Is Enough? Beyond the Mathematics of Risk Based Capital," Society of Actuaries meeting, June 2003.

[74] New Hampshire has a law (Title XXXVII, Insurance, Chapter 420-A, Health Service Corporations, §420-A:22, Annual Review) capping a non-profit health insurer's "contingency reserve fund" at 20% of premium income. The law is not enforced, primarily because New Hampshire's BCBS plan is now a for profit company. Minnesota had a maximum capital level for non-profit BCBS plans in the amount of three months' worth of medical claims expense; however it was eliminated in 2005 with the addition of the NAIC Model Health RBC Act. Hawaii had a law stating that if a non-profit health plan's network exceeded 50% of the prior year's total health care expenditures plus operating costs, the health plan is required to refund the money to clients. That law is no longer in effect.

[75] Determination and Order issued by the Pennsylvania Insurance Department in February 2005. The RBC ratio ranges are 550-750% for Highmark and IBC and 750-950% for Capital Blue Cross and NEPA.

[76] The Nonprofit Health Care Corporation Reform Act 350 of 1980, §550.1204a Unimpaired Surplus (added 2003).

issue of surplus accumulation through traditional mechanisms and oversight tools commonly available to state insurance departments, such as rating requirements and restrictions, minimum loss ratios, file and approval for rate increases, and other mechanisms, rather than relying on the RBC calculation.

Question 2: Is the approach used and range of RBC set forth by the Milliman report appropriate?

As previously noted, Milliman has identified a target RBC ratio range that CareFirst executives could use as a mechanism for managing surplus levels to appropriate risk mitigation levels. The Milliman-recommended RBC range is between 750% and 1050% under normal operating circumstances. Lewin was asked to comment on the appropriateness of the range without extensively modeling the underlying aspects of GHMSI's business.

Methodology used to assess Milliman's approach and RBC range

We have modeled surplus as a percent of revenue for many clients and updated our model to review the range of surplus for most non-profit Blue Cross Blue Shield plans. We recognize that different business dynamics will shift optimal ranges for GHMSI either above or below the output suggested by our model. However, the model produces a range that suggests the breadth of the range recommended by Milliman (i.e., 300% point range) is reasonable.

We are also familiar with the modeling concepts Milliman employed. In fact, we have performed similar modeling exercises in other situations with the same general framework and approach. Based on our review of Milliman's report, the Milliman approach was to model the potential "loss cycles" as discussed above. This analysis then develops a range of surplus levels which might be required to weather potential accumulated losses and maintain required RBC and/or surplus levels throughout the loss cycle. The range of surplus required is therefore a function of the assumptions as to what might drive losses, the specific dynamics of repricing business at GHMSI, and the desired probability of weathering a projected scenario.

Findings from assessment of Milliman's approach and RBC range

To review the breadth of GHMSI's proposed range of RBC, Lewin examined the historical surplus levels to quantify historical volatility and fluctuation of surplus for similar non-profit BCBS plans. Our model examines the number of years in a cycle and the magnitudes of surplus change observed historically during underwriting cycles. Using this historical information, the model estimates the RBC level required to remain solvent during potential loss years of an underwriting cycle. By converting the observed gains and losses of the underwriting cycle to a normal distribution, the model allows us to construct scenarios based on the likelihood of a certain magnitude of decline.

Milliman has chosen to set their range to withstand risks occurring between the 90^{th} and 98^{th} percentiles of the loss distribution. We believe that this range in the loss distribution is appropriate, especially given the current economic situation (we note that their report was written in December 2008). The breadth of their range (300%) is reasonable when we independently constructed a range. We believe that the 95^{th} percentile of the loss distribution is prudent for a point estimate, therefore Milliman's range of 90% - 98% can be justified.

The specifics of modeling potential loss cycles require processing a great deal of detail as to the underwriting and contractual characteristics of the blocks of business at GHMSI. Surplus considerations should also be addressed in modeling for capital needs and other issues beyond solvency, as discussed earlier in this letter. We did not run an independent loss cycle modeling exercise, but we are familiar with the approach taken by Milliman and find it similar to our own modeling. We also reviewed the surplus objectives and model parameters as described in the Milliman report. Based on work we have performed elsewhere and review of Milliman work, we are in agreement with the targets and rationale. The actual range would be a function of the assumptions, business modeling, and desired probability of maintaining the surplus target.
Overall, our review does not allow us to comment as to whether we would have produced the same range of surplus requirements as shown in the Milliman report. Our review does suggest:

- Given what we know about the type of modeling exercise Milliman undertook, we believe the surplus targets produced represent a reasonable range of expected outcomes.

