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November 7, 2014

Adam Levi
Assistant General Counsel
District of Columbia Department of Insurance, Securities, and Banking
810 First Street, N.E. Suite 710
Washington, DC 20002

Re: GHMSI Post-Hearing Rebuttal Statement

Dear Mr. Levi:

Enclosed please find GHMSI's Post-Hearing Rebuttal Statement and supporting Exhibits, filed in accord with Paragraph 2(e) of the DISB's Fourth Scheduling Order.

Sincerely,

Dominic F. Perella

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Group Hospitalization and Medical Services, Inc.

POST-HEARING BRIEF

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

November 7, 2014

INTRODUCTION

Group Hospitalization and Medical Services, Inc. ("GHMSI" or the "Company") respectfully submits this post-hearing report to the Commissioner of the D.C. Department of Insurance, Securities, and Banking ("DISB").

This proceeding is being held at a time of unprecedented uncertainty in the health insurance industry, and it is not possible to overstate the importance of adequate surplus levels to GHMSI's long-term viability. As former District of Columbia Insurance Commissioner Lawrence Mirel testifies, "[t]he first responsibility of an insurance commissioner is to make sure that an insurance company under his or her authority is able and willing to make good on its promise to its policyholders" and a Commissioner not only "wants to see a robust surplus," but must "insist upon it." **Exhibit 1** (*Rebuttal Testimony of Lawrence Mirel* ("Mirel Testimony") at 4, 6. Reduced surplus levels increase the risk of nonpayment of claims, increase borrowing costs, and reduce investment income available to subsidize losses in the individual insurance market.[1] Such problems are particularly acute for nonprofit insurers (like GHMSI), which face severe limits on their ability to generate new surplus. *Id.* at 9.

The risks to GHMSI's surplus levels—and thus to its subscribers—are real and tangible. As GHMSI CEO Chet Burrell testified, GHMSI and BlueChoice cover 76 percent of all individuals under 65 covered in the District by commercial insurance, 72 percent of all small groups in the District, and 80 percent of the United States Congress. Tr. 89.[2] GHMSI provides this coverage on very low margins. GHMSI's operating gains are negligible – only 0.6% on average since 2012. *Id.* at 97. In the overall period since 2011, GHMSI has incurred tens of millions of dollars in operating losses, and that trend is continuing into 2014. *Id.* The Affordable Care Act broadens coverage to new and sicker enrollees, and GHMSI's long-term sustainability depends upon obtaining accurate premium rates that cover these new costs. *Id.* at 93-94. Only a percent or two difference between projected and actual rates will lead to losses of tens of millions of dollars. *Id.* at 94. Since the June 25 hearing, however, both Maryland and the District of Columbia reduced GHMSI's and

[1] As GHMSI has previously noted, both it and BlueChoice continue to lose money in the individual insurance market. *See Report by GHMSI on the Impact of the Affordable Care Act* at 14 (filed as Exhibit 2 to GHMSI's Prehearing Brief, available at http://disb.dc.gov/node/844182).

[2] Citations to "Tr." refer to the transcript of the June 25, 2014 hearing in this proceeding, available at http://disb.dc.gov/node/858472.

BlueChoice's requested individual market rate increases by roughly half. *See GHMSI's Responses to Questions in the Third Scheduling Order*, at 2-3 (hereinafter "Third Scheduling Order Responses).[3] GHMSI expects that it will continue to lose even more money in the individual market in 2015, and that these market forces will cause its surplus to fall significantly – including a drop of up to 100 basis points in 2014 alone. Tr. 118:5-8 (Testimony of C. Burrell). Once lost, GHMSI's surplus will be almost impossible to recover, because the ACA's new medical loss ratio rules and other features limit GHMSI's ability to generate any significant funds above its costs. *See Report by GHMSI on the Impact of the Affordable Care Act* at 6, 14-15 (filed as Exhibit 2 to GHMSI's Prehearing Brief, hereinafter "ACA Impact Report").[4]

As discussed fully in Section I, below, GHMSI's year-end 2011 surplus was not excessive under the Medical Insurance Empowerment Amendment Act ("MIEAA"), as repeatedly concluded by numerous, credible experts, including Rector. The Commissioner's decision in this case must be based on sound and credible evidence. An Insurance Commissioner "is not like an elected legislator, charged with balancing the overall needs of the community and determining how much revenue should be raised through taxation and how those revenues should be spent," but is instead an "official specifically charged with protecting insurance policyholders." *Mirel Testimony* at 12. While participants such as D.C. Appleseed ("Appleseed") may argue theories, the Commissioner must base his findings on sound and credible evidence, including appropriate and qualified expert opinion such as that presented by Rector and Milliman. *Id.* at 13-14. The credible evidence in this proceeding overwhelmingly points in one direction: GHMSI's year-end 2011 surplus was not excessive.

Section II addresses Appleseed's speculative and misleading arguments, which have no factual or valid actuarial support and are based on numerous, fundamental errors. In fact, Appleseed's analysis would result in a surplus target *below* 200% RBC-ACL. The Commissioner should reject such speculation.

[3] GHMSI's Third Scheduling Order Responses are available at http://disb.dc.gov/node/893242.

[4] The ACA Impact Report is available at http://disb.dc.gov/node/844182.

DISCUSSION

I. GHMSI'S YEAR-END 2011 SURPLUS WAS NOT EXCESSIVE.

A. The Scope of the Commissioner's Inquiry

Every three years, the Commissioner must review GHMSI's surplus and determine whether that surplus is "excessive." D.C. Code § 31-3506(e). In making this determination, the Commissioner should focus on the specific framework created by the MIEAA, and not the broad, policy-based arguments on which Appleseed would prefer to focus.

For example, § 31-3506, where the MIEAA is codified, does not authorize DISB to set a hard-and-fast dollar figure for GHMSI's community giving, as Appleseed has suggested. Nor does it authorize DISB to seize "excess" surplus and use it for community expenditures, as Appleseed consistently has suggested since 2009. Nor does it authorize DISB to somehow "balance" GHMSI's community giving against its surplus level. Under the MIEAA, "community reinvestment" includes rate moderation. Indeed, GHMSI can meet the community reinvestment requirement solely by maintaining lower rates, to the extent feasible. GHMSI fully *reinvests* in the community when it keeps an actuarially sound level of surplus, but no more, because that means GHMSI is maintaining low rates to the extent that it can do so without jeopardizing its financial soundness. While GHMSI also engages in significant community *giving* as part of its non-profit mission, it is the premiums paid by GHMSI members and policyholders that fund that giving.

Under the MIEAA, the Commissioner must look backward to determine whether GHMSI's surplus was "excessive" at a specific point in time—year-end 2011. *Id.* § 31-3506(e). If GHMSI's surplus was not excessive at that time, this proceeding is at an end. *See id.* If the surplus was excessive, the Commissioner must determine what portion of the surplus is attributable to the District of Columbia, the Commissioner must confer with Maryland and Virginia, and GHMSI would develop a plan to address any excess surplus attributable to the District. *Id.* § 31-3506(e) & (g). The MIEAA is very clear that GHMSI's plan may consist entirely of rate moderation benefiting GHMSI's subscribers. *Id.* § 31-3506(g)(2).[5]

[5] The fact that this proceeding is about GHMSI's 2011 surplus also has a second important corollary: Even if GHMSI's surplus level were too high at year-end 2011 (which it was not), that would not mean it is too high now. if the Commissioner were to determine that GHMSI's surplus had been excessive in 2011 but that conditions have since changed in a way that increases the Company's risks, and makes its

B. GHMSI Meets Both Determinations Under The MIEAA

GHMSI's surplus is excessive only if it is both "unreasonably large" and inconsistent with the Company's obligation to "engage in community health reinvestment to the maximum feasible extent consistent with financial soundness and efficiency." D.C. Code §§ 31-3506(e), 31-3505.01. Those determinations "must be made in tandem, not *seriatim*." *D.C. Appleseed Ctr. for Law & Justice, Inc. v. D.C. Dep't of Ins., Sec., & Banking*, 54 A.3d 1188, 1215 (D.C. 2012). As Neil Rector testified, the Commissioner can only make these determinations by "look[ing] for a target amount [of] surplus that complies with the statutory requirements by being neither too high nor too low." Tr. 32:15-33:6. In this case, GHMSI's year-end 2011 surplus was at the surplus target calculated by Rector and below that calculated by Milliman, and was neither unreasonably large nor inconsistent with GHMSI's "community health reinvestment" obligation.

1. GHMSI's Surplus is Consistent with its Community Health Reinvestment Obligation.

GHMSI should only engage in community health reinvestment to the extent that it may do so "consistent with financial soundness and efficiency." DC Code § 31-3506(e). As made clear by GHMSI's charter, adopted by Congress, GHMSI's foremost obligation is to its subscribers: It must keep its promises to pay their claims and provide them high-quality health insurance. *See* Pub. L. 103-127; 106 Stat. 1336 (1993). The Company violates that promise if it carries surplus at a level that leaves it exposed to an undue risk of insolvency. *See* Tr. 293:6-13 (Testimony of C. Burrell) (MIEAA imposes a "duty to protect the solvency and soundness of the entity that actually bears the risk on behalf of people who can't bear that risk. To go to low levels of confidence or . . . RBC would threaten the financial soundness of the company and . . . fail to fulfill the fiduciary responsibilities we have.").

When the MIEAA was enacted, the D.C. Council itself recognized the need for GHMSI to maintain a robust surplus: "The intent of the [MIEAA] is that the company maintain reserves adequate to pay its subscribers' claims, fund capital improvements, meet contingencies, and remain a healthy participant in the market. . . . It is in the public interest for GHMSI to continue in its role as a robust non-profit health insurer, and nothing in this bill compromises that objective." **Exhibit 2** (*Report, D.C. Council Comm. on Public Servs. & Consumer Affairs, Bill 17-934, the Medical Insurance Empowerment Amendment Act of 2008*,

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surplus levels appropriate, the Commissioner would have ample discretion to approve a plan submitted by the Company that keeps surplus at current levels or even increases it. D.C. Code § 31-3506(g)(1).

Oct. 17, 2008 ("DC Council Report")) at 13. That is why the MIEAA requires GHMSI to moderate rates or otherwise engage in community health reinvestment only to the extent that it can "without undermining GHMSI's 'financial soundness and efficiency.'" *D.C. Appleseed*, 54 A.3d at 1214 (quoting § 31-3505.01). GHMSI fully meets this obligation by engaging in community health reinvestment in a manner that keeps its surplus at an actuarially-determined level that (1) accounts for all reasonably foreseeable risks to the Company and (2) is sufficient to avoid inefficiencies that would shift risks or costs to members.[6]

Financial soundness. "Financial soundness" means a surplus level that minimizes "reasonably foreseeable undue risk[s]" to the Company. *Landry* v. *F.D.I.C.*, 204 F.3d 1125, 1138 (D.C. Cir. 2000). Thus, "financial soundness" focuses not only on GHMSI's present condition, but on GHMSI's ability to withstand future negative events and reasonably foreseeable combinations of such negative events. *See, e.g.*, *id.; Matter of Seidman*, 37 F.3d 911, 927, 932 (3d Cir. 1994) (a practice is unsound where it creates an "abnormal risk of loss"); *Barber* v. *Ritter*, 196 P.3d 238, 243 (Colo. 2008) (a "sound" entity is one that can "cover future liabilities and expenses for all claims").

In recognizing the importance of financial soundness, the MIEAA requires the Commissioner to consider significant risks to GHMSI, even if they may be unlikely to arise in the immediate future. As Mr. Burrell testified, determining the level of surplus required to maintain financial soundness is not dissimilar to designing a bridge, which must withstand foreseeable adverse conditions, not just average traffic. Tr. 90:19-91:8. Neil Rector provided a similar explanation, stating that "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 [at a 98% confidence level]." Tr. 39:11-17. It would be foolhardy to simply ignore significant risks to GHMSI. For example, Mr. Mirel identifies, among other things, unexpected financial downturns, changes in law, privacy breaches, and pandemics such as the flu, or other causes for increased claims, among the many risks faced by a health insurer, noting that "[i]nsurance is one of the most tightly regulated industries … for good reason." *Mirel Testimony* at 7. Mr. Mirel speaks from personal experience, having served as Commissioner

[6] As stated by Neil Rector, GHMSI should only engage in community health reinvestment up to the point "where doing more would present an inappropriate risk of GHMSI becoming financially unsound or inefficient." Tr. 31:10-14.

during the failure, loss of Blue Cross and Blue Shield licensure, and ultimate liquidation of an Ohio insurer that was licensed in the District. *Id.* at 8.

Efficiency. "Efficiency," as used in the MIEAA, means that GHMSI's surplus must be maintained at a level that protects consumers from disruptive price swings and other market distortions, while maintaining GHMSI's ability to provide competitive services over the long term. *See*, *e.g.*, *Webster's Third New International Dictionary (Unabridged)* 725 (defining "efficient" as "[m]arked by qualities, characteristics, or equipment that facilitate the serving of a purpose or the performance of a task in the best possible manner . . . effective to an end"); *Cross-Sound Ferry Servs., Inc.* v. *I.C.C.*, 934 F.2d 327, 345 (D.C. Cir. 1991) (to be "efficient," a process cannot consider one factor alone—for example, cost—but must "incorporate the full range of possible externalities"); *accord Doe v. Miles Labs., Inc.*, 675 F. Supp. 1466, 1471 (D. Md. 1987).

GHMSI's policyholders will suffer harm if they are subjected to repeated "ups" and "downs" in insurance prices. Driving GHMSI's surplus too low would, sooner or later, require GHMSI to seek large rate increases to avoid dropping to dangerous RBC-ACL levels. Consumers, especially those in bronze and silver plans, already bear significant fractions of their own health insurance costs through deductibles, copayments and co-insurance. They should not also be subjected to artificially low rates one year and large increases the next. To the contrary, whipsawing consumers back and forth between artificially low rates and large rate increases is exactly the kind of "inefficiency" the MIEAA seeks to avoid.[7]

Driving surplus too low (through, for example, sustained inadequate rates) would cause other negative consequences to members, even if GHMSI never actually becomes insolvent. An inadequate surplus would force District residents to shoulder excessive risk that GHMSI would not be able to pay their medical bills. *See Mirel Testimony* at 4. Such risks create an inefficient "externalit[y]," *Cross-Sound Ferry*, 934 F.2d at 345, by imposing costs and burdens on members that GHMSI would bear, if it remains financially sound. Finally, when the Company's surplus drops too low, it lacks the capital it needs to update and improve its products and capabilities, thus beginning a cycle in which it becomes less competitive in the marketplace. In that circumstance, GHMSI would not be efficiently

[7] The Commissioner, in addition, should be concerned with the entire insurance marketplace, and the market impacts that would result were GHMSI required to provide insurance at artificially low rates at some times, and with large rate increases at others. Such swings in the largest carrier's market prices surely would impact the marketplace as a whole.

providing health insurance to its members, and it would once again be imposing externalities upon them. *See GHMSI Pre-Hearing Br.* at 15-16.

Applying the test. As Neil Rector testified, the MIEAA's goal of protecting GHMSI's soundness and efficiency is best addressed by setting an appropriate RBC target using actuarially sound methods. When GHMSI's surplus is within the target range, the Company meets its statutory mandate because it is engaging in community health reinvestment "to the maximum feasible extent" consistent with soundness and efficiency. Tr. 32:15-33:6 (Testimony of N. Rector); *Rector & Associates, Inc., Report to the Department of Insurance, Securities and Banking: Group Hospitalization and Medical Services, Inc. (Dec. 9, 2013)* ("Rector Report") at 12. In this case, Rector reviewed every aspect of Milliman's surplus model, developed its own modelling assumptions, made some modifications to the model, and determined that financial soundness and efficiency dictated a 2011 surplus target of 958% RBC-ACL, and a range of 875%-1,040% RBC-ACL. GHMSI meets this test – its surplus was 998% RBC-ACL at year-end 2011, 921% at year-end 2012, and 932% at year-end 2013, all within the target range.[8]

There is ample evidence in the record to support the review performed and conclusions drawn by Rector. Certainly, it would be a reasonable exercise of the Commissioner's discretion to accept the advice of his disinterested expert. *See D.C. Appleseed*, 54 A.3d at 1215-16 (discussing the Commissioner's discretion); *Mirel Testimony* at 13-14. Rector's overall conclusion that GHMSI's year-end 2011 surplus was not excessive matches the conclusion of every other responsible actuary who has analyzed GHMSI's surplus.[9]

2. GHMSI's Surplus Is Not Unreasonably Large.

GHMSI's surplus likewise is not "unreasonably large." The maximum-feasible-extent determination and the unreasonably-large determination must be made "in tandem," *D.C. Appleseed*, 54 A.3d at 1215, and both rely upon the same fundamental analysis of how much surplus GHMSI needs to remain financially sound. It is axiomatic that, if GHMSI maintains its surplus at the level needed to remain sound and efficient, but not higher, then the

[8] Milliman's own analysis produced a somewhat higher target range, but GHMSI's surplus is not excessive under either the Rector or Milliman standard.

[9] In addition to the Rector and Milliman analyses of GHMSI's 2011 surplus, and the Lewin analysis attached to GHMSI's prehearing brief, Rector and Milliman both found that GHMSI's 2008 surplus was not excessive. McGladrey and Invotex also have reviewed GHMSI's surplus for the Maryland Insurance Commissioner, and have found it not to be excessive.

surplus cannot be "unreasonably large." The analyses of both Rector and Milliman, therefore, demonstrate that GHMSI's year-end 2011 surplus was not "unreasonably large," as do the surplus ranges adopted by the GHMSI Board and the Maryland Insurance Commissioner. Excepting Mr. Shaw's idiosyncratic views (discussed below), every actuary or regulator to analyze GHMSI's surplus has found that it was not unreasonably large at the time of the analysis.

C. The ACA Imposes Further Downward Pressure on Surplus

GHMSI's surplus has fallen dramatically since its 2010 high of 1098% RBC-ACL. Regardless of the outcome of these proceedings, GHMSI is facing a time of unprecedented market disruption and risk, and believes that its surplus will fall another 80 to 100 basis points in 2014, and will continue falling in 2015 and 2016. *See* Tr. 114:7-13 (Testimony of C. Burrell) ("[W]hile we support the basic objectives of ACA, we think the impacts of ACA are creating an environment that is probably the most uncertain the company has ever been through."); *id.* at 118:5-8 ("[O]ur surplus is now at 932 for GHMSI, as I said earlier. We believe it will head down and is in the process of heading down in '14."). *See also Third Scheduling Order Responses* at 12-13 (explaining why GHMSI expects a drop of 80 to 100 basis points in surplus as a percentage of RBC-ACL in 2014). The significant risks to GHMSI arising from the ACA must be part of the Commissioner's analysis in this case because the ACA itself makes it far more likely that GHMSI will lose the surplus it has and very unlikely that GHMSI will rebuild surplus once it is lost.

These impacts are discussed in detail in GHMSI's Report on the Impact of the Affordable Care Act ("ACA Impact Report"), which was filed as Exhibit 2 to GHMSI's Prehearing Brief,[10] and Mr. Burrell testified at length regarding the ACA at the June 25 hearing. The key impacts include:

- ***Guaranteed Issue***: Carriers now must provide coverage to anyone who applies, including individuals who were previously too sick to obtain coverage. While good for the public at large, GHMSI will incur increased medical costs that it must recover in rates. As of May 1, 2014, GHMSI's individual market enrollment had increased nearly 8% since year-end 2013, while BlueChoice's individual market enrollment increased approximately 256% during that time period. *See ACA Impact Report* at 16. GHMSI and BlueChoice can only recover such additional costs through adequate rates.

[10] Available at http://disb.dc.gov/node/844182.

- ***Constraints on Recovery of Surplus Through Rate Filings***: The largest single risk faced by GHMSI is that its rates will not cover its costs, let alone be sufficient to generate surplus. As Neil Rector testified,

> [A]s a health insurer, by far, the biggest risk factor that GHMSI faces is adequacy of premium rates. Rates are developed a year or more in advance of the rating period . . . [I]n that time, the assumptions used to determine them may prove to be inaccurate. And this risk has been exacerbated by the rollout of ACA.

Tr. 72:12-19; *see also Mirel Testimony* at 3 ("Insurance is an unusual product in that the price at which it is sold must be determined before it is known how much the product will cost to provide . . ."); Tr. 295:9-296:1 (Testimony of C. Burrell) ("[T]he thing . . . that I worry about most is . . . that the rates turn out to be wrong . . . . All the rules have changed and the people that are coming into the products, we think, have more adverse risk than the people who have been in the products that we sell. How much sicker, how much poorer, how much needier are they? Could you get that 1 percent wrong, 2 percent wrong, 5 percent wrong even though you made your best effort? You probably could. . . . Each error of 1 percent for us . . . is $40 million.").