- We support the use of a wide range of targets such as the 300% (750-1050%) range of potential outcomes that Milliman adopted. This finding is reinforced by both the results of our analysis, as well as the difficulty in managing to a narrow range of RBC given the limitations of the calculation Events associated with potential loss cycles can have a wide range of impact, and the ability of the company to respond can be confounded by a wide range of environmental factors.
- Models of the type used by Milliman are developed based ranges of likely assumptions which then create a probability-weighted range of potential outcomes. We support Milliman's recommendation that surplus targets should be chosen which represent a 90% to 98% likelihood of occurring among potential projected outcomes. Choices of a target with a 10% probability that surplus becomes inadequate (90% targets) do not represent sufficient assurance that company objectives can be achieved. On the other hand, the range of outcomes is sufficiently broad that achieving 100% assurance will be overly conservative. As previously noted, the case of a BCBS plan in which underwriting gains are the primary source of both surplus and capital needs argues for choosing targets with a higher probability of sufficiency.

Question 3: Is the concept of attributing "excess" surplus to a geographic area reasonable? What are potential mechanisms for attributing surplus in this manner?

Per Section 2(d) of the Medical Insurance Act,[77] the District's Insurance Commissioner is required to review only "the portion of the surplus of [GHMSI] that is attributable to the District and shall issue a determination as to whether the surplus is excessive." The answer to this question attempts to address if the attribution of surplus to a specific geographic region is reasonable and mechanisms that might be used to attributing surplus, regardless of the "reasonableness" of the concept.

Reasonableness of surplus attribution

GHMSI is a federally chartered Health Services Corporation that writes healthcare policies in three insurance jurisdictions: Washington D.C., Maryland, and Virginia. As such, GHMSI faces regulations from the three separate jurisdictions; however the company is centrally administered and managed.

Since GHMSI serves three contiguous geographical areas and invests in corporate infrastructure that allows economies of scale which accrue to all three areas, allocating surplus among the three areas is challenging. The infrastructure would be difficult to divide amongst the three areas, and if it was divided up the three separately administered areas would not achieve the operational advantages that a centrally administered organization is able to achieve. Similarly, by maintaining combined surplus that covers all three geographies, GHMSI is able to increase the financial protection afforded to all three. In light of the economies of scale provided to all three areas, it is difficult to attribute surplus (or any plan assets) to specific geographies. Additionally, the surplus and other plan assets have been accumulated over many years, and to attribute them appropriately may require a longer term historical view of the entities.

Potential mechanisms for attributing surplus

Insurance involves the payment of premium in exchange for financial protection afforded to the subscribers who receive the benefits. Bearing this in mind, we believe that any allocation of surplus should accrue to the subscribers. Furthermore, the accumulation of surplus occurs over a long period of time and not necessarily accruing evenly from all policyholders, further complicating the question of allocation.

It is important to note that nothing in the RBC formula anticipates an attribution of surplus within a regulated entity. Risk factors applied in the RBC formula, or other modeling exercises which might be applied to develop target surplus, could very well differ significantly among various geographies. They are not currently anticipated in the development of either the factors or the underlying financial data to which the factors are applied. Since the concept of attribution is not currently anticipated in surplus management, the foundations for modeling process which might accomplish such attribution is therefore even less clear.

In summary, our findings from our analysis across all three questions are below:

77 D.C. Code §31-3506(e)

- The RBC calculation was never designed to regulate the upper limits for insurer surplus. RBC calculations should be applied as an element in determining minimum regulatory solvency – consistent with the purpose which they were developed.
- Our review of the development of surplus targets set forth by the Milliman report suggests that the approach and range of potential targets developed is generally reasonable. We have several models we might apply, and exercises such as the loss cycle model that can produce a range of answers based on input assumptions and output parameters. We might, therefore differ as to the precise RBC percentages recommended. However, the model applied is consistent with an approach we might undertake, the outcomes do not differ significantly from those we might expect, and the choice of probability for sufficiency among potential outcomes seems appropriate.
- The attribution of any "excess" surplus to a geographic area is not a straightforward or easily determined outcome. Assuming that such an attribution is warranted, potential mechanisms for attributing surplus do not exist and would have to be developed. However, such logic was not anticipated in current surplus exercises and would have to be extrapolated from basic principles which are underlying minimum RBC determination and development of surplus management targets