Rate adequacy is already an issue for GHMSI. As GHMSI discussed when responding to the Third Scheduling Order, GHMSI suffered underwriting losses in both 2012 and 2013, even with 50% of the BlueChoice results included. To date in 2014, GHMSI has suffered more than $65 million in underwriting losses, under statutory accounting principles, which are only minimally offset by a $3.5 million gain from GHMSI's 50% share in BlueChoice. *See Third Scheduling Order Responses* at 12-13, 22. Despite these losses, GHMSI's requested individual market rate increases for 2015 were cut by nearly half in both Maryland and the District of Columbia, and GHMSI is now projecting significant individual market losses in 2015. [11]

- ***New MLR Rules***: The new medical loss ratio rules "cap" GHMSI's ability to generate any new surplus. Since 2011, carriers must pay rebates if their medical costs are

[11] The ACA also significantly limits carriers' ability to respond to changed market conditions in their rate filings because, whereas individual and small group rates for a calendar year must be filed in May/June of a given year, the ACA's various risk-adjustment programs designed to mitigate insurers' losses will not be put into effect until midway through the following calendar year. *ACA Impact Report* at 8. It now takes carriers more than two years to fully respond to changes in market conditions in the individual and small group markets. This makes it increasingly likely that GHMSI will not be able to recover losses through rate increases, because those rate increases will not even take effect for two years after they are needed. *Id*.

less than 85% of premium in the large group or 80% of premium in the small group and individual markets. *See ACA Impact Report* at 4-5. The MLR rules carve up GHMSI's market into 18 segments, and do not allow GHMSI to offset low medical costs in one segment against high costs in another. *See id.* at 5, 12. In other words, the MLR rules can force carriers to pay rebates in segments where they are doing better than break-even, even if they are losing money elsewhere. It is now much less likely that a carrier's rates will be adequate across its entire book of business, and much more likely that losses will not be recovered. *See id.* at 5. Even more important, the MLR rules limit GHMSI's ability to rebuild surplus once lost. Even if GHMSI is in dire financial straits, it cannot take extra funds into surplus if federal law requires that those funds be paid out as rebates. A carrier now can quickly lose surplus, but cannot quickly rebuild it.

- ***New Subsidies, Taxes, and Fees on Health Insurance***: The ACA also imposes significant new taxes and fees on health insurance, which raise GHMSI's costs and the cost of its products to consumers. *See id.* at 7, 13. The subsidies provided under the ACA for low-income persons who purchase insurance through the exchanges are positive for consumers, but also impose new implementation risks - GHMSI is now dependent on the exchange and the government to accurately determine and pay a significant portion of premium dollars needed to pay medical claims, and GHMSI is at risk for any delays in payment or changes to the subsidy rules by regulators or legislators. *See id.* at 7. Such concerns, along with significant implementation costs—GHMSI and CareFirst spent upwards of $100 million in 2013 alone on costs associated with implementation of the ACA—put substantial downward pressure on the Company's surplus.

These changes create an environment in which coverage costs are greatly increased, the risk of losses are much greater, and it will be nearly impossible to build surplus or recover it once it has been lost. GHMSI's surplus as a percentage of risk based capital will drop both this year and in the years to come, and the Commissioner's decision in this case should reflect that reality.

II. APPLESEED CITES NO VALID EVIDENCE TO SUPPORT ITS POSITIONS, AND THEY SHOULD BE REJECTED.

Only Appleseed claims that GHMSI's year-end 2011 surplus was too large, and it does so on the basis of fundamentally flawed arguments that lack evidentiary support, misconstrue the MIEAA, and rely exclusively on Mr. Shaw's analysis, which itself is riddled with basic factual inaccuracies.

A. Appleseed Presents An Analysis That Is Not Credible And Inconsistent With The Commissioner's Role.

The D.C. Court of Appeals has emphasized that the Commissioner has broad discretion to address how GHMSI's surplus should be evaluated, based on his "expertise in this subject matter." *D.C. Appleseed*, 54 A.3d at 1215. Appleseed's entire analysis lacks credibility, because it presents a surplus model for GHMSI that would actually push GHMSI's surplus below 200% RBC-ACL and put GHMSI into regulatory supervision, *immediately*.

Appleseed sums up its adjustments to Rector's surplus model on page 43 of its pre-hearing brief. As shown on page 43, if the Commissioner were to accept the Appleseed's adjustments, GHMSI would have a surplus target of ***205% RBC-ACL***. Appleseed's position, however, is actually even worse, because the chart on page 43 is incomplete and does not include the $153 million surplus reduction proposed by Appleseed on account of supposed "inefficiencies" in GHMSI's administrative expenses. *See Mark E. Shaw, Report to the Department of Insurance, Securities, and Banking, Group Hospitalization and Medical Services, Inc. MIEAA Surplus Review* (June 10, 2014) ("Shaw Report") at 33 & 58, Chart 25. Appleseed argued at length for this adjustment at the hearing, and when this adjustment is included, Appleseed's "analysis" leads to a proposed surplus target of ***55% RBC-ACL***. *See* **Exhibit 2** (*Milliman Response to June 10, 2014 Reports by D.C. Appleseed and Mark Shaw* ("Milliman Rebuttal") at 1.

No serious expert or participant has advocated or would advocate a string of "adjustments" leading to a surplus target of 205% RBC-ACL, much less 60%. Like many other states, the District sets 200% RBC-ACL as the regulatory *minimum* surplus level that insurers must avoid at all costs. *See* D.C. Code § 31-2001(13)(A).[12] Under D.C. law, 250% RBC-ACL is a warning level under which carriers must propose corrective actions to DISB, D.C. Code § 31-2003, and 100% RBC-ACL is the "Mandatory Control Level RBC" at which the Commissioner is obligated to take the company over, *id.* § 31-2001(13)(D). If the

[12] *See also* Ala. Code § 27-2B-3; Ark. Code § 23-63-1502(c); Cal. Ins. Code § 739.2(d); Del. Code tit. 18, § 5802(d); Fla. Stat. § 624.4085(2)(f); Ga. Code § 33-56-2(d); Haw. Rev. Stat. § 431:3-402(e); 215 ILCS 5/35A-10(e); Idaho Code § 41-5402(4); Kan. Stat. § 40-2d03; La. Rev. Stat. § 22:639(F); Minn. Stat. § 60A.61 (subd. 4); Miss. Code. § 83-5-403(5) (same); Mont. Code § 33-2-1903(4); N.D. Cent. Code § 26.1-03.1-02(4); N.H. Rev. Stat. § 404-F:2(IV); N.M. Stat. § 59A-5A-3(D); N.C. Gen. Stat. § 58-12-4; Ohio Rev. Code § 1753.32(D)(1); R.I. Gen. Laws § 27-4.7-3(c); Tenn. Code § 56-46-103(d); Va. Code § 38.2-5502(E); Wash. Rev. Code § 48.43.305(3); W. Va. Code § 33-40-2(d); Wyo. Stat. § 26-48-202(d).

Commissioner were to accept Appleseed's positions and analysis, GHMSI's surplus target would fall below every one of these regulatory levels.

In fact, GHMSI's viability would be threatened long before its surplus fell to 200% RBC-ACL. The Blue Cross and Blue Shield Association ("the Association") polices the surplus levels of its members assiduously, as discussed in detail in GHMSI's answers to the DISB's Third Scheduling Order. If GHMSI's surplus were to fall below 375% RBC-ACL, it would be required to present a plan to the Association for recovery of its surplus, would be subjected to monitoring by the Association to determine if GHMSI is complying with that plan, and potential adverse action by the Association if it determines that GHMSI is not or cannot comply with that plan. *See Third Scheduling Order Responses* at 6-11. GHMSI's financial condition and the Association's supervision would create significant challenges for the company in the marketplace. Under the Association's own rules, GHMSI would be required to make special disclosures of its surplus and financial condition to every current and prospective group and individual policyholder or self-insured employer plan. *Id.* GHMSI's financial stability is a matter of concern to employers, who frequently ask for evidence of financial soundness during the process of selecting a carrier or administrator. *Id.* at 18-19 (providing examples of employer inquiries regarding GHMSI's financial status). Businesses who are informed that GHMSI is in financial distress are unlikely to buy or renew policies, leading to a potential acceleration of the company's downward spiral.

Appleseed and Mr. Shaw present disconnected arguments intended to push surplus down by any means possible. Appleseed itself does not believe all of these arguments, because it also proposes an overall surplus target of 400% to 500% RBC-ACL (instead of the 205% or 60% RBC-ACL level dictated by its own calculations). *See D.C. Appleseed Report to Department of Insurance, Securities, and Banking: Surplus Review of Group Hospitalization and Medical Services, Inc. ("GHMSI") (June 10, 2014)* at 44 (hereinafter "Appleseed Report"). In doing so, Appleseed undermines its claim that all of its adjustments are "required by MIEAA." *Id.*

In his rebuttal testimony, former Commissioner Mirel addresses the problem faced by an Insurance Commissioner in a case such as this. A public interest group may choose to adopt inconsistent positions, but the Commissioner has a broader and more important responsibility to protect GHMSI's subscribers and the insurance market in the District:

> Not only are Appleseed and its expert less disinterested than the expert retained by the Commissioner, but if their advice turned out to be wrong, and

> GHMSI (and perhaps its parent company, CareFirst) ended up becoming financially distressed or insolvent, the Commissioner would have failed in his primary responsibility, which is to protect the insureds. The failure of GHMSI, the largest health insurer in the District of Columbia, the largest insurer of federal government employees, and the largest component of CareFirst, which dominates the DC, Maryland and Northern Virginia health insurance market, would be a disaster of major proportions.

Mirel Testimony at 15. Appleseed's surplus "model" makes no effort to determine how much surplus GHMSI actually needs to remain financially sound, and it should be rejected in its entirety.

B. Appleseed's Proposed Confidence Level Is Far Too Low And Has No Actuarial Support.

1. For the 200% RBC-ACL threshold, the only evidence supports the 98% confidence level used by Rector.

In its prehearing brief and at the hearing, Appleseed urges the Commissioner to set surplus at a level at which he is only 90% confident that GHMSI's surplus will not drop below 200% RBC-ACL. In other words, Appleseed asks the Commissioner to cut GHMSI's surplus to a level where, once every ten years, the National Capital Area's largest health insurer would approach insolvency, and risk losing its membership in the Association and a substantial portion of its membership (through loss of FEP business). Appleseed presents no evidence to justify its proposal to subject GHMSI to a 10% risk of failure as a viable insurance company, and it is alone in recommending this confidence level.

DISB made a concerted effort at the outset of this proceeding to identify actuarial points on which Appleseed, Rector, and GHMSI agreed, and the 98% confidence level was one of them. As Mr. Rector testified, "[a]t the outset, before the numbers were run, everyone agreed that . . . GHMSI should have no more than a 2 percent chance of crossing the 200 percent RBC threshold." Tr. 36:5-37:20. Appleseed and its actuary, Mr. Shaw, have repeatedly conceded throughout these proceedings that the 98% percent confidence level is appropriate. *Letter from M. Shaw to W. Smith, Jan. 18, 2013*, at 4 (agreeing that it would be appropriate to use a "near certainty threshold of 98% relative to 200% RBC"); [13] *Letter from Appleseed to S. Schroeder*, Jan. 18, 2013 at 3 (agreement by Appleseed that "[t]here appears to be agreement that the primary element the model should measure is the amount of GHMSI surplus needed to avoid falling below 200% RBC/ACL with 98%

[13] *Available at* http://disb.dc.gov/node/850492.

confidence"); *Letter from M. Shaw to W. Smith*, July 31, 2012 at 4 (stating that "it seems appropriate to use the 98% confidence interval relative to the 200% RBC standard");[14] *Letter from M. Shaw to W. Smith*, April 12, 2012 at 5 (same).[15] Mr. Shaw did not address the confidence level in either his report or his testimony. Appleseed is proceeding on this issue alone, without the endorsement of its actuary.

The only *evidence* in this proceeding shows that the Commissioner should set a target where GHMSI's surplus will remain above 200% RBC-ACL with ***98%*** confidence. As Phyllis Doran from Milliman testified, "all areas of insurance, including . . . health insurance, typically have standards of 99 percent confidence levels." Tr. 171:914. This evidence includes:

- Milliman, Rector, Invotex, and McGladrey all have deemed it appropriate to use a 98% confidence level. *See* Exhibit 12 to Pre-Hearing Br. (Milliman 2011 Report) at 13; Rector Report at 15; RSM McGladrey, Inc., *Maryland Insurance Administration Examination and Auditing: Surplus Evaluation Consulting Services Report: CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc.*, May 29, 2012 ("McGladrey Report") at 21; Invotex, Group, *Report on: Surplus Evaluation Consulting Services*, Oct. 30, 2009 ("Invotex Report") at 53.

- Under the Standard & Poor's rating system, a 99.4% confidence level is required for A ratings, 99.7% for AA, and 99.9% for AAA, whereas a 90% confidence level equates to junk status. *Standard & Poor's, Criteria: New Risk-Based Insurance Capital Model*, at 3, May 31 2007.[16]

- A.M. Best, a rating agency focused on the insurance industry, uses a 99.97% confidence level for "AAA" ratings. *A.M. Best Methodology, Best's Credit Rating Methodology: Global Life and Non-Life Insurance Edition*, April 2, 2014.[17] The Solvency Capital Requirement used in Solvency II, an EU Directive for insurance regulations, uses a 99.5% confidence level to calculate the capital insurance firms must hold to cover risk. *Lloyd's, Solvency II: Detailed Guidance Notes*, at 13, March 2010.[18]

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[14] *Available at* http://disb.dc.gov/node/850432.

[15] *Available at* http://disb.dc.gov/node/311282.

[16] *Available at* http://www.naic.org/documents/committees_c_071201_sandp_new_capital_model.pdf.

[17] *Available at* http://www.ambest.com/ratings/methodology/bcrmfull.pdf.

[18] *Available at* http://www.lloyds.com/~/media/Files/The%20Market/Operating%20at%20Lloyds/Solvency%20II/Dry%20run%20guidance/Section4.pdf.

- Maryland likewise has endorsed a 98% level. *See* Exhibit 15 to GHMSI's Pre-Hearing Br. (MIA 2012 Consent Order).

Appleseed presents no evidence to support its claim that "confidence levels in the 90-95% range have industry support." Appleseed Report at 17. Appleseed relies on a single sentence in a single report from the Academy of Actuaries that says "*certain risk factors* were developed on the basis of a 90%-95% confidence level." *Id.* (emphasis added). This does not suggest that a complete surplus model should be based on a lower confidence level. *See Milliman Rebuttal* at 2. This lone sentence does not show any "industry support" for Appleseed's argument.

2. Appleseed ignores the seriousness of the issues before the Commissioner.

Appleseed is wrong to mischaracterize its proposed shift from a 98% to 90% confidence level as a "slight[]" change or "marginal" difference. Appleseed Report at 15-17. Even at the 98% level adopted by Rector, GHMSI would have a one in fifty chance of dropping to 200% RBC-ACL in any three year period, and would be expected to approach insolvency twice every hundred years. As Neil Rector observed, there have been two great economic catastrophes within the past hundred years (the Great Depression of the 1930's and the Great Recession of the early 2000's), even though economists have long considered the chance of such events to be remote. Tr. 39:4-17. A 90% confidence level increases those risks fivefold, and assumes that GHMSI should face the risk of insolvency every ten years. The Commissioner should neither accept a 1 in 10 chance (at the 90% confidence level) nor a 1 in 20 chance (at the 95% confidence level) of such a catastrophe occurring.

Appleseed is equally wrong in its efforts to minimize the consequences to GHMSI were its surplus to fall below 200% RBC-ACL. Rector, as DISB's independent expert, correctly recognized that the consequences of dropping to 200% RBC-ACL would be "severe and potentially catastrophic": GHMSI members would lose access to Blue Cross Blue Shield networks nationwide; GHMSI would lose its BCBSA license; GHMSI would lose hundreds of thousands of members participating in the Federal Employee Health Benefits Program; and large customers would flee in droves. Rector Report at 16-17; Tr. 139:19-140:1 (Testimony of C. Burrell) (discussing "catastrophic" consequences of GHMSI falling below 200 percent). GHMSI likely would not survive that string of losses. That, no doubt, is why every state classifies 200% as a danger zone. The D.C. Council explicitly recognized in

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its MIEAA deliberations that a 200% RBC-ACL "*represents a high risk of insolvency.*" *D.C. Council Report* at 5 (emphasis added).

Appleseed's contention that GHMSI would not actually lose its BCBSA license if it fell to 200% RBC-ACL is based upon pure speculation and contradicted by the record evidence, including that submitted by BCBSA itself. The President and CEO of the BCBSA stated in this proceeding that if GHMSI's RBC-ACL "were to fall below 200 percent, BCBSA's Board of Directors . . . would immediately commence actions to terminate that company's license to use the Blue Brands." *Letter from Scott B. Serota, President and CEO of BlueCross BlueShield Assoc. to the Honorable Chester A. McPherson*, June 24, 2014.[19] During Mr. Mirel's tenure as D.C. Insurance Commissioner, he supervised the liquidation of an insurer that had fallen below 200% RBC-ACL and had lost its BCBSA license. *See Mirel Testimony* at 8. There simply is no evidence to support Appleseed's claim.

Nor would the regulatory protections triggered at 200% protect GHMSI from harm. As Neil Rector testified, "[i]f GHMSI were to [drop to 200% RBC] . . . it would cause extreme distress in the DC market, even if GHMSI could be pulled out of the nosedive before it becomes insolvent." Tr. 39:18-22. "Unlike publicly held, for-profit insurance companies, GHMSI does not have the ability to go to the capital markets to obtain funds if needed, nor does GHMSI have a parent company that might have cash available to contribute to GHMSI." *Id.* at 40:5-10. Moreover, "although GHMSI, in theory, could raise its premium rates to offset the losses, there are limits because of rate regulation and because of market restrictions on the size of premium increases allowed and the speed with which GHMSI could implement the increases." *Id.* at 40:11-16. The MLR rules in particular will place a cap on any ability of GHMSI to rebuild surplus once lost. *See ACA Impact Report* at 14-15.

The harm to GHMSI would start long before its surplus fell to 200% RBC-ACL. As Mr. Burrell testified, GHMSI would lose major customers "well before you reach that point." Tr. 128:7-18. Once its surplus fell below 375% RBC-ACL, GHMSI would be placed on the Association watch list, be subject to a corrective action program overseen by the Association, and be required to disclose its financial condition to every current and potential group and individual policyholder, or self-insured plan. *See Third Scheduling Order Responses* at 6-11.

[19] *Available at* http://disb.dc.gov/node/853782.

There is no reasonable basis for subjecting the subscribers and members covered by GHMSI to that level of risk. As former Commissioner Mirel observes in his testimony, the Commissioner has an ongoing role in reviewing the surplus for GHMSI, and certainly can adjust his analysis in the future as needed:

> If it turns out that some of the concerns that led Rector and Milliman to urge the maintenance of GHMSI's current surplus level do not come to pass, the Commissioner can always decide based on the consideration of new and convincing data to adopt a lower surplus target at a future date. On the other hand, were the Commissioner to order now that the GHMSI surplus be reduced, against the advice of his own outside expert, and the risks against which the surplus is maintained come to pass, triggering the financial failure of GHMSI, it would be too late to increase the surplus.

Mirel Testimony at 15. The Commissioner should reject Appleseed's efforts to minimize the seriousness of this proceeding.

C. Appleseed's Statutory Interpretation is Unfounded.

1. Appleseed's Results-Driven Analysis Is Contrary To The MIEAA.

Appleseed made very clear that its analysis in this case is based upon an effort to extract as much money from GHMSI's surplus as possible. Appleseed made this plain in its discussion of the confidence level that it proposed for the 200% RBC-ACL threshold:

> [M]illions of dollars for community health reinvestment become available when even a slightly lower confidence level is employed . . . ***The greatly diminishing amount available for community reinvestment above 91% confidence provide support for a confidence level of 90%.***

Appleseed Report at 15-16 (emphasis added); *see also* Tr. 187:23-188:1 (Testimony of W. Smith) ("[I]t's pretty startling how much more money can become available for community reinvestment if you move [the confidence level] down only a few points").

The MIEAA, however, forbids the Commissioner from sacrificing GHMSI's financial soundness and efficiency in the name of additional reinvestment -- that is the whole point of the "maximum feasible extent" clause in Section 31-3505.01. The D.C. Council made this very clear when it stated: "The intent of [MIEAA] is that the company maintain reserves adequate to pay its subscribers' claims, fund capital improvements, meet contingencies, and remain a healthy participant in the market . . . It is *excess* funds that will go to

community health reinvestments." *See* D.C. Council Report at 13 (emphasis in original). The Commissioner cannot simply make a determination that the Company should give more and then calibrate the confidence level to achieve that result. *See Mirel Testimony* at 12 (observing that "[a]n insurance commissioner is not like an elected legislator, charged with balancing the overall needs of the community and determining how much revenue should be raised through taxation and how those revenues should be spent"). The Commissioner, rather, is tasked by the MIEAA to ensure that GHMSI maintains sufficient surplus to remain financially sound and efficient.[20]

2. The D.C. Council Never Concluded That GHMSI's Surplus Was "Too High."

Appleseed is simply and demonstrably wrong when it argues that MIEAA "was passed because the Council thought GHMSI's surplus was *already too high.*" *Appleseed Report* at iii (emphasis in original). In their MIEAA deliberations, Council members emphasized that they had *not* concluded that GHMSI's surplus was too high, but rather that it should be regularly examined with the assistance of responsible experts. *See Public Hearing on Bill 17-934, Medical Insurance Empowerment Act of 2008,* Oct. 10, 2008, at 12:9-15 ("Since this bill establishes a framework and does not set any rigid statutory caps or ceilings or floors on surplus or amounts, it is quite possible that the Mayor, Department of Insurance, the experts will conclude that CareFirst is currently meeting its obligations, and in that regard, CareFirst should have nothing to fear from this bill."); *id.* at 102:8-11 ("This is not a prescription, but *if it turns out that there is more money that could be made available* for community health care by this company . . .") (emphasis added).

D.C. Council members also made clear that their foremost priority was to ensure that GHMSI remained strong and sound, and that the MIEAA should never be read to undermine those goals. The official Report on the legislation, for example, stated: "The Committee emphasizes that these standards are flexible . . . the Mayor must also take into account the need to keep the company financially sound and efficient." *D.C. Council Report* at 13. One of the legislation's primary proponents was even more explicit: "You know,

[20] Appleseed is also simply wrong to claim that a lower confidence level would "free up" funds for particular health projects in the District. The MIEAA specifically defines rate moderation as community health reinvestment. *See* D.C. Code § 31-3505.01. If the Commissioner ever found excess surplus, GHMSI would propose to bring it down by moderating the rates paid by its subscribers—the very people whose premium payments help build the surplus in the first place. *See* Tr. 86:4-11 (Testimony of C. Burrell); *see also id.* 86:14-87:1 (quoting former MIA Commissioner Tyler's 2009 surplus hearing testimony that excess surplus "belongs to policyholders because they generated it").

again, I think it just bears repeating that none of us want to see this company put in a financially compromised position because we would be doing a disservice to the rest of our constituents." *Public Hearing* at 158:8-12.

Similar statements abound, demonstrating that the Council was focused on GHMSI's financial soundness and did not want the MIEAA to become a tool to undermine it. *See*, *e.g.*, *id. at* 8:21-9:3 ("The Mayor would also make a[] . . . determination of the appropriate surplus range for GHMSI . . . consistent with financial soundness and efficiency."); *id.* at 11:14-19 ("[MIEAA] establishes a framework, with all due consideration for CareFirst financial soundness and efficiency . . . of course, this Committee, this Council wants CareFirst to remain a robust and prosperous participant in the District's health insurance market"); *id.* at 37:10-16 ("[T]his bill creates a framework to at the same time keep this company in robust financial good health . . ."); *id.* at 193:20-22 ("[T]his bill seeks to maintain the financial soundness of CareFirst."). Appleseed is now attempting to do exactly what the Council did *not* want.

3. The MIEAA Does Not Require Actuaries To Abandon Standard, Professional Methods Or Ignore Foreseeable Risks To GHMSI.

Appleseed is wrong when it tries to apply the MIEAA's "maximum feasible extent" requirement as a "thumb" on the actuarial scale. In other words, Appleseed argues that the actuaries should drive the surplus target lower by adopting less conservative assumptions than they normally would choose in their professional judgment, or by ignoring lower-probability events that they normally would include when modeling the level of surplus needed by a company to remain financially sound. This is what Appleseed means when it contends that Rector should have "adjust[ed] the model's assumptions in accordance with" the "maximum feasible" requirement, *Appleseed Report* at 5; Tr. 189-190 (Testimony of W. Smith), or that Rector should "discard[] . . . occurrences with magnitudes or probabilities that do not validate against experience," *id.* at 21. [21] These arguments are contrary to the MIEAA, which instructs GHMSI only to engage in community reinvestment when doing so

[21] In the second phrase, Appleseed actually contends that the actuaries can only consider events that have actually happened in the past few years, and that they must ignore all foreseeable risks to GHMSI that have not actually occurred in that limited time frame. Thus, if GHMSI has not experienced a data breach, or a pandemic has not occurred in the D.C. area in the past few years, Appleseed thinks that the actuaries should just ignore those issues and pretend they will never occur.

will not undermine its financial soundness and efficiency. *See* D.C. Code § 31-3505.01; *D.C. Appleseed*, 54 A.3d at 1214.

The D.C. Council's concern that GHMSI should remain financially viable in the long term would be wholly undermined if the Commissioner or the actuaries were to change their actuarial methods for calculating future risk by ignoring well-known and foreseeable risks to the company. As Mr. Rector testified: "You might think that it's impossible for GHMSI to [drop to 200% RBC], 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. We tend to forget the calamities that we think could never happen do happen, including at that level of frequency." Tr. 39:4-17.

GHMSI's surplus could be decimated by any number of realistic but "improbable" events—another market collapse, the outbreak of an epidemic like Ebola, or the fallout from a data breach by a cybersecurity incursion, to name just a few possibilities. For example, in 2013, Target faced a massive cybersecurity breach in which it had information from 70 million credit and debit cards stolen. Paul Ziobro and Danny Yadron, *Target Now Says 70 Million People Hit In Data Breach,* WALL STREET JOURNAL, Jan. 10. 2014.[22] Consultants have predicted that the full cost of that data breach—including reissuing millions of cards, paying fines, and other direct costs associated with the breach—will be between $400 and $500 million. Anne D'Innocenzio, *Data Breach Costs Take Toll on Target Profit,* WASHINGTON TIMES, Feb. 26, 2014.[23] Home Depot and JP Morgan are now facing similar breaches. Jake Swearingen, *Why The JP Morgan Data Breach Is Like No Other*, THE ATLANTIC, Oct. 2, 2014[24] ***;*** Robin Sidel, *Home Depot's 56 Million Card Breach Bigger Than Target's*, WALL STREET JOURNAL, Sept. 18, 2014.[25] Certainly, while those risks were not probable, they were both catastrophic and foreseeable, and it would be irresponsible simply to ignore them.

Because the MIEAA does not require community reinvestment when it would undermine GHMSI's financial soundness or efficiency, the Commissioner cannot properly apply the MIEAA without first determining the level of surplus that GHMSI actually needs

[22] *Available at* http://online.wsj.com/news/articles/SB10001424052702303754404579312 23254 6392464.

[23] *Available at* http://www.washingtontimes.com/news/2014/feb/26/data-breach-costs-take-toll-on-target-profit/?page=all.

[24] *Available at* http://www.theatlantic.com/business/archive/2014/10/why-the-jp-morgan-data-breach-is-like-no-other/381098/.

[25] *Available at* http://online.wsj.com/articles/home-depot-breach-bigger-than-targets-1411073571.

to remain financially sound and efficient. The Commissioner, therefore, cannot satisfy the statute without performing an unbiased analysis of surplus needs based on realistic assumptions. To do anything else would undermine the MIEAA's plain goal of maintaining GHMSI as a financially sound carrier.

4. Appleseed's Interpretation of "Efficiency" as a Limit on Surplus is Incorrect.

Finally, Appleseed misconstrues the MIEAA when it attempts to apply the term "efficiency" as a limit on GHMSI's surplus, or as a reference to GHMSI's administrative efficiency in processing claims. *See, e.g.*, Appleseed Report at 18; Tr. 192:14-18 (Testimony of W. Smith) (interpreting the term "efficiency" in the MIEAA as "limit[ing] th[e] company's surplus"); *id.* at 195:10-11 ("So our bottom line point here is that efficiency limits [GHMSI's] . . . surplus").[26] Under the plain text of the statute, the MIEAA uses the term "efficiency" to limit the amount of *community health reinvestment* in which GHMSI may engage, not its surplus: "A corporation shall engage in ***community health reinvestment*** to the maximum feasible extent ***consistent with financial soundness and efficiency***." D.C. Code § 31-3505.01 (emphases added).

In other words, GHMSI cannot be required to engage in any additional community reinvestment (whether giving or rate moderation) if it would make GHMSI less efficient to do so. The Court of Appeals recognized as much, concluding that the "twin objectives" of the MIEAA were "(1) obligating GHMSI to reinvest in community health "to the maximum feasible extent," (2) *without undermining GHMSI's 'financial soundness and efficiency*.'" *D.C. Appleseed*, 54 A.3d at 1214 (emphasis added). The MIEAA's legislative history similarly confirms that "efficiency," like "soundness" is a cap on the Company's reinvestment obligation, not a further downward drive on its surplus. *See, e.g.*, D.C. Council Report at 13 (in evaluating community health reinvestment, "[t]he Mayor must also take into account the need to keep the company financially sound and efficient."). In trying to use "efficiency" to drive GHMSI's surplus down, Appleseed turns the MIEAA on its head.

Lacking any support in the actual language of the MIEAA, Appleseed relies exclusively on a 2005 surplus determination by ***Pennsylvania's*** Insurance Department in an attempt to rewrite the MIEAA. *See* Appleseed Report at 19-20 (citing *In re: Applications*

[26] This is a new argument for Appleseed, which it did not make in the earlier surplus proceedings or before the Court of Appeals.

of Capital Blue Cross, Highmark Inc., Hospital Service Assoc'n of Northeastern Pennsylvania d/b/a Blue Cross of Northeastern Pennsylvania and Independence Blue Cross for Approval of Reserves and Surplus, Misc. Dkt. No. MS05-02-006 at 36 (Ins. Dep't of Comm. Of Pa. Feb. 9, 2005) ("Koken Decision").[27] This Pennsylvania Decision, which uses the term "efficiency" in a wholly different context, cannot modify the MIEAA's plain language or the Court of Appeals' holding.[28] While Appleseed claims that "the D.C. Council effectively codified the Pennsylvania concept of efficiency," Appleseed Report at 20, the D.C. Council has never said anything of the kind.[29]

Nor is there any merit to Appleseed's argument that, because the MIEAA refers to "efficiency", GHMSI's target surplus should be reduced to penalize the Company for supposed inefficiencies in its operations. Appleseed Report at 41-42. The word "efficiency" operates in the MIEAA as a limit on *community health reinvestment*, not surplus. It would make no sense for the MIEAA to refer to operating efficiencies, because GHMSI's administrative expenses are recovered in annual rate filings, and neither contribute to nor draw from surplus. *See Written Hearing Testimony of Phyllis Doran, F.S.A., M.A.A.A., June 25, 2014*, at 8. If GHMSI were to reduce expenses, those reductions would be passed on to members in the next year, and GHMSI's surplus would remain unchanged. *See id.* Nothing in the MIEAA authorizes the Commissioner to consider the Company's administrative efficiency in conducting the surplus review.[30]

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[27] *Available at* http://www.portal.state.pa.us/portal/server.pt/community/industry _activity/9276/ blues_reserve_ and_surplus_determination/623159.

[28] Commissioner Koken used the term "inefficient" to refer to unreasonably large surplus. *See* Koken Decision at 21 ("[A]t what point is the statistical likelihood of insolvency so remote that a surplus level at or above that point would be considered inefficient?"). As set forth above, the MIEAA does not.

[29] Appleseed also mischaracterizes the Koken Decision with respect to Appleseed's claim that the actuaries should ignore foreseeable events in their modeling. The Koken Decision never said anything of the kind - it states only that insurers should not "accumulate enough premiums to cover any and all catastrophic events *no matter how remote and unforeseeable*." Koken Decision at 12 (emphasis added). Neither Rector nor Milliman attempted to cover unforeseeable future events. *See* Tr. 69:19-70:6 (Testimony of J. Toole) ("I definitely wouldn't say . . . that we're recommending surplus levels protecting against any and all possible catastrophic events").

[30] This second "efficiency" argument also fails on the facts. GHMSI undertakes significant efforts to ensure it is comparable to other plans in terms of efficiency, including participating in studies commissioned by the BCBSA that thoroughly analyze and, to the extent possible, compare plan efficiency. In those studies, GHMSI comes out in the middle of the pack relative to other Blue Plans. *See* GHMSI Responses to DISB Questions, Sept. 5, 2014 (Exhibit C); Tr. 112:17-17-25 (Testimony of C. Burrell) (GHMSI is "in the middle of the pack as far as efficiency despite . . . having invested substantially

D. Appleseed's Positions Are Otherwise Flawed.

Appleseed makes three additional claims that merit a brief response.

Impact of the ACA. Appleseed dramatically underestimates the downward pressure the ACA will impose on GHMSI's surplus. Appleseed and its actuary simply ignore the features of the ACA that increase risk for carriers, discussed *supra* Section I.C, and focus solely on provisions of the Act that are designed to mitigate risk (even if they are wholly new and untried in the market place). Mr. Shaw also commits a number of fundamental errors in his analysis:

- He misapplies the MLR rules by ignoring the 18 different market segments into which GHMSI and BlueChoice business is fragmented, *see* Shaw Report at 14-15; *Milliman Rebuttal* at 34.

- He erroneously applies the risk corridor program to all market segments, even though it applies only to Qualified Health Plans sold in the individual and small group markets. *Id.*

- He incorrectly assumes that the effects of the ACA's guaranteed issue requirements will be completely offset by the "three Rs" (reinsurance, risk adjustment, and risk corridors), Shaw Report at 13-14, even though (1) those programs were never designed to offset all market risks, (2) the reinsurance and risk corridors are temporary programs that will be phased out; (3) funding for the risk corridors program is uncertain;[31] and (4) the risk adjustment program has never been tried before and there is substantial uncertainty regarding how that program will work. *See Milliman Rebuttal* at 34-35; Tr. 133:12-20 (Testimony of M. Chaney) ("[Risk adjustors are] going

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more dollars in preparing for ACA"). Mr. Shaw's claim that GHMSI is less efficient than other companies is based solely upon examining the statutory statements of a cherry-picked selection of other plans. *See* Shaw Report at 33-38. Mr. Shaw made no effort to account for operational differences between plans. For example, BCBS of Georgia is a WellPoint subsidiary and part of a large for-profit corporation. *Milliman Rebuttal* at 13, 23. Other companies on Mr. Shaw's list are similarly part of large holding companies, including large for-profit families of insurers, with access to capital markets and the ability to spread costs over much larger claims volumes. *Id.* There is no evidence in the record that GHMSI is less efficient than its peers.

[31] *See ACA Impact Report* at 8-9 & 18 n.18; Tr. 95:4-10 (Testimony of C. Burrell) ("Just in the last several months, [the risk corridor program] has been on the table, off the table, in terms of regulatory oversight from CMS and different opinions as to whether the protection that was intended would be there or be there in the form which it was originally understood creates incredible uncertainty."); *id.* at 145:13-25 ("Well, if you knew you had that cushion [from the risk corridor program], it might influence the way you price. It, in fact, influenced us. We counted on that cushion. And then we were told in March, no, it's not there. There will be no federal money. Well, then what do you do? You don't have it. We already priced it. Is that going to come back? . . . As we go along, we're expecting unintended effects from the rules that are clearly existing, some changes in the rules that are being made as they're being made.").

> to be the wild card in this. And it's just—it is a huge uncertainty, and with huge uncertainty comes risk, but this is even more than that. It's an asymmetric risk. We don't have any upside.").

Community Reinvestment. Appleseed repeatedly contends that if the DISB adopts Rector's surplus target, GHMSI's community reinvestment will be "zero" and its community reinvestment mandate will be "nullified." Appleseed Report at 6, 12, 15, 16. That assertion has no basis in reality and is contrary to the evidence. It is undisputed and indisputable that the Company reinvests tens of millions of dollars in the community each year, with a focus on catalytic giving designed to stimulate longer-term, systemic improvements in the health care delivery system, and expanding access to vulnerable populations. Indeed, since 2008, GHMSI has given *hundreds of millions of dollars* to a wide variety of initiatives dedicated to improving access to healthcare in the communities the Company serves. *See* Exhibit 1 to Pre-Hearing Br. (GHMSI 2013 Community Giving Report). The Company has also engaged in substantial rate moderation for the benefit of its subscribers, as well as seeking rate increases lower than some actuarial models predicted would be necessary in order to cover medical costs for new products under the ACA's guaranteed issue requirements. *See* GHMSI Pre-Hearing Br. at 7-8. The notion that GHMSI's community reinvestment, including rate moderation and giving, will drop off to zero under Rector's approach is entirely baseless.

Procedural Complaints. Appleseed complains that Rector's analysis was a "black box," Appleseed Report at 29, and that "Milliman and Rector Fail to Explain their Work in Accordance with Actuarial Standards of Practice," Shaw Report at 6. Like many other features of Appleseed's report, those assertions are demonstrably false. Milliman and Rector provided extensive documentation of their analyses to GHMSI and the DISB, much of which the DISB passed on to Appleseed. Indeed, DISB bent over backwards to ensure that Appleseed had all the information it needed, even delaying this proceeding to give Appleseed more information and more time.

The fact that Mr. Shaw was able to run his own simulations and replicate Milliman's analysis substantially undercuts his procedural complaints. *See Milliman Rebuttal* at 38; Tr. 25:1-15 (testimony of N. Rector). As DISB's expert observed: "[I]t is also clear to me that as a substantive matter, Mr. Shaw has been given information sufficient to allow him to analyze and understand [Rector's] work . . . Mr. Shaw's 61-page report sets out in detail his analysis of the structure of the model, the assumptions used by both Milliman and R&A, and his own conclusions with respect to GHMSI's surplus . . . [A]ny material differences

between Mr. Shaw's conclusions and [Rector's] pertain to the assumptions selected rather than because Mr. Shaw did not have sufficient information to understand the model or the work that we did." Tr. 25:1-15. Moreover, Appleseed and Mr. Shaw have failed to identify what specific information they were supposedly "missing" from Rector's and Milliman's reports. *See* Tr. 245:7-247:3 (Testimony of M. Shaw). Appleseed had ample information to participate fully in this proceeding and to analyze supposed flaws in Milliman's and Rector's approaches.

E. Appleseed Proposes Surplus Targets Far Below Any Mainstream Analysis.

Given all the errors above, it is no surprise that the surplus targets Appleseed derives are wildly out of line with surplus targets proposed by experts and accepted by regulators across the country.

- Every one of the actuaries that have analyzed the Company's surplus in the last four years—Rector, Milliman, McGladrey, and Lewin—has proposed a surplus target or range of at least 900% RBC-ACL. *See* Rector Report at 12-13 (target of 958% with a target range of 875%-1,040% RBC-ACL); McGladrey Report at 2, 11 (1,000%-1,300% RBC-ACL range); Exhibit 12 to Pre-Hearing Br. (Milliman 2011 Report) at 22 (1,050%-1,300% RBC-ACL range); Exhibit 16 to Pre-Hearing Brief (Lewin 2011 Report) at 7 (1,000%-1,550% RBC-ACL range).

- Maryland has adopted a surplus target range for GHMSI of 1,000%-1,300% RBC-ACL. *See* Exhibit 15 to Pre-Hearing Br. (MIA 2012 Consent Order) at 7.

- The few states that have set surplus ranges by statute or regulation have much higher targets, ranging from a presumptive target of 700% (Massachusetts)[32] to 1,000% (Michigan). *See* Mass. Gen. Laws Ann. ch. 176O, § 21(d); Mich. Comp. Laws Ann. § 550.1204a(5). Even Pennsylvania, the state on whose surplus report Appleseed so heavily relies, set 750% RBC-ACL as the appropriate target for insurers like GHMSI, far above what Appleseed advocates. Koken Decision at 36. Notably, Pennsylvania set its 750% RBC-ACL target in 2005—long before the increased risks associated with the ACA were even on the horizon.

[32] Massachusetts sets a presumptive 700% RBC-ACL ceiling but affords insurers whose surplus exceeds that level the opportunity to justify their surplus levels. Mass. Gen. Laws ch. 176O, § 21(d).

Appleseed's proposed surplus target conflicts with the regulatory approach adopted in Maryland. Under the MIEAA, the Commissioner must undertake this surplus review "in coordination with the other jurisdictions in which the corporation conducts business," Maryland and Virginia. D.C. Code § 31 -3506(e). Virginia and Maryland have both taken a strong interest in these proceedings. *See Statement of the Maryland Insurance Commissioner* (June 18, 2014);[33] *Statement of the Virginia Bureau of Insurance* (September 29, 2014);[34] *Statement of Maryland Commissioner re Surplus Attribution* (October 10, 2014).[35]

In reviewing GHMSI's 2011 surplus, the Maryland Insurance Commissioner adopted 1,000%-1,300% RBC-ACL as "[t]he approved target surplus range for GHMSI," and concluded that the Company's surplus was not excessive, unreasonably large or otherwise inappropriate. Exhibit 15 to Pre-Hearing Br. (MIA 2012 Consent Order) at 7. The Maryland Commissioner has explained, in a letter filed in this proceeding, that the surplus target she adopted fulfills Maryland's responsibility to ensure that GHMSI "maintain[s] a surplus sufficient to satisfy its current and future obligations to policyholders and creditors." *Statement of Therese M. Goldsmith*, June 18, 2014, at 2-3.

Appleseed's proposal—which would mean adopting a target far lower than that Maryland requires—is at odds with the coordination mandate of Section 31-3506(e). Adopting it would put GHMSI in an impossible position: The Company could hew to D.C. law only by violating Maryland law, and vice versa. GHMSI asks the DISB to ensure that the Company is not subjected to inconsistent regulatory commands.

III. APPLESEED'S ACTUARIAL ANALYSIS IS RIDDLED WITH FLAWS.

While Appleseed relies upon Mark Shaw for its evidentiary presentation in this case, Mr. Shaw's analyses are riddled with basic errors and unwarranted assumptions. The attached rebuttal report by Phyllis Doran of Milliman, at **Exhibit 2**, sets forth the errors in Mr. Shaw's analysis in detail. Those errors include:

[33] *Available at* http://disb.dc.gov/node/849762.

[34] *Available at* http://disb.dc.gov/node/905652.

[35] *Available at* http://disb.dc.gov/node/921442.

Equity Portfolio Asset Values. Mr. Shaw's analysis of Equity Portfolio Asset Values ("EPAV") contains three serious conceptual errors. First, by developing a distribution of values that represent three-year full rates of return, rather than deviations from an expected rate of return, Mr. Shaw double counts the revenue generated by returns on equity assets. *Milliman Rebuttal* at 15. Second, Mr. Shaw includes returns on pension assets, which overstates expected returns because future returns on pension assets are incorporated in reported pension values. *Id.* Third, he omits Care First Blue Choice premium and equity amounts, thereby significantly overstating the impact of expected asset returns. *Id.* Correcting those errors would eliminate the $216 million "overstatement" in the surplus target that Mr. Shaw purports to identify. *Id.*

Rating Adequacy and Fluctuation. Mr. Shaw contends that GHMSI's surplus could be reduced by "roughly $193 million" due to alleged problems with Rector's computation of rating adequacy and fluctuation. Rector and Milliman simulated GHMSI's rating processes using a large universe of health care costs measured over the period 1986-2010. *See Milliman Rebuttal* at 10. Mr. Shaw, by contrast, limited the range of possible outcomes to those experienced by a cherry-picked group of 10 companies over the limited period of 2002-2013. The "peer" companies Mr. Shaw selected are not comparable to GHMSI in terms of size, mix of business, or nonprofit status. *Id.* at 10-11.[36] Mr. Shaw ignored ownership interests in health insuring subsidiaries and affiliates and, in one instance, he misidentified a Blue Plan subsidiary as the company itself. *Id.* at 10. He included only companies that experienced overall net gains during his selected period for review, and excluded several companies that experienced net underwriting losses. His approach is "infinitely malleable—selection of ten different companies would lead to completely different results from those posited by Mr. Shaw." *Id.* at 12.[37]

Mr. Shaw attempts to justify his decision to limit his analysis to the 2002-2013 timeframe by stating that underwriting results have become much more stable since the

[36] Mr. Shaw's assertion that he "selected the 10 Blue Cross Blue Shield Plans most comparable to GHMSI," Shaw Report at 9, is incorrect; in fact, he cherry-picked and made obvious errors.

[37] Compounding his already flawed approach, the 12 years to which Mr. Shaw limited his analysis (2002-2013) was a period of unprecedented stability in health plan underwriting results. *Milliman Rebuttal* at 13-14. Among the 10 companies Mr. Shaw selected, all experienced underwriting gains during the period he selected, whereas all but three experienced underwriting losses in the three years *preceding* the period he chose to review (1999-2001) and all but one experienced losses in the preceding five years (1997-2001). *Id.*

implementation of RBC requirements in the 1990s, so more historical data would be "unrealistically skewed in the direction of uncertainty—thereby inflating surplus requirements." Shaw Report at 9. But given that the RBC system was implemented in the early 1990s,[38] that explanation does not hold up. In any event, for forecasting purposes, it is inappropriate to conclude that the recent period of stability will continue, particularly given the massive uncertainty and major new risks introduced by the ACA. *See* Milliman Rebuttal at 14. Mr. Shaw's approach to evaluating rating adequacy and fluctuation, and his corresponding $193 million surplus reduction proposal, should be disregarded.

Premium Growth Assumptions. Like his analysis of rating adequacy and fluctuation, Mr. Shaw's analysis of the premium growth ratio is based on a limited and uncharacteristic time period (the five-year period between 2009-2013). *See Milliman Rebuttal* at 18. Again, Mr. Shaw assumes—in the face of substantial indicators to the contrary—that the atypically low growth rates seen between 2009-2013 will continue. *See id.* at 22-26. In addition to the factors that render premium growth atypically low during the last five year period, [39] implementation of the ACA is expected to produce significant increases in medical costs (and therefore premium growth) due to the disproportionate enrollment of high-cost individuals, new fees, and other alterations to market conditions that will increase costs. *Id.* at 22. Based on all of those factors, Mr. Shaw's 3.8% premium growth assumption is unreasonably low, and his suggestion that Rector's RBC-ACL target should be reduced by $207 million is inappropriate.

Other Conceptual Errors. Mr. Shaw's analysis includes numerous other conceptual errors. For example, Mr. Shaw contends that the actuarial model should not include any provision for catastrophic events, on the assumption that catastrophic events would already be reflected in historic underwriting results. Shaw Report at 40. But, Milliman's assumptions for rating adequacy are not dependent upon historical underwriting results.

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[38] *See National Assoc. of Insurance Commissioners*, *Risk Based Capital*, May 14, 2014, *available at http://www.naic.org/cipr_topics/topic_risk_based_capital.htm.*

[39] According to a study published by the Employee Benefit Research Institute, employment-based insurance coverage declined nationwide by 6% between 2008-2011. *See* Employee Benefit Research Institute, *Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2013 Current Population Survey*, dated September 2013, available at http://www.ebri.org/pdf/briefspdf/EBRI_IB_09-13.No390.Sources1.pdf, page 5. In addition, health care utilization often declines during periods of economic downturn. These factors are likely to have depressed recent premium growth rates for GHMSI, and indicate that premium growth is likely to increase as the economy recovers. *See Milliman Rebuttal* at 21.

See Milliman Rebuttal at 25. Equally important, historic underwriting results for a limited period of time obviously would not reflect foreseeable catastrophic events that must be guarded against, but may not have occurred during a limited window of time.

As another example, Mr. Shaw proposes a $20 million surplus reduction based on an alleged overstatement of the impact of changes in interest/discount rates. Shaw Report at 39. Here, Mr. Shaw misinterprets the probabilities used in Milliman's model, which are supported by an analysis of historical interest rate patterns; he argues that interest rates would not change over a three-year period, even though interest rates change constantly; and he ignores the fact that interest rates in 2011 were historically low and therefore more likely to go up than down. *Milliman Rebuttal* at 26-28.

Given the number of errors committed by Mr. Shaw in this case, it is surprising that his first agenda item at the June 25 hearing was to accuse every other actuary in this case, both the Milliman actuaries and Mr. Toole, of violating the standards of Actuarial Practice. His analysis is riddled with flaws and conceptual errors and should be disregarded in its entirety.

CONCLUSION

For all of the foregoing reasons, the Commissioner should conclude that GHMSI's year-end 2011 surplus was not excessive within the meaning of the MIEAA.

November 7, 2014

Respectfully submitted,

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EXHIBIT 1

REBUTTAL TESTIMONY

The Discretionary Authority of an Insurance Commissioner

Lawrence H. Mirel
October 30, 2014

QUALIFICATIONS

My name is Lawrence H. Mirel. I am a partner in the Washington, DC office of Nelson Brown & Company. I have more than 30 years of experience with insurance regulatory matters at the state, federal, and international levels.

I served as Commissioner of Insurance, Securities and Banking for the District of Columbia from 1999 to 2005, with authority to regulate all aspects of the insurance and financial services industries in the District of Columbia. Among other duties, I was responsible for the financial solvency of insurance companies licensed and domiciled in the District of Columbia, to ensure that they were able to meet their contractual obligations to pay DC policyholders for covered losses. By statute I served as rehabilitator of impaired companies domiciled in the District of Columbia and as liquidator of those that became insolvent. Although the District of Columbia is a small jurisdiction geographically, it has a robust insurance industry. There are some two dozen domestic commercial insurance companies domiciled in DC, the largest of which is Group Hospitalization and Medical Services, Inc. ("GHMSI"), a major health insurer for federal government and private employees, as well as more than 150 captive insurance companies that operate throughout the world. More than 1,200 regional, national and international insurers are licensed to do business in DC, and I was responsible for regulating their local operations.

As Commissioner, I was a full voting member of the National Association of Insurance Commissioners ("NAIC") and I played an active role in that organization. I served on many NAIC committees and chaired the Industry Liaison Committee, the International Regulatory Cooperation Working Group, and the Class Action Working Group. Both before and after my service as Commissioner I represented insurance companies and insurance trade associations in the District of Columbia and elsewhere, seeking regulatory approval for my clients for the purchase and sale of other insurance companies, the offering of new products, the restructuring of insurance companies and groups, and the dissolution and wind-up of insurance companies, among other activities. I have been a frequent speaker on regulatory issues at meetings of insurance companies and insurance trade organizations, I have written many articles on insurance regulatory issues and I have testified before Congress on numerous occasions—both the House and the Senate—and before State legislative bodies on pending bills dealing with insurance issues.

I have been asked by GHMSI for comments, based on my experience and background, regarding the scope of a Commissioner's discretionary authority when assessing the surplus of a large health insurer.

INTRODUCTION AND SUMMARY

GHMSI is a very large insurance company. In 2013 it provided health insurance to more than 728,460 individuals in the greater D.C. metropolitan area, paying an average of more than $10.3 million in claims each day. Although in dollars the surplus retained by GHMSI seems very large, in proportion to the enormous size of its ordinary and routine obligations to its policyholders it is not large at all. The entire surplus of GHMSI in 2013— approximately $935 million dollars—would be used up in just three months, even if no unexpected events occurred.

But a reasonable insurance commissioner must consider that unexpected events may and probably will happen, and that therefore GHMSI must retain a surplus sufficiently large that it can be expected to survive a major adverse situation with a high level of certainty. With the carefully explained analysis of his own expert, the Commissioner can reasonably conclude that GHMSI's year-end 2011 level of surplus is not excessive and that GHMSI has engaged in community health reinvestment to the maximum extent feasible consistent with the need for financial soundness and efficiency.

THE ISSUE

The Medical Insurance Empowerment Amendment Act of 2008 (MIEAA), enacted by the Council of the District of Columbia, requires that the D.C. Commissioner of Insurance, Securities and Banking determine whether a health insurance company's surplus is excessive to its need and whether the company has met its obligation to engage in community health reinvestment to the "maximum extent feasible consistent with financial soundness and efficiency." The D.C. Court of Appeals has held that the Commissioner must consider BOTH whether the company met the need to maintain financial soundness AND the requirement to engage in community health reinvestment "in tandem" and not seriatim. In making that determination the Court said that "we defer to the agency's reasonable discretion in light of its expertise in this subject matter."

In the report that follows I offer my opinion on what would be a reasonable exercise of discretion by the D.C. Insurance Commissioner in the circumstances of this case.

A. The authority of a state insurance commissioner

Insurance is an unusual product in that the price at which it is sold must be determined before it is known how much the product will cost to provide. An insurance contract is a

promise. In exchange for the payment of a fee (the insurance premium), the insurance company promises to pay the policyholder in the event of a covered loss occurring during the policy period. Since at the time the premium is paid it is not known whether the insured will suffer a covered loss during the policy period, and if so how much the loss will cost, the insurance company must make an educated guess of its financial exposure to all of the policyholders it insures, and therefore how much money it must be able to come up with to keep the promises it has made. If the insurance company runs out of money and cannot pay a covered loss that occurs in the future, the policyholder will have paid premiums and received nothing in return. The insurer would have failed to keep its promise.

The business of insurance is primarily regulated in the United States at the state level. The District of Columbia is a state for purposes of insurance regulation and the DC Commissioner has all the legal and regulatory authority of any state insurance commissioner.

The first responsibility of an insurance commissioner is to make sure that an insurance company under his or her authority is able and willing to make good on its promise to its policyholders, namely to pay for any covered losses that occur during the policy period. For that purpose the commissioner is given very broad statutory authority to consider, among other things, the premium rates charged by the insurer (to make sure they are not excessive, inadequate or unfairly discriminatory), the number of insureds covered by the insurer, the insurance contract and plan design, the underwriting criteria used by the insurance company, and the calculations made by the insurance company that it will be able to pay future claims, including whether the insurer has made adequate provisions for contingent or unexpected demands on its contractual obligations to its policyholders.[1]

[1] *See* Title 31 of the D.C. Code in general and §§ 31-3311.01 - .10 (Health Insurance Ratemaking) in particular.

To predict how much money they will need in the future to pay their obligations under the insurance contracts they have signed, insurance companies employ actuaries who make educated guesses about future losses, based primarily on detailed analyses of past losses plus a sufficient allowance for unknown and unprecedented events that could alter a calculation based on past experience alone. Insurance departments have their own actuaries on whom the commissioner relies to check the work of insurance company actuaries for accuracy. There are also elaborate rules about what the insurance company can do with the premiums it collects, how it invests those funds and how it otherwise protects the assets it needs to keep its contractual obligations to its policyholders.[2]

Insurance companies are required by their regulators to maintain reserves. "Reserves" is a term of art that refers to those funds which an insurance company must segregate and set aside to pay for losses *that have already occurred*, including losses that have been incurred but not yet reported.[3] So, for example, if a policyholder suffers a major injury today that will require treatment over the next twenty years, the insurance company must set up a specific reserve account now to pay for that treatment over the entire time. "Reserves" are considered liabilities on the books of insurance companies.[4]

But insurance companies are also required by law to maintain a surplus. "Surplus" is likewise a term of art. Unlike the common usage of the word "surplus" to mean something that is in excess of what is needed, in the insurance world the term "surplus" means all of the assets of an insurance company, including funds for operating costs, profit (in the case of for-profit insurers), and—crucially—funds needed to ensure the ability of the insurance company to pay

[2] *See* D.C. Code §§ 31-1371.01 - .07 (Investments of Insurers).

[3] Robert Klein, *A Regulator's Introduction to the Insurance Industry* (2nd Ed. 2005) at 144-145. (This manual was prepared for the National Association of Insurance Commissioners)

[4] D.C. Code § 31-3509(b).

any and all future claims for losses *that have not yet occurred*, including those losses that are reasonably likely to occur and those losses that are unlikely to occur but could.[5] An insurance company cannot refuse to pay a covered claim on the ground that the loss was not considered likely to occur or was not anticipated. A more descriptive term for surplus, perhaps, would be "net worth," because an insurance company's surplus is determined basically by comparing its assets—primarily the premiums paid by policyholders and the earnings on the investment of those premiums—to its liabilities—primarily its obligations to pay for claims already made or incurred but not yet reported (i.e. its reserves) together with operating costs. If unexpected demands are made on an insurance company—such as unanticipated claims, changes in laws governing its operations, or a decline in investment income on its assets—the entire net worth of the company is on the line to make good on the promises made to policyholders. Therefore an insurance commissioner wants to see a robust surplus, in fact to insist upon it. Surplus is a measure of the health of an insurance company (and is recognized as such by rating agencies)[6], and the healthier a company the better the policyholders are protected. A financially healthy insurance company is one that will have the money to pay for any and all covered claims that are submitted to it in the future. In the words of a recent report issued by the Federal Insurance Office:

> Capital and surplus is the regulatory measure of capital available to an insurer (i.e., the amount by which reported assets of an insurer exceed its reported liabilities), and is an important measure of financial health because it reflects the ability of an insurer to satisfy obligations to policyholders (particularly in the event of unexpectedly large or

[5] D.C. Code § 31-3501. The term "Surplus" is defined as "the amount by which all admitted assets of the corporation exceed its liabilities . . ."

[6] *Understanding BCAR for U.S. and Canadian Life/Health Insurers*, A.M. Best Methodology, April 2, 2014; *see also, Insurers: Rating Methodology*. Standard & Poor's Rating Services: RatingsDirect, May 7, 2013 at 24 – 25.

catastrophic losses). Surplus is also indicative of the capacity of an insurer to write new business (i.e. to make insurance products more available to consumers).[7]

For an insurance commissioner the worst nightmare is that an insurance company under his or her authority is unable to make good on its promise to pay covered losses. The commissioner has extensive legal authority to prevent this from happening, including the authority to declare an insurance company financially distressed, to put an ailing insurance company into receivership, and—in extremis—to liquidate the company and distribute its assets.[8] (Insolvent insurance companies cannot declare bankruptcy; instead they are liquidated by their insurance regulators, who are charged by statute with the obligation to marshal assets on behalf primarily of policyholders).

Insurance is one of the most tightly regulated industries, and for good reason. The future is always unknowable, and many unanticipated events could occur that could reduce the ability of an insurance company to meet all its obligations to its policyholders, including:

- Sharp and unexpected increases in either the frequency or size of claims—for example, due to a pandemic (Ebola, perhaps, or a new variant of influenza) or a new disease (like HIV was in the 1980s)
- Unanticipated downturns in the value of a company's assets—such as can result from a financial crisis like the one over the past several years that sharply diminishes income from the investment of the assets (primarily premiums paid by policyholders in the case of non-profit insurers) held for the payment of future claims.

[7] *Annual Report on the Insurance Industry*, Federal Insurance Office, U.S. Department of the Treasury, September 2014, p. 18.

[8] *See* D.C. Code §§ 31-1301 – 1357 (Insurers Rehabilitation and Liquidation Procedures).

- Changes in the laws governing how the insurance company must operate—for example, the enactment of the Affordable Care Act.

Health insurers must even be prepared to pay claims resulting from a terrorist attack, such as the release of anthrax or ricin, or for claims resulting from the exposure of confidential medical information. Several large insurers have recently been sued for millions of dollars because of the loss of personal data as a result of negligence or deliberate attacks by hackers.[9]

And there are business risks. If a Blue Cross/Blue Shield company shows signs of financial distress—for example falling below the surplus considered essential and expected by the Blue Cross/Blue Shield Association—the risk is that large accounts would lose confidence in the ability of the company to pay claims and would switch to other, more financially healthy, competitors. Eventually the company could lose its Blue Cross/Blue Shield license, often an essential element to the survival of that company. I know this from my own experience, having participated directly in the liquidation of a former Blue Cross/Blue Shield company, Central Benefits Mutual Insurance Company of Ohio, which lost its "Blues" license and floundered for several years trying to regain its footing before finally being liquidated under the authority of the DC Commissioner.[10] In the case of GHMSI, which is the Blue Cross/Blue Shield plan for federal government employees and for many other large employers, loss of the license would

[9] *See, e.g.*, Class Action Complaint, *Hancox v. Nationwide Mutual Ins. Co.*, No. 13-cv-2047 (D. Kan. filed Jan. 29, 2013) (Lawsuit stemming from an attack on Nationwide's computer network that compromised over a million consumers' personally identifiable information); Class Action Complaint, *Pekeleney v. Horizon Healthcare Services, Inc.*, No. 2:14-cv-00584 (D. N.J. filed July 8, 2013) (Lawsuit stemming from theft of two laptops with personal information for more than 839,000 policyholders); Order Granting Motion for Final Approval of Class Action Settlement Agreement, and Motion for Attorney's Fees, Expenses and Incentive Awards, *Curry v. Avmed, Inc.*, No. 10-cv-24513-JLK (S.D. Fla. filed Feb, 28, 2014) (The lawsuit stemming from the theft of two laptops with personal information was settled for $3,000,000).

[10] See *Central Benefits Mut. Ins. Co. v. Blue Cross and Blue Shield Ass'n*, 983 F.2d 1065 (6th Cir. 1992). Although based in Ohio, the company eventually redomesticated to the District of Columbia and was liquidated by the DC Commissioner.

almost certainly mean losing a major portion of its business, which would likely result in insolvency for GHMSI and perhaps for its parent, CareFirst, as well.

In addition, a lower level of surplus, which essentially means a less healthy company, will increase the cost of borrowing by the insurer. Rating companies, such as A.M. Best and Standard & Poor's, use the amount of surplus held by an insurer as one of their rating measures,[11] and a company rated AA will pay less to borrow money than one rated B or worse. For a non-profit insurer especially this is a problem, because it cannot raise capital from investors; typically its primary source of surplus is the premium payments from its policyholders. For the same reason it is much more difficult for a non-profit insurer to recover from an unanticipated drain on its surplus; it has no investors to go to for additional funding.[12] As an insurance regulator I understood that a non-profit insurer needs to maintain a higher level of surplus than an equivalent sized for-profit would. If there is a significant decline in its surplus a non-profit insurer is in great danger of entering a financial death spiral, where the lower surplus will trigger a loss of confidence by customers, rating agencies and banks, reducing premium income and raising the cost of borrowing, thereby lowering surplus still further. There will be no opportunity for a non-profit insurer to recover its balance through an infusion of cash from investors, as a for-profit insurer can.

It is the job of the insurance commissioner to make sure that an insurance company under his or her authority retains sufficient assets to pay all of its future obligations no matter the

[11] *Understanding BCAR for U.S. and Canadian Life/Health Insurers*, A.M. Best Methodology, April 2, 2014; *see also*, *Insurers: Rating Methodology*. Standard & Poor's Rating Services: RatingsDirect, May 7, 2013 at 24 – 25. (An insurer's ability to build capital through net retained earnings is part of the ratings methodology).

[12] "Many [Blue Cross Blue Shield] plans proposing or undergoing conversion [to for-profit companies] cited access to equity capital as the key driver for conversion." Leemore Dafny & Subramaniam Ramanarayanan, *Do For-Profit Insurers Charge Higher Premiums?*, Presentation at RAND Labor & Population & RAND Health Econ. Seminar, 9 (Oct. 12, 2011), http://www.rand.org/content/dam/rand/www/external/labor/seminars/adp/pdfs/2011/dafny.pdf.

circumstances it faces. If any one of the unfavorable events described above—however unlikely—were to occur, or if the insurer were subject to other adverse pressures that cannot even be imagined, the company will still be expected to pay covered claims, and the commissioner must do his or her best to make sure that the insurer has sufficient assets (that is, sufficient *surplus*) for that purpose.

When a terrorist attack destroyed the World Trade Center in New York in September of 2001, claims for insured losses exceeded $40 billion.[13] Insurers were able to pay all of those claims, even though they had collected essentially no premiums for the coverage because no one had anticipated such a horrendous event. They paid those losses in large part out of their retained surplus. Despite the unprecedented nature of the disaster, very few insurance companies—and no major insurer—became insolvent as a result. The last thing anyone wants at a time of crisis is for the insurance company that promised to pay for insured losses to run out of money.

Of course an insurer cannot be 100% sure that it will be able to meet all future payments. Such certainty does not exist in this world and regulators do not insist on it. Insurance companies can and do fail, with some regularity. GHMSI itself came very close to failing in the 1990s and was only saved by emergency loans from other Blue Cross/Blue Shield companies, facilitated by the then D.C. Commissioner, one of my predecessors—a mechanism not likely to be available in today's more competitive and regulated climate for health insurers. But regulators do seek and expect a high likelihood that an insurance company can meet its obligations under virtually all circumstances. In this case the actuarial experts for CareFirst, the DISB, and for Appleseed agree that for safety GHMSI needs to retain a surplus above a 200%

[13] *Terrorism Risk and Insurance*, Insurance Information Institute (August 2014).

RBC level (the level at which regulators will consider the company to be financially impaired) with a 98% certainty. A 98% certainty means there is still a 2% chance—one in 50—that the company will face financial trouble sometime in the next three years.[14]

But Appleseed argues that a certainty level of 90% provides sufficient fiscal safety to GHMSI. At 90% certainty there is a one in ten chance that sometime within the next three years GHMSI will run into serious financial difficulty. That is a level of risk that no responsible insurance regulator should ever permit. Even Appleseed's own actuary says that a 98% certainty of meeting the 200% RBC level is appropriate.[15]

While the primary responsibility of an insurance commissioner is to ensure that insurance companies are able to meet all their obligations to their policyholders, under virtually any circumstances, commissioners are also mandated by law to carry out other responsibilities. As examples, they are required to collect premium taxes,[16] to educate the public about the insurance market,[17] and to prevent fraud and false advertising.[18] In the District of Columbia, the insurance commissioner also is required to determine whether certain nonprofit health insurers are meeting their legal requirements for community reinvestment. Under the MIEAA, that obligation consists of engaging in community health reinvestment to the "maximum extent feasible" consistent with financial soundness. As the Court of Appeals has found, the insurance commissioner must consider this obligation "in tandem" with his obligation to ensure that CareFirst maintains enough surplus to operate safely and efficiently.

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[14] The European Union Commission has recently adopted standards for EU insurers requiring that they maintain sufficient capital (i.e. "surplus") to remain solvent with a *99.5 percent certainty*. See Pillar One of Solvency II, the insurance company solvency standards established for all insurers operating in the European Union that becomes mandatory on January 1, 2016; Directive 2009/138/EC of the European Parliament and of the Council of 25 November 2009; 17.12.2009, *Official Journal of the European Union*, L 335/51.

[15] Letter of Mark Shaw, United Health Actuarial Services, Inc.to Walter Smith dated April 11, 2012, p.5.

[16] D.C. Code § 31-205.

[17] D.C. Code § 31-207.

[18] D.C. Code § 31-3506.

B. Reconciling "Financial Soundness" with "Community Health Reinvestment"

How can an insurance commissioner reasonably reconcile his or her duty to provide maximum protection to policyholders with the requirement of the MIEAA that GHMSI engage in community health reinvestment to the maximum feasible extent? An insurance commissioner is not like an elected legislator, charged with balancing the overall needs of the community and determining how much revenue should be raised through taxation and how those revenues should be spent. He or she is a statutory official charged specifically with protecting insurance policyholders. To do anything that would deliberately endanger those policyholders could be considered malfeasance.

The Court of Appeals has said that the Commissioner must determine whether GHMSI has engaged in community health reinvestment to the maximum extent feasible consistent with the requirement that it remain financially sound and efficient. His determination must be based on sufficient findings in the record. It is for that purpose that the issue was remanded to the Insurance Commissioner. The Commissioner accordingly must develop a record that will provide substantial factual evidence for making a determination of an actual surplus level at which GHMSI is financially sound.[19] If the Commissioner determines that a lower surplus level is consistent with the financial soundness of the company, he must have a factual basis for determining the amount of the decrease. Likewise, the Commissioner's subsidiary factual findings—including findings about, for example, actuarial assumptions, and the propriety of a given confidence level—must be supported by substantial record evidence. Otherwise his ruling would be arbitrary and capricious.

[19] See *Black v. D.C. Dep't of Employment Serv.*, 801 A.2d 983, 985 (D.C. 2002).

The prudent course for a regulator charged with making such a finding is to seek the help of outside experts, in particular actuaries. Actuaries are highly trained, sophisticated professionals who predict the future risks faced by insurers primarily by applying mathematical techniques and probability theory to a vast data base of past experience. Insurance companies—and insurance regulators—rely heavily on the skills and judgments of these experts when making crucial decisions.

But as exacting and professional as actuaries are, they still disagree among themselves. In this case the Commissioner has heard and read conflicting testimony from actuaries engaged by the disputants. Actuaries testifying on behalf of GHMSI, Milliman, Inc. ("Milliman"), have argued that the surplus currently maintained by GHMSI is appropriate and necessary for the company to meet its future obligations with the requisite level of confidence, and that any diminution of that surplus would endanger the financial soundness and efficiency of the company. Actuaries retained by Appleseed, United Health Actuarial Services, Inc. in contrast, testified that GHMSI will be perfectly safe (albeit with a lower level of confidence) with several hundred millions of dollars less in surplus. The two actuarial reports differ essentially in the assumptions they make, assumptions about the potential impact of future (and therefore unknowable) events on the assets of GHMSI.

When, as here, experts disagree—in particular experts hired by opposing sides in a legal dispute—a reasonable commissioner will hire his own expert to review the work of the actuaries for the two sides and be guided by that expert's advice.

In this case that is exactly what the DC Commissioner did. He retained the highly respected financial firm of Rector & Associates, Inc. ("Rector") to review the submissions of the competing actuaries and render its own disinterested advice to the Commissioner. While

disagreeing on minor points with the Milliman report, Rector came to the same basic conclusion as Milliman, namely that the surplus maintained by GHMSI is necessary to the financial health of the company, and therefore for the protection of the company's subscribers. Rector did not ignore the obligation of the Commissioner under the MIEAA. Instead it found that GHMSI already reinvests significantly in community health, as defined in the statute, and that to do more would be a potential threat to the financial safety of the company.

The Rector conclusion is not surprising. Many of the same issues were raised before the Maryland Insurance Commissioner at a hearing on the GHMSI surplus in that state in 2009. The Maryland Insurance Commissioner retained as its outside impartial expert the financial firm Invotex Group ("Invotex"). The Invotex report came to the same conclusion as the Rector report, namely that the surplus maintained by GHMSI was appropriate and necessary to the financial soundness of the company.[20] (The Maryland Commissioner was not bound by the MIEAA, which is a statute enacted by the D.C. Council and applicable only in the District of Columbia, but the safety and soundness of CareFirst is of great importance to that state, where most of the subscribers insured through GHMSI live.)

Although he is not required to do so, it would be a reasonable exercise of his discretion, for the DC Commissioner to accept and follow the findings of his own disinterested expert. Following the advice of his outside expert would also be in accord with the primary role and obligation of the Commissioner, which is to protect those persons insured by GHMSI.

Conversely, in my view, it would not be a reasonable exercise of discretion if the Commissioner were to rely on the advice of the actuarial firm retained by Appleseed and require that GHMSI lower its level of surplus and increase its level of community health reinvestment.

[20] See *In re: Targeted Surplus Ranges for CareFirst of Maryland and Group Hospitalization and Medical Services*, Consent Order, MIA-2012-09-006 (2012).

Not only are Appleseed and its expert less disinterested than the expert retained by the Commissioner, but if their advice turned out to be wrong, and GHMSI (and perhaps its parent company, CareFirst) ended up becoming financially distressed or insolvent, the Commissioner would have failed in his primary responsibility, which is to protect the insureds. The failure of GHMSI, the largest health insurer in the District of Columbia, the largest insurer of federal government employees, and the largest component of CareFirst, which dominates the DC, Maryland and Northern Virginia health insurance market, would be a disaster of major proportions.

It is worth noting that under the MIEAA the Commissioner's obligation to review the GHMSI surplus is not a one-time event but a periodic process. Every three years the Commissioner is required by law to review the GHMSI surplus to see if it could be reduced and the company's community reinvestment increased. If it turns out that some of the concerns that led Rector and Milliman to urge the maintenance of GHMSI's current surplus level do not come to pass, the Commissioner can always decide, based on the consideration of new and convincing data, to adopt a lower surplus target at a future date. On the other hand, were the Commissioner to order now that the GHMSI surplus be reduced, against the advice of his own outside expert, and the risks against which the surplus is maintained come to pass, triggering the financial failure of GHMSI, it would be too late to increase the surplus.

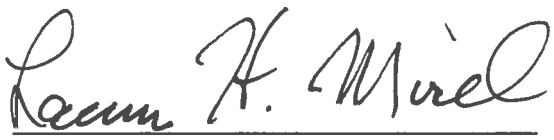

EXHIBIT 2

Milliman

Group Hospitalization and Medical Services, Inc.

Milliman Response to June 10, 2014 Reports by D.C. Appleseed and Mark E. Shaw, FSA, MAAA, CERA, FLMI

November 6, 2014

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Group Hospitalization and Medical Services, Inc.

Milliman Response to June 10, 2014 Reports by D.C. Appleseed and Mark E. Shaw

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November 6, 2014

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Background and Introduction

This report has been prepared by Milliman for Group Hospitalization and Medical Services, Inc. (GHMSI) and is submitted in connection with proceedings before the District of Columbia Department of Insurance Securities and Banking (DISB) to review GHMSI's 2011 year-end surplus. This report responds to several analyses advanced by Mark E. Shaw of United Health Actuarial Services, Inc., and arguments raised by D.C. Appleseed, in reports filed with DISB on June 10, 2014[1] and at a June 25, 2014 hearing before the D.C. Insurance Commissioner.

Section I responds to two arguments raised by D.C. Appleseed. First, D.C. Appleseed has no reasonable basis to advocate for a 90% confidence level, when used with the 200% RBC-ACL threshold. As we address below in Section I.A., we find that the use of a 98% confidence level is reasonable, financially sound, and widespread in the insurance industry, and that the use of a 90% confidence level would not be consistent with financial soundness. Second, D.C. Appleseed is wrong when it seeks to minimize the consequences to GHMSI if its surplus were to fall below 200% of RBC-ACL. As we address in Section II.A, the consequences to GHMSI of falling below 200% of RBC-ACL would be catastrophic.

Section II responds to various errors, inaccuracies, and misstatements by Mr. Shaw. Mr. Shaw proposes "adjustments" to the surplus targets developed by Milliman and by Rector that, taken together with Appleseed's proposals, produce a surplus target as low as 205% of RBC-ACL. That result on its face discredits Mr. Shaw's work. Mr. Shaw also asserts that GHMSI's target surplus could be reduced by an additional $153 million[2], which equates to a further reduction of approximately 150% of RBC-ACL, in recognition of purported "inefficiencies" reflected in GHMSI's administrative expense levels. The net effect of Mr. Shaw's adjustments, and the confidence level advocated by D.C. Appleseed, would therefore produce a surplus target of approximately 55% of RBC-ACL – far below the NAIC Authorized Control Level of 100%. Such a position is clearly beyond any level of reasonable consideration.

We assert that Mr. Shaw's criticisms, assumptions, and conclusions regarding Milliman's analysis and results are inaccurate and without foundation – apparently reflecting either incorrect understandings or simply being actuarially unsound – and that his report is grossly misleading. In Section II of this report we address Mr. Shaw's allegations and describe many of his errors and misstatements.

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[1] D.C. Appleseed, *Report to the D.C. Department of Insurance, Securities and Banking: Surplus Review of Group Hospitalization and Medical Services, Inc.* dated June 10, 2014 (hereinafter *"D.C. Appleseed")*, and Mark E. Shaw, FSA, MAAA, CERA, FLMI, *Report to the D.C. Department of Insurance, Securities and Banking; Group Hospitalization and Medical Services Inc.; MIEAA Surplus Review* dated June 10, 2014, (hereinafter *"Shaw"), available at* http://disb.dc.gov/node 844192.

[2] *Shaw*, Page 37.

I. Comments on D.C. Appleseed Report of June 10, 2014

A. D.C. Appleseed's Contention that a Confidence Level of 90% is Consistent with Financial Soundness

D.C. Appleseed proposes in its June 10, 2014 report that the Commissioner should adopt an analysis giving GHMSI only 90% confidence of remaining above 200% RBC-ACL, as follows: ***"... as Rector says, 'although the health RBC formula was not originally calibrated to achieve specific confidence levels with respect to the entire formula or individual risk factors, certain risk factors were developed on the basis of a 90% to 95% confidence level.' This confirms that confidence levels in the 90% to 95% range have industry support. Given that those levels were assigned even in the absence of a command to maximize community reinvestment, a 90% level is a sensible accommodation of that command and is the most reasonable level..."***[3]

D.C. Appleseed concludes that a 90% confidence level, for use in developing a surplus target for GHMSI that will prevent the company from dropping below 200% of RBC-ACL, is consistent with financial soundness. D.C. Appleseed appears to draw this conclusion by asserting that there is "industry support" for a 90% confidence level, based on the quote from Rector's report[4], which was taken from the Report of the American Academy of Actuaries (AAA) to the NAIC Capital Adequacy (E) Task Force dated January 31, 2011[5]. This conclusion and its apparent basis are simply unfounded and incorrect.

As the Rector quote states[6], the health RBC formula was not originally calibrated to achieve specific confidence levels with respect to the entire formula or even to individual risk factors identified in the formula. Instead, only certain very specific components that go into some of the individual risk factors were developed in such a way that they had a statistical foundation which supported the identification of a 90-95% confidence level for that specific component alone. Other specific components that go into the various individual risk factors had no specific confidence levels established, neither 90-95% nor any other level; and the entire formula had no specific confidence level established.

The cited AAA report states that ***"The Work Group's research has not discovered any intended or expected safety levels for RBC in aggregate for the original Health RBC formula or any***

[3] *D.C. Appleseed*, Page 17.

[4] Rector & Associates, Inc., *Report to the D.C. Department of Insurance, Securities and Banking Group Hospitalization And Medical Services, Inc*., report dated December 9, 2013, Page 13, Footnote 21 (hereinafter *"Rector"), available at* http://disb.dc.gov/node 756762.

[5] American Academy of Actuaries, report to Capital Adequacy (E) Task Force, National Association of Insurance Commissioners; January 31, 2011 (hereinafter "*AAA*"), *available at* http://www.actuary.org/pdf/life/American_Academy_of_Actuaries_SMI_RBC-Report.pdf.

[6] *Rector,* Page 13, Footnote 21.

safety level calibrations underlying individual risk factors within the current formulas."[7] The meaning of this quotation is clear: there is no finding that the RBC formula was calibrated to achieve specific confidence levels.

The fact that certain components are indicated to have been developed on the basis of a 90% to 95% confidence level is a statement of fact regarding the statistical characteristics of the development of some of the factors involved. It is not an indication of industry support or endorsement regarding the appropriateness of such a range for any particular purpose. To conclude that the cited AAA report conveys actuarial or NAIC regulatory endorsement for a specific application – development of a surplus target for GHMSI or otherwise – is completely unfounded and incorrect.

The implications of GHMSI having a surplus level that drops below the level of 200% of RBC-ACL are severe, as discussed in the subsection below. That is why it is paramount to assure financial soundness at a high degree of confidence. D.C. Appleseed's proposed confidence level permits an excessive level of risk – under its approach, the Company would have a 1 in 10 chance of falling below 200% RBC-ACL. In other words, one could expect that GHMSI's surplus would fall below 200% RBC-ACL, triggering regulatory supervision and potential loss of the BlueCross BlueShield trademarks, once every ten years. Such a risk is exceedingly high and not financially sound. By contrast, this adverse result would be expected to occur every 50 years using a 98% confidence level, which is the confidence level used by Milliman and Rector in their respective analyses.

No actuary in this proceeding has supported use of a 90% confidence level to assess GHMSI's likelihood of remaining above 200% RBC-ACL. By contrast, there has been wide support among other actuaries who have reviewed GHMSI's surplus – including Mark Shaw in connection with this very proceeding[8] – for a confidence level of 98%. During a January 2013 meeting at DISB's offices – and in subsequent correspondence – both Mr. Shaw and representatives of D.C. Appleseed agreed that 98% was the appropriate confidence level for assessing GHMSI's likelihood of remaining above 200% RBC-ACL. In addition, Walter Smith of D.C. Appleseed has stated, with respect to the use of a standard involving *". . . a surplus that avoids falling below 200% RBC with 98% confidence. . .,"* that *"It seems to us that this is sufficient to protect soundness and efficiency, both as a matter of actuarial soundness, as well as under the MIEAA standard."*[9]

The State of Maryland has also endorsed a 98% confidence level. In its 2012 Consent Order, it adopted the analysis of its consultant, RSM McGladrey, Inc., which approved a 98% confidence metric as reasonable.

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[7] *AAA*, page 48

[8] Letter from Mark Shaw to Walter Smith, dated April 12, 2012, Page 5, *available at* http://disb.dc.gov/node/311282; and Letter from Mark Shaw to Walter Smith, dated January 18, 2013, Page 4, *available at* http://disb.dc.gov/node/850492

[9] Letter from Walter Smith to Sarah Schroeder, dated January 18, 2013, Page 4, *available at* http://disb.dc.gov/node/850492

Those conclusions comport with other analogous data points in the industry. To take just one example, under the Standard & Poor's Rating Services' risk-based capital (RBC) adequacy model for insurers, a 99.4% confidence level is required for A ratings, 99.7% for AA, and 99.9% for AAA. In other words, under the S&P rating system a confidence level of at least 99% is required to avoid dropping to a BBB or lower rating. Furthermore, a 90% confidence level would equate to junk status under the S&P rating system. The Standard & Poor's confidence levels are somewhat higher than the 98% confidence level used by Milliman and Rector for GHMSI, and are clearly incompatible with the 90% recommended by D.C. Appleseed.

Further, Milliman consulting actuaries in the life, health, and casualty insurance sectors have observed that the use of a 99% confidence level in capitalization (surplus) and enterprise risk management development work is widespread in the industry. In developing a target surplus level for GHMSI, we find that the use of a confidence level as high as 98% is reasonable, financially sound, and widely accepted in the insurance industry, and that the use of a 90% confidence level would not be consistent with financial soundness.

B. D.C. Appleseed Comments on Prospects for and Consequences of Falling Below 200% of RBC-ACL

D.C. Appleseed takes issue with the significance of the 200% RBC-ACL threshold, stating that BCBSA would not act to terminate GHMSI's license if GHMSI fell below that level: ***"BCBSA maintains various capital requirements because it and its members consider a failure by any licensee to reduce the credibility of the Blues brand for all licensees. However, termination of the Blues mark requires a supermajority vote of three-fourths of other Blues licensees . . . . Such a vote would bring about the result that the BCBSA and its licensees seek to avoid, i.e., reducing the credibility of the Blues brand. The vote would be self-defeating unless the licensee in question, in addition to having fallen below 200%, had no reasonable prospect of regaining its footing."***[10] ***"And, the likelihood is low that supermajorities of BCBSA licensees would vote to withdraw GHMSI's license to use the Blues marks."***[11]

D.C. Appleseed, however, provides no support for its assertion, which appears to be unfounded. The BCBSA has maintained capital benchmarks and minimum surplus requirements for many years, substantially pre-dating the development and adoption of RBC as the basis for its standards. The reasons are not only the "credibility of the Blues brand" as cited by D.C. Appleseed, but also because of the risk of liability to all other Blues entities if one member plan becomes insolvent.

In this regard, BCBSA has informed Commissioner McPherson in its letter dated June 24, 2014[12] that *"If a Plan's HRBC ratio were to fall below 200 percent, BCBSA's Board of Directors (composed of the CEO's of all 37 Plans and BCBSA) would immediately commence actions to terminate that company's license to use the Blue Brands. BCBSA intentionally set its minimum capital requirement at the same point as the highest of the four Levels of Action under the NAIC''s Risk-Based Capital Model Act."*

Thus, D.C. Appleseed's argument about the lack of seriousness of BCBSA and its member licensees regarding the loss of trademark threshold and the severity of the consequences should GHMSI fail to meet licensure requirements is without merit. More broadly, D.C. Appleseed's argument that falling below 200% RBC-ACL would not entail serious consequences for GHMSI is baseless and unsupported by any evidence.

[10] *D.C. Appleseed,* Page 12.
[11] *D.C. Appleseed,* Page 15.
[12] Letter from Scott B. Serota, President and Chief Executive Officer, BlueCross BlueShield Association, to The Honorable Chester A. McPherson, Interim Insurance Commissioner, DISB, dated June 24, 2014, *available at* http://disb.dc.gov/node/853782.

II. Comments on Mark Shaw Report of June 10, 2014

A. Rating Adequacy and Fluctuation

The surplus target analyses undertaken by Milliman and Rector & Associates ("Rector") incorporate assumptions regarding risks associated directly with rating adequacy and fluctuation. These assumptions, in the form of probability distributions, were appropriately developed and reflect the manner in which rating assumptions were incorporated in our pro forma modeling approach. In addition, Milliman's approach directly reflects the potential impact of the ACA on rating adequacy and fluctuation.

Mr. Shaw has taken a completely different and more highly aggregated approach to evaluating the combination of the risk of rating adequacy and fluctuation and a number of other unspecified variables. His conclusions are based on an approach that is indirect, potentially biased, and of limited (if any) applicability to GHMSI and therefore should be disregarded.

Mr. Shaw's assertion that the surplus target established by Rector should be reduced by $193 million, based on the alternate assumptions that he has proposed, is unfounded.

Comparison of Approaches

In choosing his assumptions for rating adequacy and fluctuation, Mr. Shaw has chosen to tabulate underwriting results from a disparate group of health plans as a "proxy" which he attempts to extend to GHMSI. For this proxy, he uses the underwriting results reported by a handpicked group of 10 companies reflecting varying corporate structures, conducting business in different markets, offering a different mix of products, and operating under widely varying practices and circumstances (some of the problematic issues with his analysis are addressed in a subsequent section below); therefore, Mr. Shaw's approach relies on indirect inferences and is potentially biased in any applicability to rating adequacy and fluctuation for GHMSI.

By utilizing reported underwriting results he does not measure rating adequacy and fluctuation, which in turn serves to obscure and may materially distort an assessment of this important variable. Historical underwriting results as measured from the statutory statements of health insurance companies are subject to numerous structural, operating, and accounting differences which significantly affect gross comparisons among companies. For example, premium taxes and fees often vary by state. Corporate business structures and practices – such as the use of subsidiaries versus lines of business for different types of health care plans and products; owning versus leasing of plant, equipment, and technology; and direct provision of services versus contracting for or purchasing such capabilities – severely distort broad-based comparisons among companies. The relative magnitude and accounting treatment of self-funded or ASC groups and of the "other income/expense" category in a particular company's

statutory reporting can vary greatly among companies. The existence, magnitude, and reporting of community investment and charitable expenditures may differ significantly among companies. All of these types of differences, when not addressed in detail, serve to distort gross comparisons of reported underwriting results among companies.

Further, Mr. Shaw's approach of simply making a gross comparison among disparate companies does not enable the direct recognition of GHMSI's business characteristics or rating processes, or the market constraints under which the company operates. These include pricing margins, as well as the mix of product lines and the characteristics unique to each, such as regulatory restrictions on pricing or average rating lag (i.e., time lag between historical experience and rate effective period). It also does not allow for appropriate recognition of the impact of changes to the rating process resulting from the ACA. Further, he limited his analysis of these companies to the period from 2002 to 2013, apparently selecting the time period most favorable to his argument.

Overall, we believe that it cannot be reasonably assumed that the many factors affecting underwriting results at a handful of selected companies – factors such as pricing practices, regulatory restrictions, marketing strategy, mix of products, healthcare delivery networks and competitive environments, and state and local taxes and fees – are sufficiently consistent with those of GHMSI to justify the use of these results to assess surplus requirements for GHMSI. In addition, there are a number of specific problems with the information relied upon by Mr. Shaw in his development of particular assumptions, including the choice of companies to represent "peers" of GHMSI, and the potential for inconsistencies in the tabulated data, as discussed further below.

Milliman and Rector, by contrast, evaluated directly the various underlying elements affecting rating adequacy and fluctuation. The methodological approaches taken by Milliman and Rector to evaluate the rating adequacy and fluctuation risk are comparable (albeit with certain differences in specific assumptions made by each firm). The remainder of this section will focus on this common methodology as employed by Milliman.

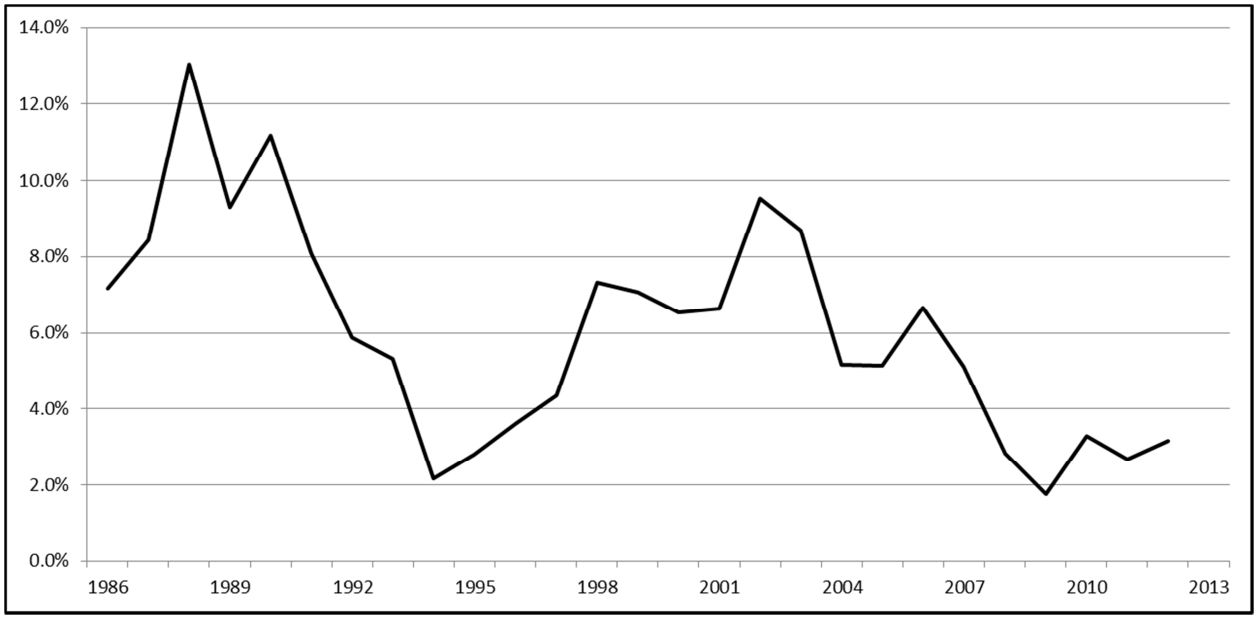
In contrast to Mr. Shaw's arbitrary selection of 10 companies, which involved using underwriting gain/loss percentages from statutory filings for each of the companies for a specific period of 12 years, Milliman's approach simulates GHMSI's rating processes using a large universe of health care costs (nationwide health expenditures for the non-Medicare population), measured over an extended period of time (from 1986 through 2010). This approach focused directly on measuring rating adequacy and fluctuations, using GHMSI's rating approaches applied to a data set of health care cost variations that represents a diverse range of potential circumstances. From these data we have measured the inherent underlying fluctuation in cost levels, net of underlying medical care inflation, that characterizes the commercial health care marketplace. We then simulated GHMSI's rating process in order to observe the impact of fluctuations in health care costs on rating, and the resulting range of experience patterns (gains and losses) that emerge.

Foundation for Milliman's Rating Fluctuation Assumptions

As described above, Milliman simulated GHMSI's rating processes for its major business segments using a stochastic process for developing claim costs underlying the simulation of the company's rating processes. The claim costs used in this process were generated from a probability distribution, reflecting the period-to-period fluctuations that could reasonably be expected to arise based on historical experience. We used a large universe of health care costs (nationwide health expenditures for the non-Medicare population), measured over an extended period of time, in order to represent a diverse range of potential circumstances. The data used were adjusted to remove the effects of underlying medical care inflation (which was addressed as a separate rating parameter).

Chart A-1 below presents data representing the non-Medicare component of the National Health Expenditures (NHE)[13] for the period from 1986 to 2012. It indicates the pattern of annual changes, or trends, in the per capita health care expenditures throughout this time, illustrating the degree of trend variation that has occurred.

Chart A-1
National Healthcare Expenditures (NHE) Per Capita Expenditure Excluding Medicare: Annual Trend Observations

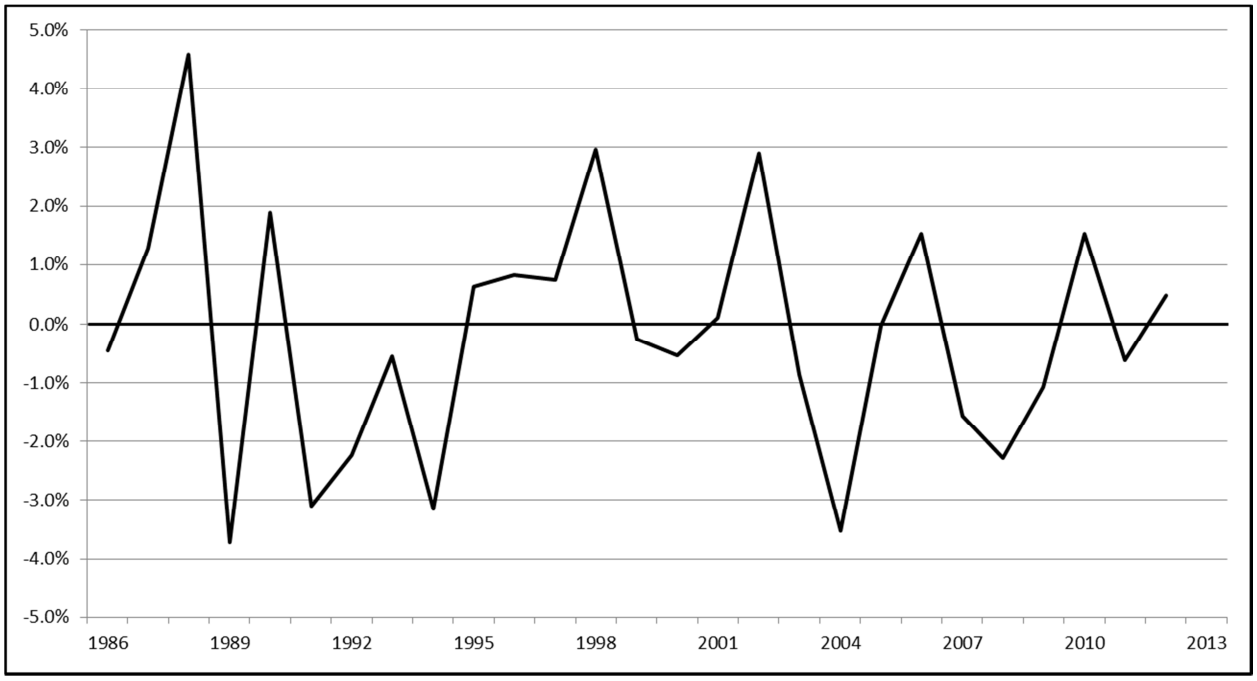


[13]See description at: http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/index.html?redirect=/NationalHealthExpendData/02_NationalHealthAccountsHistorical.asp
Non-Medicare expenditures were based on Medicare data as reported in the NHE data, as well as estimates of beneficiary copayment amounts.

The patterns in this chart highlight the volatility in health care cost levels and the resulting uncertainty associated with predicting trends and future cost levels. One consequence of this sort of pattern is that health insurers tend to under-estimate future premium levels needed during periods when trends are rising, thereby tending to produce losses; and conversely, they tend to over-estimate future premium levels needed during period when trends are falling, thereby tending to produce gains. The overall decline in trend rates during recent time periods explains, at least in part, why health insurer underwriting results have tended to be more favorable than normal during the last few years.

Chart A-2 displays the year over year change in observed per capita trends from Chart A-1.

Chart A-2
National Healthcare Expenditures (NHE) Per Capita Expenditure Excluding Medicare: Year Over Year Change in Observed Trends



The approach that Milliman followed in developing our assumptions related to rating adequacy and fluctuation was to measure fluctuations in historical health costs using a proprietary index that produces results similar to those of the non-Medicare NHE tabulations presented above. In addition, we considered other sources of fluctuation that affect underwriting results. We also incorporated in our modeling of this impact the potential effects of the medical loss ratio (MLR) provisions and the effects of regulatory review, including delay of rate increases, under health care reform.

This approach, which considers the range of factors that contribute to the risk that actual claims and expenses differ from the amounts for which provision is made in premium rates, is an appropriate basis for evaluation of GHMSI's surplus target.

Problems with Mr. Shaw's Application of His Approach

It is our opinion that the approach that Mr. Shaw has taken in establishing assumptions related to rating adequacy and fluctuation, relying on results for an arbitrary selection of companies, is not appropriate. In addition to the fact that his approach does not address rating adequacy and fluctuation directly, Mr. Shaw's approach is highly sensitive to the particular set of companies and the specific time period for measurement selected.

Mr. Shaw describes his selection of companies and time period for measurement as follows: ***"To establish an appropriate peer group for rating adequacy, we selected the 10 Blue Cross Blue Shield Plans most comparable to GHMSI in non-FEP premium revenue in the 2000's"***[14]***,*** and goes on to say: "***We sourced the Annual Statements for each of the peers for the 12-year period from 2002–2013 and for GHMSI for the 15-year period from 1999–2013, and used the underwriting gain/loss for each company in each time period as the historical proxy for rating adequacy."***[15]

Our first observation is that Mr. Shaw did not, in fact, select the 10 Blue Cross Blue Shield Plans most comparable to GHMSI in non-FEP premium revenue in the 2000's as he asserts in the above statement from his report. His analysis includes other problems as well; for example, in one instance he has misidentified a Blue Plan subsidiary as the company itself; and in no instance has he included ownership interests in health insuring subsidiaries and affiliates (i.e., the parent Blue Cross Blue Shield Plan plus its subsidiaries and owned affiliates).

While Mr. Shaw referenced the Invotex report as a source for some of the companies that he selected[16], there were two companies identified by Invotex that Mr. Shaw chose not to include. Those two companies experienced net underwriting losses overall during the 2002-2013 time period that Mr. Shaw selected, while each of the companies that he did include experienced overall net gains during that period. Mr. Shaw makes no effort to explain why other companies were excluded from his analysis.

In order to illustrate the significance of the particular set of companies selected, we have tabulated data for a different set of 10 companies. We selected the 10 non-profit BCBS plans (generally the primary licensee[17]) closest in size to GHMSI based on average reported non-FEP

[14] *Shaw,* Page 9.
[15] *Shaw*, Page 10.
[16] *Shaw*, Page 9, footnote 21.
[17] This analysis was based on data for BCBS primary licensees, with the exception of certain Pennsylvania plans (Independence Blue Cross, Capital Blue Cross, and Blue Cross of Northeastern Pennsylvania) for which the majority of the company's indemnity (non-HMO) business is underwritten by a subsidiary; in those instances the larger subsidiaries, rather than the primary licensees, were considered.

premium revenue for the period of 2002 to 2013. This is the same period and stated criteria as indicated by Mr. Shaw; however, we excluded any for-profit BCBS Plans due to their fundamentally different control, expense, and capitalization structures. We did not include health insuring affiliates and subsidiaries, although we would have done so if we were to use the results for any meaningful analysis.

Chart A-3 summarizes the average premium amounts for these 10 companies, along with the same information for the companies actually selected by Mr. Shaw. Only one company among those in Mr. Shaw's group meets our criteria in terms of size and non-profit status. We observe that Mr. Shaw's list has a clear bias toward Blue Cross Blue Shield Plans that are larger than GHMSI, and therefore likely to exhibit less volatility in their underwriting results.

Chart A-3
Summary of Reported Non-FEP Premium Revenue for 2002-2013[1]
For Selected Blue Cross Blue Shield Reporting Entities

Reporting Entities Similar in Size to GHMSI[2]		Reporting Entities Included in Shaw Analysis	
Company Name	**Average Annual Premium (Millions)**	**Company Name**	**Average Annual Premium (Millions)**
Blue Cross & Blue Shield of RI[3]	$1,392	QCC Insurance Co. [5]	$2,574
Louisiana Hlth Svc & Indem Co.	$1,324	Horizon Healthcare of NJ Inc.[6	$2,502
BC&BS of Kansas Inc.	$1,260	BlueCross BlueShield of TN Inc	$2,418
Blue Cross & Blue Shield of SC	$1,234	Blue Cross Blue Shield of MN	$2,188
Grp Hospitalization & Med Svcs	**$1,176**	Premera Blue Cross	$2,066
Capital Advantage Insurance Co[4]	$1,044	Regence BlueShield	$1,862
Blue Cross & Blue Shield of NE	$938	Regence BCBS of OR	$1,715
Blue Cross Blue Shield of AZ	$911	BC&BS of Georgia Inc.	$1,535
Blue Cross Blue Shield of AR	$877	Blue Cross & Blue Shield of RI[3]	$1,392
Blue Cross of Idaho Health Svc	$856	**Grp Hospitalization & Med Svcs**	**$1,176**
CareFirst of Maryland Inc.	$813	Regence BCBS of UT	$581

(1) Based on data reported by SNL Financial.
(2) Includes the 10 non-profit BCBS plans closest to GHMSI in terms of average annual non-FEP premium for 2002-2013.
(3) Plan was included under both selection criteria.
(4) Subsidiary of Capital Blue Cross
(5) Subsidiary of Independence Blue Cross
(6) HMO subsidiary. This company was incorrectly identified as Horizon BCBS of New Jersey by Mr. Shaw.

Chart A-4 presents the results of a tabulation of the mean and standard deviation of 3-year underwriting gain/loss amounts for each set of companies, consistent with the calculations presented in Chart 2 on page 11 of Mr. Shaw's report. The alternative set of companies exhibits a lower mean and higher standard deviation of results than Mr. Shaw's companies. As this comparison illustrates, Mr. Shaw's approach is infinitely malleable – selection of ten different companies would lead to completely different results from those posited by him.

We note that the standard deviation of underlying gain/loss observations (12.3%) exceeds the standard deviation of the Rector rating adequacy distribution (10.7%, as shown on page 11 of Shaw Report) and the mean of the two Milliman distributions (10.6% and 13.1%). If Mr. Shaw

had used this set of companies, following his same approach in other respects, his calculations would have produced a much smaller reduction in surplus requirements.[18]

Chart A-4
Summary of Reported 3-Year Underwriting Gain/Loss for Non-FEP Lines of Business
For the Above Reporting Entities, 2002-2013:

Reporting Entities Similar in Size to GHMSI		**Reporting Entities Included in Shaw Analysis**	
Number of Reporting Entities	11	Number of Reporting Entities	11
Gain/Loss Observations(1)	132	Gain/Loss Observations(2)	134
Mean Gain/Loss	8.2%	Mean Gain/Loss	8.5%
Standard Deviation	12.3%	Standard Deviation	9.8%

(1) Number of distinct annual underwriting gain/loss amounts reported by SNF Financial for 2002-2013.
(2) Shaw analysis included 3 additional underwriting gain/loss observations for GHMSI – for the period 1999-2001 – but not for any other reporting entity.

Beyond Mr. Shaw's failure to meet his own selection criteria, failure to combine parent and insuring subsidiaries and affiliates, and a bias toward relatively larger Plans, we note a number of problems regarding specific "peer" companies selected by Mr. Shaw. Among them are several companies of different structures and circumstances that make them poor choices for comparison to GHMSI:

- Blue Cross Blue Shield of Georgia is a for-profit company, and is part of a large and very differently structured corporation (Wellpoint).

- Data for the company that Mr. Shaw indicates as Horizon Blue Cross Blue Shield of New Jersey is actually information only for Horizon HMO, a subsidiary of BCBS of New Jersey.

- QCC is one of many subsidiaries of Independence Blue Cross.

In addition to the inappropriateness of the approach and problems with Mr. Shaw's selection of "peer" companies, the time period he selected, 2002 to 2013, was historically unprecedented in terms of the relative stability of underwriting results. Among the 10 companies that Mr. Shaw

[18] We are not proposing this alternative approach. It is still limited to a period of relatively favorable underwriting results, fails to include insuring affiliates and subsidiaries, and relies on reported statutory results that are subject to the same concerns outlined above. Rather, we point to these results as illustration of the arbitrary nature of any selection of "peer" companies.

analyzed, all but 3 experienced underwriting losses at some point in the preceding 3 years (1999-2001) and all but 1 of them in the preceding 5 years (1997-2001). Leaving such periods of loss out of the study period results in a distorted distribution of gain/loss amounts.

Over time, health insurance business in this country has been characterized by periods of external change due to factors such as changes in government policy, changing trends in the health insurance marketplace, economic developments, or changes in the practice of medicine. Despite the major restructuring of health insurance that is now beginning to take place as a result of health care reform, and that will significantly affect GHMSI's operations over the next several years, Mr. Shaw has selected as a basis for evaluation of underwriting fluctuations a period where conditions were largely favorable.

For purposes of developing a surplus target which is intended to ensure the company's financial viability, it is not appropriate to assume that this level of stability will continue in the future nor to assume that a limited sample of observed events represents the universe of potential outcomes. Even in the absence of health care reform, it is important to acknowledge and allow for the possibility that the types of experience deviations that have occurred over a longer term period, such as the period from 1986 through 2009 that underlies the assumptions in Milliman's and Rector's analyses, will recur.

Impact of ACA

The passage of federal health care reform legislation in the form of the ACA in 2010 has resulted in significant changes in the health insurance marketplace. The effects of these changes continue to emerge with the startup of the health care exchanges and the implementation of the risk mitigation programs this year, and the ongoing evolution of the regulatory environment. GHMSI and other health plans will continue to face uncertainty and challenges over the next several years, as the effects of the various components of the law unfold.

Mr. Shaw addresses his interpretation of the expected impact of certain ACA provisions through application of adjustments to the historical underwriting experience of the 10 "peer" plans he selected. In his discussion of the Affordable Care Act Mr. Shaw inappropriately limits his analysis to those provisions intended to mitigate risk while downplaying the features of the ACA that will enhance risk. Further, his application of the provisions he does consider is flawed in a number of several respects.

These issues are discussed in more detail below, in Section F ("Impact of Affordable Care Act").

B. Equity Portfolio Asset Values

Mr. Shaw argues that Rector's surplus target should be reduced by $216 million based on a supposed evaluation of the Company's expected equity returns, but his analysis underlying that argument is completely wrong based on a number of analytical errors. First, he double-counts the revenue generated by returns on corporate equity assets. Second, he inappropriately includes returns on pension assets, which are already reflected in the pension valuation; this treatment is duplicative. Third, he omits CareFirst BlueChoice ("CFBC") premium and equity asset amounts from his adjustment ratio, thereby significantly overstating the impact of any change in expected asset returns. As a result of these inappropriate assumptions, he has claimed that Rector's estimate of needed surplus is overstated by approximately $216 million.

The surplus analyses carried out by Milliman and Rector incorporate assumptions regarding the risks associated with equity portfolio asset values. These assumptions, in the form of a probability distribution, were appropriately developed and reflect the manner in which the investment rate of return was incorporated in our modeling approach.

Milliman and Rector Assumptions

In the analysis underlying both the Milliman and the Rector reports, an overall average annual investment rate of return of 3.75% on corporate assets was assumed. This investment yield assumption includes dividends, coupons, and realized and unrealized capital gains, and reflects the entire portfolio (stocks, bonds, and cash). This 3.75% assumption was provided by CareFirst as representing the company's expectations for its portfolio. It was incorporated in the pro forma model and applied to projected investment funds on an annual basis.

In our modeling we have reflected underlying average rates of return of 7.0% for equities, and 3.5% for the bond portfolio, consistent with this overall 3.75% rate of return. The risk and contingency distribution for equity asset portfolio values, summarized below, represents the potential impact on surplus of a deviation from the assumed 7.0% underlying rate of return on equities, due to fluctuations in market values during the projection period.

Chart B-1
Milliman and Rector
Risk and Contingency Category: Equity Portfolio Asset Values

Probability	3- Year Surplus Change as % of Non-FEP Insured Premium
10%	11.5%
12	3.8
25	0.9
29	-3.0
14	-6.9
10	-10.7
100%	

This distribution reflects an underlying assumption that the distribution of variations in asset values over a three-year period will be consistent with the distribution of three-year price changes in the Standard and Poor's (S&P) 500 Index for the period from 1/1/1950 through 4/1/2011. The surplus change values shown above include the following components:

- The impact of variations in the rate of return on corporate assets, from the assumed 7% average rate of return on equities assumed in our pro forma model.

- With respect to the equity portfolio of the pension plan, the impact of variations in the future rate of return from the rate of return assumed in the pension valuation.[19]

Alternative Assumptions Presented by Mr. Shaw

The alternative assumptions and calculations presented by Mr. Shaw start with a summary of three year changes in the Dow Jones Industrial Average (DJIA) for the period from 1/1/1975 to 12/31/2013 (Chart 10 on page 30 of his report). While our analysis was based on the S&P 500 Index, we find that our results would not have changed materially if we had instead used the DJIA.

Milliman's pro forma projection model generates annual investment income based on an expected average rate of return on invested assets. The purpose of the risk assessment for

[19] The "assumed" rate of return is reflected in the calculations underlying the pension valuation as reported in the statutory statement. To the extent that actual returns do not conform to the assumed rate of return, a below-the-line adjustment to surplus is required, consistent with Statutory Accounting Principles (SAP).

return on equities is to reflect the risk that the actual rate of return deviates from this average rate, and our assumed Equity Portfolio Asset Values (EPAV) values represent the financial impact of such deviations. While we have used the S&P Index to measure potential deviations from our assumed rate of return on equities, Mr. Shaw has developed a distribution of values that represent three-year full rates of return, rather than deviations from an expected rate of return. This results in a redundancy, in effect including the return on corporate equities twice.

In addition, we noted the following issues with respect to the information presented in Chart 11 on page 30 of Mr. Shaw's report:

- Mr. Shaw's calculations of alternative risk factors for equity portfolio asset values include returns on pension assets. This produces an overstatement in the level of expected returns, because future returns on pension assets are incorporated in reported pension values. Changes in the rate of return on pension assets affect the company differently, as outlined above.

- In Chart 11 of Mr. Shaw's report he purports to present a summary of GHMSI investment in stocks as a percentage of non-FEP premiums by year for 2008 through 2013. His table indicates a material reduction in this percentage for 2010 through 2013 (ranging from 22% to 26% during that period) compared to the percentage in 2008 and 2009 (when he shows it to be 32%). He goes on to state that ***"Rector increased the EPAV factor dramatically between its 2009 and 2013 reports, despite total assets invested in stocks having significantly declined as a percentage of non-FEP premiums since 2009."***

  However, the asset amounts shown in Mr. Shaw's chart erroneously include the value of affiliates for 2008 and 2009, overstating the assets for those years and thereby leading to his false conclusion that there was a significant reduction in assets invested in stocks as a percentage of non-FEP premiums subsequent to 2009. He correctly excludes such affiliate values for 2010 and later, although apparently he does not realize the inconsistency (and inappropriate amounts he shows for 2008 and 2009). When this error is corrected by excluding affiliates from his stock investment amounts, the values for 2008 and 2009 decrease from 32% to 17%, leading to an observed increase in the percentage between 2009 and subsequent years.

- CFBC premium and equity asset amounts were omitted from the development of the ratio of equity assets to non-FEP premium. The resulting ratio is therefore overstated (25% vs. the correct ratio of 16%), which in turn leads to an overstatement of the impact of any change in expected asset returns on GHMSI's surplus.

It is the inclusion of the redundancies in returns on corporate and pension assets, and a failure to properly reflect the CFBC premium and equity assets, that produces Mr. Shaw's purported $216 million overstatement in the surplus target; if these errors were corrected, this "overstatement" would be eliminated.

C. Premium Growth Assumptions

Mr. Shaw's analysis of the premium growth ratio is based on an examination of premium increases for the limited and uncharacteristic five-year period between 2009 and 2013. GHMSI experienced atypically low growth rates for the non-FEP business during that period, almost certainly driven to a significant degree by the recent economic recession. It is our understanding that this period was also characterized by significant benefit downgrades (i.e., increases in member cost-sharing) and other changes in mix of business, which tend to obscure the underlying rate of growth in premium. This produces an average growth assumption that is unreasonably low for the purpose of establishing a surplus target for the company, particularly in anticipation of an improving economy and the implementation of health care reform.

Potential growth due to the individual and employer mandates, as well as possible increases in medical costs due to enrollment of higher-cost individuals, coupled with the ACA fees and other marketplace influences all increase the likelihood that premium growth rates will increase in future years. Further, when the rate of benefit downgrades slows or reverses, the premium growth rate will increase, all other factors remaining equal.

As is true of Mr. Shaw's rating adequacy analysis, there is no reasonable basis to believe that the negative patterns with respect to premium growth that occurred during the particular years that he selected will continue. To the contrary, improving economic circumstances and the implementation of health care reform are likely to lead to an upturn in premium growth. The 3.8% average premium growth assumption developed by Mr. Shaw for GHMSI's total non-FEP business is, in our judgment, unreasonably low for the purpose of establishing a surplus target for the company. Accordingly, we disagree with his contention that the 958% of RBC-ACL surplus target proposed by Rector should be reduced by $207 million dollars to reflect this inappropriately low growth rate.

The influence of these factors as well as the expected enrollment increases due to the ACA lead us to conclude that future premium growth rates are likely to be higher than those selected by Mr. Shaw, perhaps materially so.

Considerations for Premium Growth Assumptions

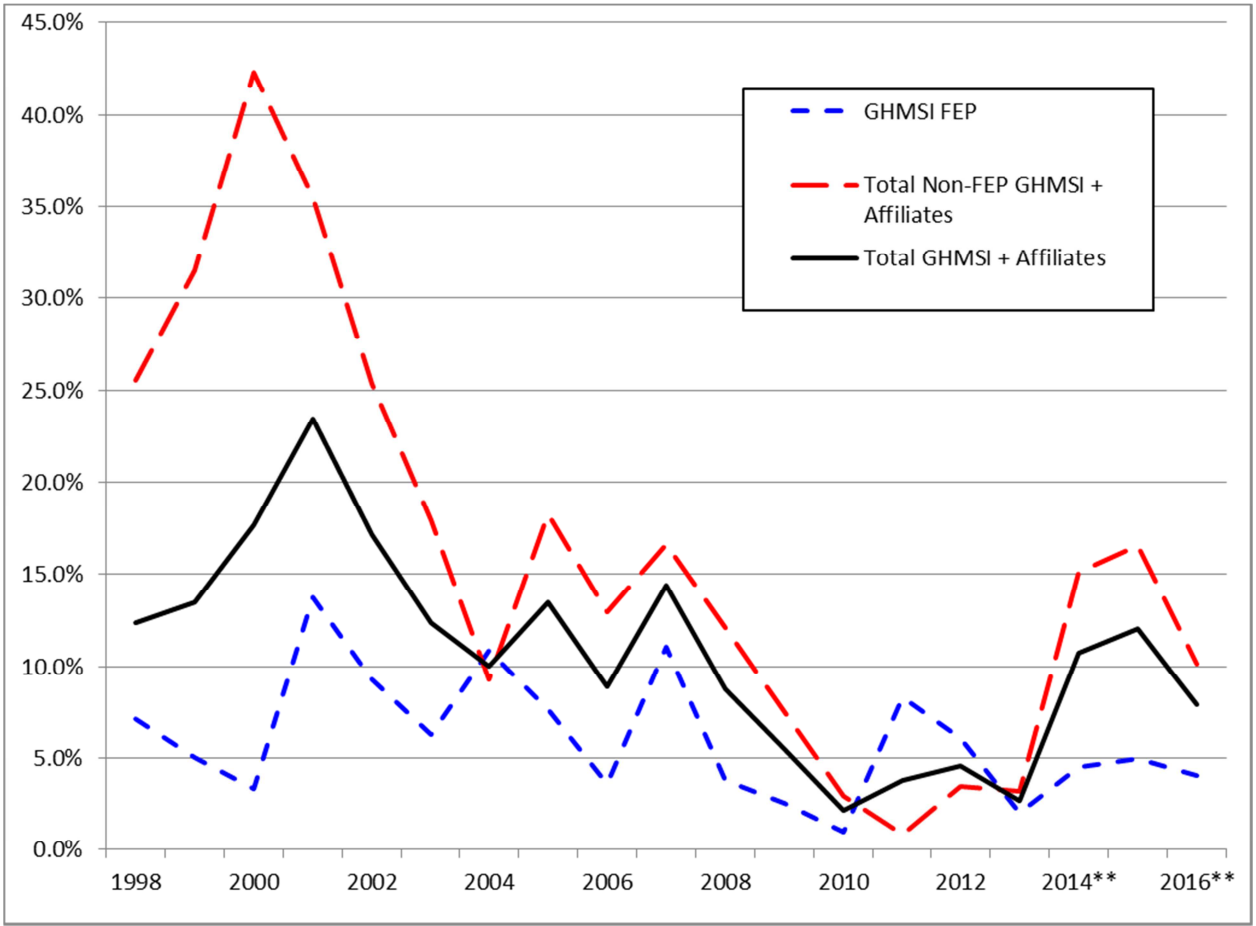
The premium growth assumptions utilized to assess surplus requirements for a company such as GHMSI should represent a range of potential growth rates that could occur over the next several years. Such growth assumptions need to incorporate a number of important elements of change in aggregate premium income for GHMSI. These include enrollment changes, medical care cost and utilization changes, changes in the mix of business by market segment and geographic area, demographic changes, benefit level changes, and the impact of fixed dollar cost sharing amounts on benefit costs.

Historical GHMSI Premium Growth Rates

Mr. Shaw has selected annual premium growth rates that produce a mean value of 3.8% for non-FEP business and 5.8% for FEP business. He points to recent growth rates experienced by GHMSI for the period 2009 through 2013, and describes these mean values as being consistent with actual average historical growth for this period.

Chart C-1 shows historical and projected premium growth rates for GHMSI's FEP segment, its non-FEP business (directly written business plus its proportionate share of affiliate business), and for the company as a whole (including its share of affiliate business). The company's growth rate has varied significantly over time, as evidenced by this graph. Also evident is the fact that the growth rates experienced by GHMSI for the non-FEP insured segment during the 2009 through 2013 period that Mr. Shaw relied upon are lower than those of any other period shown.

Chart C-1
Historical and Projected Annual Premium Growth Rates
For GHMSI Including Proportional Share of Affiliates*



Notes:

* Growth rates for 2008 have been adjusted to neutralize the impact of the population changes that occurred at that time as a result of the new cross-jurisdictional reinsurance arrangement; For purposes of consistency, growth rates for 2002 and later all reflect the current 50% ownership percentage in CareFirst BlueChoice.

**Values for 2014 through 2016 reflect projected growth rates, prepared by GHMSI management for its Board of Directors.

The selection of a range of premium growth rates should take into consideration a number of factors, one of which is historical growth rates – both longer term patterns and more recent rates of change. This is not simply a matter of assuming that growth will continue at either longer term average rates or some recent historical levels. Rather, an important component of

this process is considering the conditions and factors that underlie the experience observed, how those may differ in the future, and the uncertainty surrounding any expectations.

Expectations for Future Premium Growth

Chart C-1 includes projected growth rates for 2014 – 2016, prepared by GHMSI management for its Board of Directors. Projected growth is higher than experienced during very recent years, but not as high as experienced during some of the prior years. The step-up in premium growth anticipated for the next several years reflects the conditions that are expected, which involve some notable differences from those experienced during the very recent past.

For example, economic conditions have changed and are expected to continue to do so. Economic contractions such as the recent recession that began in 2008 tend to result in declines in health plan membership, as employment rates decline. According to a study published by the Employee Benefit Research Institute[20], employment-based insurance coverage declined nationwide by 6 % during the period 2008 through 2011. In addition, health care utilization often declines during such periods. These factors are likely to have depressed recent premium growth rates for GHMSI, and point to the potential for higher growth rates as the economy recovers.

Further, while medical care cost trends have recently been at relatively low levels, the potential for higher inflation in the economy generally and in the health care sector specifically cannot be prudently ignored or disregarded.

Finally, the implementation of health care reform, with its individual and employer mandates, is expected to produce substantial growth in certain market segments, and such growth is expected to continue for a period of time. Increased medical costs associated with ACA growth, due to disproportionate enrollment of higher cost individuals, are likely to occur; and the ACA imposes new fees and alters market conditions in ways that almost certainly will increase costs.

Although ACA enrollment was lower in early 2014 than expected for GHMSI and for most if not all other health plans, CareFirst enrollment accelerated at the end of the Open Enrollment period and will likely end 2014 close to expectations. Technical problems with the exchanges have been a significant factor in these low enrollment results, as have been a number of unexpected delays and extensions in implementation provisions. From all indications to date, it is reasonable to assume that ACA enrollment will grow over time, and this growth could prove to be significant.

In light of the economic improvements that are occurring and expected to continue, the prospects for substantial future growth over the next several years under the ACA, and the uncertainty present in the health insurance market today, the assumptions made by Milliman in

[20] Employee Benefit Research Institute, *Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2013 Current Population Survey*, dated September 2013, available at http://www.ebri.org/pdf/briefspdf/EBRI_IB_09-13.No390.Sources1.pdf, page 5.

its 2011 surplus target study of 7% and 11% appear reasonable, if not potentially on the low side for use in evaluating surplus needs. The 3-year mean assumption developed by Mr. Shaw of 3.8% for GHMSI's total non-FEP business (including its share of affiliate premium) is, in our judgment, unreasonably low for the purpose of establishing a surplus target for the company.

D. Administrative Expenses

Mr. Shaw's conclusion regarding a reduction in GHMSI's expense and the impact that such a reduction would have on the company's target surplus is incorrect and should be disregarded completely. Mr. Shaw's treatment of this item implies that he believes that any reduction in expense level that might occur for GHMSI would be kept by the company year after year as profit; this obviously would not be the case, either as a matter of GHMSI policy or of DISB oversight.

Further, Mr. Shaw concludes that GHMSI is inefficient administratively using only a gross comparison among a selection of hand-picked "peer" companies, with no attempt to adjust for differences in characteristics among companies and their marketing and operating environments, some of which are clearly apparent without any detailed analysis. He then goes on to say that "***It is possible (depending on how Milliman and Rector derived their RAAF factor curves) that GHMSI's relative inefficiency caused Milliman and Rector to assume surplus changes that are systematically more negative than an efficient company would experience."***[21]

In fact, neither Rector's nor Milliman's surplus analysis would change if GHMSI reduced its administrative expenses, because annual rate filings and group rate renewals reflect actual and expected future administrative expenses. If GHMSI reduces expenses, those reductions will be passed on to members and GHMSI's surplus requirements would remain unchanged. Accordingly, the "projected reduction in required surplus" of $153 million as put forth by Mr. Shaw to reflect the purported expense inefficiency has no basis in fact.

Flaws in Mr. Shaw's Analysis

Mr. Shaw bases his claim of GHMSI's supposed administrative inefficiency on a tabulation of claims adjudication and other administrative expenses as a percentage of revenue as reported in the 2013 statutory statements of each of the "peer" companies that he identified previously. From this tabulation he concludes that GHMSI was significantly less efficient than all but one peer company, due to a higher expense ratio.

Mr. Shaw's comparison of the administrative expenses incurred by GHMSI's supposed "peer" companies is skewed. As we stated previously, a number of the "peer" companies have significantly different characteristics than GHMSI. For example, BCBS of Georgia is a Wellpoint company, and as such is a part of a large for-profit corporation. The expense structure of such a company can be expected to reflect the ability of such a large organization to spread or allocate costs across many operating companies, meaning direct comparisons are not meaningful. In addition, Horizon (an HMO) and QCC represent subsidiaries of their parent BCBS

[21] *Shaw*, Page 37.

plans (BCBS of New Jersey and Independence Blue Cross), and are subject to unknown arrangements with those parent companies with respect to allocation of expenses.

Further, statutory reporting has several limitations that make direct comparison of reported expenses between companies difficult. In particular, the SAP treatment of fees for self-funded or ASC business, as well as variations in treatment of expense amounts included in the "other income/expense" line, can greatly distort the comparison of expense ratios among companies. For this reason, most expense analysis is based on GAAP accounting rather than statutory.

There are other reasons that a direct comparison of expense data for these companies is not useful. These data may reflect different levels of taxes and fees, including premium taxes, which often vary by state. Each company may have a different mix of market segments, requiring different levels of administrative expenses. Mr. Shaw makes no effort to adjust his analysis for these differences or other factors.

For all of these reasons, the tabulations of expense ratios presented in Mr. Shaw's report do not provide a valid basis on which to judge the relative efficiency of GHMSI, and his analysis does not support any conclusion that GHMSI is less efficient than other carriers.

E. Other Risk Factors

1. Provision for Impact of Catastrophic Events

Every health insurer faces the risk of catastrophic events occurring. Such events include dramatic increases in medical costs due to terrorism, epidemics or pandemics, and natural or public health disasters. They also include other events with a potentially extraordinary adverse financial impact – such as major fire or other business interruption disaster, excessive damage awards from major class action or other litigation, or extraordinarily large changes in the financial markets with attendant adverse impacts on asset valuations and financial obligations.

A prudent insurer must provide protection against such risks, so that the company is not exposed to ruin or incapacity from such an event. This is necessary to remain a viable company. It is also necessary to protect the ability of GHMSI's members, providers, and vendors to safely rely on the company for the financial security that they believe they have contracted for or purchased. Prudence dictates that surplus for GHMSI be sufficient to withstand the risk created by such threats, to the maximum extent possible.

Mr. Shaw argues that there should be no additional provision for catastrophic events, on the presumption that they would already be reflected in historical underwriting results and hence to include them separately would amount to double counting. But this statement reflects an erroneous assumption that Milliman's development of assumptions for the rating adequacy and fluctuation component of our risk assessment involved looking at historical underwriting results for GHMSI and peer companies. He states that ***"many catastrophic events would already be reflected in underwriting results and therefore in the RAAF factors.*** This is a completely false premise by Mr. Shaw; as we described previously, our approach did not consider historical underwriting results for any individual company.

The occurrence of catastrophic events is expected to be infrequent, and may encompass events that have not recently occurred and therefore cannot be measured in a meaningful way from historical underwriting results (e.g., extreme pandemics, natural disasters or terrorism events), or even events that may not have been envisioned – so-called "unknown unknowns" – perhaps resulting from the occurrence of multiple events simultaneously. Should they occur, however, the effect could be truly devastating medically, operationally, and financially – to the community and to GHMSI. We believe it is critically important to ensure adequate provision for such events in surplus, for the benefit of these parties.

The selection of assumptions related to catastrophic events requires a considerable degree of judgment. Data to support such modeling for health insurers have not been captured or reported. The probability assumptions that have been used by Milliman and those that have been used by Rector are not intended to reflect a prediction of the frequency with which such events will occur in the short term. Rather, they are intended to reflect a minimal level of

financial protection that a prudent company should reasonably maintain in order to withstand a potential catastrophic event along with the other risks that it faces and retain financial viability.

2. Change in Interest/Discount Rate – Impact on Bond Portfolio and Pension Plan

As with our assumptions regarding equity asset values, our analysis of surplus requirements for GHMSI incorporated a probability distribution to recognize the risks associated with changes in interest and discount rates on the company's bond portfolio and pension plan values.

Regarding our assumptions, Mr. Shaw stated that ***"It is a remarkable proposition that the company should expect over any given 3-year period that a change in the interest/discount rate will occur, and that 90% of the time it will increase and have a negative impact on the company's bond portfolio and the value of the pension plan."***[22] He has proposed that these risk assumptions be ignored, implying that as a result Rector's estimate of needed surplus is overstated by an estimated $20 million.

Mr. Shaw makes three errors with respect to the interest/discount rates. First, he misinterprets the probabilities in Milliman's development, which relate to the impact on surplus of (i) potential changes in interest rates affecting the value of corporate bonds that are liquidated, and (ii) potential changes in discount rates affecting the pension plan valuation. They reflect a 55% probability of increase in bond interest rates over three years, not a 90% probability as asserted by Mr. Shaw. The Milliman assumptions are supported by an analysis of historical interest rate patterns, and they are consistent with and reasonable in view of today's very low interest-rate environment.

Second, his assertion, or at least clearly implied position and treatment in his analysis, that rates would not change over three years is contradicted by actual experience, which shows that rates are continually changing. Third, Mr. Shaw simply ignores the fact that interest rates in 2011 were historically low and thus more likely to go up than down.

The following chart presents the history of the market yield on 5-year Treasury bonds. This pattern illustrates the fluctuation that has occurred generally over time, as well as the historically low levels that today's interest rates represent.

[22] *Shaw*, Page 39.

Chart E-1
Market Yield on U.S. Treasury Securities
at 5-year Constant Maturity

In order to demonstrate the reasonableness of our assumptions, we tabulated historic interest rates by month as reported by the Federal Reserve Bank for the period from April, 1950 through December, 2013. For each month we derived an average portfolio yield rate reflecting the distribution of GHMSI bond holdings by class and duration as of December 31, 2010, as well as the 3-year change in these average portfolio yield rates.

We then identified those 3-year periods for which the average portfolio yield at the beginning of the period ranged from 1.75% to 2.75%, which includes values within a .5-point range of the approximately 2.25 % average portfolio yield applicable in the first quarter of 2011, when our study was carried out. Of the 41 such instances that were observed, 92% involved a net increase in the average portfolio yield rate over a 3-year period, demonstrating the reasonableness of our assumption that interest rates are substantially more likely to increase over a 3-year period than to decrease, in the current interest rate environment.

Chart E-2 summarizes the components of the assumed impact on surplus due to changes in interest rates, as reflected in the Milliman and Rector surplus analyses.

Chart E-2
Milliman and Rector
Risk and Contingency Category: Change in Interest/Discount Rate –
Impact on Bond Portfolio and Pension Plan by Component

Change in Interest/Discount Rate [1]					
Amount of Change	Probability	Surplus Change as % of Non-FEP Insured Premium			
		(a) Held by Corporation	(b) Held by Pension Plan	(c) Pension Plan Valuation (PBO)	(a)+(b)+(c) Total Surplus Impact
-1.0%	10%	1.6%	0.2%	-1.4%	0.5%
0.0	35	0.0	-0.1	0.0	-0.1
2.0	45	-2.9	-0.6	2.5%	-1.0
4.0	10	-5.5	-1.1	4.7%	-1.9
	100%				

[1] Deviation of actual interest/discount rates from current valuation rates, over a three-year period. Positive deviation percentages reflect a rise in market interest rates generally, which would have an adverse impact on the market value of the bond portfolio and a favorable impact on the projected Pension Benefit Obligation (PBO).

As outlined in this table, the assumed changes in interest rates result in: (i) changes in the value of the corporate bond portfolio, to the extent that such bonds must be liquidated to meet the company's financial obligations, (ii) changes in the value of bonds held by the pension plan, to the extent they change from those assumed in the pension valuation, which will directly affect the pension values reported in the statutory statement, and (iii) changes in the value of the Projected Benefit Obligation (PBO), which again will directly affect the pension values reported. With respect to the pension plan PBO, recognition of a change in interest rate (i.e., a change in the discount rate used to calculate the PBO) will result in a below-the-line adjustment to surplus, consistent with Statutory Accounting Principles (SAP).

3. Overhead Expense Recovery and Fee Income Risks – Commercial Business

The assumptions related to overhead expense recovery and fee income risks for commercial business represent the likelihood of unanticipated fluctuation in the level of administrative expense recoveries. These recoveries are made, under normal circumstances, through the administrative expense component of premium rates for insured business, fees paid by self-

funded groups, and fees or revenue generated from other business activities. An adverse fluctuation may occur, for example, because a large group terminates unexpectedly, with a resulting decrease in expense revenue or self-funded fees. A corresponding decrease in expenses would not occur immediately, and expense ratios would therefore increase.

Mr. Shaw has erroneously eliminated the impact of this risk component, stating that ***"Presumably, as we have done in our alternative RAAF calculations, [Milliman] derived the RAAF factor and its proposed distribution of results by looking at the historical underwriting results for GHMSI and peer companies. If so, any excess expenses or fee income shortfalls would already be reflected in underwriting results and therefore in the RAAF factor."***[23] As a result of this elimination, Mr. Shaw understated the required surplus target by an estimated $10 million.

Contrary to Mr. Shaw's presumption, Milliman's development of assumptions for the rating adequacy and fluctuation component of our risk assessment did not involve looking at historical underwriting results for GHMSI and peer companies. As discussed earlier, our approach considers the range of factors that contribute to the risk that actual claims and expenses differ from the amounts for which provision is made in premium rates. Therefore the rating adequacy and fluctuation assumptions do not reflect any shortfall in expense recovery.

The assumptions for this risk component recognize the expected portion of overhead expense that would not be eliminated or replaced through future rates or self-funded fess over the short term, and are appropriately incorporated separate and apart from the assumptions related to rating adequacy and fluctuation.

4. Expense Recovery and Fee Income Risks – FEP Indemnity Business and FEP Operations Center

The risk related to loss of overhead expense recovery and fee income for FEP business is similar to that of commercial business. FEP premium revenue and revenue from the FEP Operations Center contribute to coverage of GHMSI overhead expenses, and an unexpected loss in this revenue represents a financial risk to the company.

Mr. Shaw comments that ***"As of 12/31/2013 GHMSI reported a special reserve of $681 million for GHMSI's FEP business that, per the footnotes on page 26.3 of its annual statement, "may be utilized by the participating plans in the event that funds set aside from annual premiums are insufficient or fall below certain prescribed levels by OPM.". . . It appears that GHMSI has unfettered access to the special reserve to address any shortfalls in expenses due to FEP***

[23] *Shaw*, Page 39.

business."[24] Mr. Shaw inappropriately eliminated this risk factor from his analysis, resulting in a reduction of an estimated $6 million in the required surplus target.

The above comments by Mr. Shaw demonstrate a fundamental misunderstanding of the purpose of the OPM reserve fund and how it works. GHMSI does not have "unfettered access" to the special reserve fund held by OPM with respect to administrative expenses. Rather, the Blue Cross Blue Shield Association (BCBSA) negotiates a contract expense limitation with OPM each year, and allocates a portion of that to each plan. It is reasonable to assume that if GHMSI were to experience a material reduction in FEP membership, it could expect the expense allocation to decline accordingly, resulting in a reduction in reimbursement for a portion of overhead expense that could not be immediately eliminated.

The FEP Operations Center also contributes to the offset of certain overhead expenses for CareFirst, which would be forfeited if GHMSI were to lose the Operations Center contract. Under the circumstance of a significant reduction in GHMSI surplus of the nature simulated in Milliman's analysis, leading to potential concerns about the long-term viability of the company, there is the risk, which cannot be ignored, that the Operations Center contract would be terminated by BCBSA.

5. Provision for Unidentified Development and Growth

To maintain competitiveness and ongoing viability, GHMSI must periodically make substantial investments in developmental activities and the acquisition of operational capabilities. These include such far ranging items as new product development, rebuilding of delivery networks, enhancement of care management capabilities, acquisition of new communications or information technology capacities, and adaptation of existing and integration of new administrative processes.

Often these capital expenditures do not produce admitted assets, which means that they generally must be absorbed directly and immediately out of surplus. Milliman's assumptions for the provision for unidentified development and growth are intended to recognize the risks associated with such expenditures due to their impact on surplus.

Mr. Shaw states that in his report that ***"any excess expenses for unidentified growth and development would have been reflected in underwriting results and therefore are already embedded in the RAAF factors."***[25] As described previously, this reflects an incorrect premise by Mr. Shaw that Milliman looked at historical underwriting results for GHMSI and peer companies in order to develop assumptions for the rating adequacy and fluctuation component of our risk assessment. Therefore, his claim that any excess expenses for unidentified growth and development are imbedded in these assumptions is false. Mr. Shaw also criticizes Rector's

[24] *Shaw*, Page 40.
[25] *Shaw*, Page 41.

assertion that "Because non-admitted assets cannot be included in an insurer's total assets for purposes of determining the insurer's financial condition, increases in non-admitted assets result in a direct charge to an insurer's surplus position."[26] He claims that *"[T]his is an incomplete and misleading description of how non-admitted asset purchases affect an insurer: it does not address how non-admitted asset purchases affect underwriting results as shown in the Statement of Revenue and Expenses as shown on page 4 of the Statutory Annual Statement. A more complete and accurate statement would be as follows:*

> *Because non-admitted assets cannot be included in an insurer's total assets for purposes of determining the insurer's financial condition, purchase of (i.e., increases in) non-admitted assets results in such expenses flowing through an insurer's underwriting results in the year of purchase and the reduced underwriting results impacts the insurer's surplus position."*[27]

This characterization of the treatment of non-admitted assets by Mr. Shaw is incorrect. Under statutory accounting principles a company does not charge the entire expense for such assets in the first year. Rather, the expense is amortized and the company reflects the change in non-admitted assets directly to surplus. In subsequent years the company charges amortization to underwriting gain/loss and releases the non-admitted asset, and surplus is increased.

[26] *Rector*, Page 26.
[27] *Shaw*, Page 41.

F. Impact of the Affordable Care Act

In his discussion of the impact of the Affordable Care Act (ACA) in relation to the rating adequacy and fluctuation risk (see Section A. above), Mr. Shaw dramatically underestimates the downward pressure the ACA will impose on GHMSI's surplus. His discussion of the ACA's impact inappropriately downplays those provisions intended to mitigate risk, and Mr. Shaw makes mistakes in how he applies those provisions.

The passage of federal health care reform legislation in 2010 has resulted in significant changes in the health insurance marketplace. The effects of these changes continue to emerge with the startup of the health care exchanges and the implementation of the risk mitigation programs this year, and the ongoing evolution of the regulatory environment. GHMSI and other health plans will continue to face uncertainty and challenges over the next several years, as the effects of the various components of the law unfold.

As noted in Milliman's 2011 report, we reflected the impact of health care reform provisions related to the medical loss ratio (MLR) and premium rate reviews that had been implemented at that point in time, but did not attempt to reflect provisions to be implemented in 2014 and later, due to lack of information regarding the details of the implementation as of that point in time. We did, however, estimate the impact on the GHMSI surplus target range of potential increases in adverse selection in the individual and small group markets that would not be anticipated in premium rates, and would not be fully offset by the risk mitigation programs that are required by the PPACA to be established after the implementation of new rating and underwriting rules in 2014.

While any such estimate was then and is now subject to significant uncertainty, we estimated that the surplus target range for GHMSI could be expected to increase by 100% to 150% of RBC-ACL, if the potential for such adverse selection were taken into account. We characterized this estimate as an indication of the directional nature of the impact of the health care exchanges, rather than a precise quantification of their potential financial consequences.

Risks Associated with ACA Implementation

The ACA has brought a wide range of operational changes to the health care marketplace, including an individual mandate for coverage and an employer mandate (which has been delayed as a result of regulatory changes). A series of new market rules have been implemented, requiring guaranteed availability of coverage and restrictions on the manner in which premium rates can vary by age and by geographic area. One of the largest changes involves the health care exchanges, premium subsidies, and the standardization of benefits sold through the exchanges.

The combination of these marketplace changes can be expected to lead to increased adverse selection, both in terms of the population choosing to enroll and in the selection of benefit

levels. Recent regulatory changes allowing for the temporary renewal of certain individual and small group plans that did not comply with the ACA are likely to exacerbate such adverse selection, as the affected members choose whether to retain their plans or select new ones on the exchange.

At the same time, health plans are now subjected to extended timelines for the filing of new premium rates, as well as increased regulatory scrutiny of such rates. GHMSI must file its individual and small group premium rates in May and June for the following year. This timing does not allow the company to assess any of the experience of the current year in making assumptions for the subsequent year. Given the rapidly changing environment, such timing lags add significantly to the risk of inadequate premium rates. Further, while it is impossible to anticipate the impact of increased regulatory scrutiny of rates, it is reasonable to assume that, in combination with the competitive nature of the exchanges, there will be pressure on GHMSI to limit rate increases.

The medical loss ratio standards and rebate requirements established by the ACA were first implemented in 2011. These provisions require GHMSI to separately report experience by market segment (individual, small group and large group), jurisdiction (D.C., Maryland and Virginia), and company (GHMSI and CareFirst BlueChoice), resulting in 18 different segments for reporting purposes. Rebates must be paid for any such segment that does not meet the minimum medical loss ratio, with no opportunity to offset losses in other segments. This situation severely limits the ability of the company to increase surplus levels if they should become depleted.

In addition to the impacts of these changes in market rules and medical loss ratio standards, the ultimate costs of the new exchange plans will be affected by the cost transfers under the new premium stabilization or risk mitigation programs which became effective on January 1, 2014. These include the permanent risk adjustment provision as well as the transitional reinsurance and temporary risk corridor programs, both of which will expire at the end of 2016. The effects of these new programs are unknown and will not be determined until after the close of each respective plan year – and after the submission of the following year's premium rates.

GHMSI has provided a more extensive discussion of the impact of the ACA on the company's operations and on its surplus in its Pre-Hearing Brief[28], which opens with the following comments:

"***The Affordable Care Act (ACA) has dramatically changed the market rules under which Group Hospitalization and Medical Services, Inc. d/b/a CareFirst BlueCross BlueShield ("GHMSI") and its HMO subsidiary CareFirst BlueChoice, Inc. ("BlueChoice") must operate. Because of these sweeping changes, GHMSI believes that its surplus level is likely to fall in future years. The real concern should not be whether GHMSI's surplus is too high at present, but whether***

[28] Group Hospitalization and Medical Services, Inc*., Pre-Hearing Brief, DISB Review of GHMSI Surplus Pursuant to the Medical Insurance Empowerment Act of 2008, D.C. Code §31-3501, et seq.,* June 10, 2014; See Exhibit 2: *Report by GHMSI on the Impact of the Affordable Care Act on GHMSI's Surplus ("ACA Impacts Report"),* (hereinafter "*GHMSI Pre-Hearing Brief Exhibit 2*"), available at http://disb.dc.gov/node/844182.

GHMSI will be able to maintain surplus levels that are adequate to ensure that it remains financially sound in the future.

Under the new market rules created by the ACA and uncertainties regarding the medical costs of new members in the new plans, it is more likely than ever before that an insurer such as GHMSI will face rate inadequacies due to misjudging the nature of the risk pool of covered members. Once rates become inadequate, the ACA will make it harder than ever before to increase those rates to an adequate level for future years, and very unlikely that a carrier would recover past losses."[29]

Mr. Shaw's Calculations of ACA Impact

Mr. Shaw addresses his interpretation of the expected impact of certain ACA provisions through application of adjustments to the historical underwriting experience of the 10 "peer" plans he selected. In his discussion of the Affordable Care Act Mr. Shaw inappropriately limits his analysis to those provisions intended to mitigate risk while downplaying the features of the ACA that will enhance risk. Further, his application of the provisions he does consider is flawed in a number of respects.

Specifically, Mr. Shaw misapplies the medical loss ratio ("MLR") rules by effectively assuming that every segment of a company's business will achieve a gain if the company achieves an overall gain. That is not correct. As outlined above, between GHMSI and BlueChoice there are 18 different market segments in which GHMSI may suffer a loss or be required to pay rebates independent of any other results in any other market segments. Mr. Shaw also erroneously or inappropriately applied the risk corridors to all market segments, even though the risk corridor program only applies to Qualified Health Plans sold in the individual and small group markets.

Mr. Shaw downplays the potential effects of the ACA's guaranteed issue requirements by assuming that they would be completely offset by reinsurance and risk adjustment. The reinsurance program is temporary, and its effects will diminish each of the next two years before it terminates. The risk adjustment program is completely new, and the extent to which it will benefit or harm GHMSI is unknown.

Regarding the risk corridors program, as noted by GHMSI in its Pre-Hearing Brief[30], there is a risk that there will be more carriers with losses than carriers with gains, and there may not be sufficient appropriated funds to cover the full needs of the program, in which case the protections intended by this feature of the ACA would not be fully available. In addition, the risk corridor program is temporary; any benefit to GHMSI will be limited to the three year transition period.

In addition, Mr. Shaw fails to acknowledge the changes to GHMSI's distribution channels

[29] *GHMSI Pre-Hearing Brief Exhibit,* Page 1.
[30] *GHMSI Pre-Hearing Brief Exhibit,* Page 10.

wrought by the ACA, and the individual and employer mandates, all of which increase GHMSI's risks and costs, particularly in the short-term, while at the same time increasing enrollment in the long term. These are fundamental components of the ACA, which cannot be reasonably ignored as Mr. Shaw has done.

G. Validation

An essential component of Milliman's approach to developing a target surplus level for GHMSI was to test the impact of the risks identified and quantified in the course of our analysis on the company's surplus level. This testing was a forward-looking process, applied using a pro forma financial projection model.

Milliman undertook a rigorous process of validating all aspects of its target surplus development for GHMSI. This included: (i) the production of a baseline pro forma model projection that reproduced GHMSI forecast results; (ii) verification that all risk variable distributions were consistent with information available and informed actuarial judgment and that appropriate mean values were reproduced using the identified risk probability distributions; (iii) validation tests that rating simulations reproduced appropriate overall mean rate increase values; and (iv) detailed checking to determine that all calculations were being performed correctly throughout all model components. Further, all variable changes introduced to the simulation and pro forma models were tested separately for accuracy and reasonableness.

Mr. Shaw asserts, with no foundation or evidence, that "Rector and Milliman have provided very little validation of assumptions and results" (page 44). This assertion is simply false. Milliman's work was documented for its intended users, and every component of our analysis, results, and work product were fully checked and validated.

III. Milliman Compliance with Actuarial Standards of Practice

Mr. Shaw states in his report that ***"Milliman and Rector Fail to Explain their Work in Accordance with Actuarial Standards of Practice".***[31] This assertion by Mr. Shaw has no basis in fact.

Milliman documented all of our work in accordance with Actuarial Standard of Practice No. 41(ASOP 41), as explained below:

- ASOP 41 states the following:

  > *"The actuary should complete an actuarial report if the actuary intends the actuarial findings to be relied upon by any intended user. The actuary should consider the needs of the intended user in communicating the actuarial findings in the actuarial report.*
  > *An actuarial report may comprise one or several documents. The report may be in several different formats (such as formal documents produced on word processing, presentation or publishing software, e-mail, paper, or web sites). Where an actuarial report for a specific intended user comprises multiple documents, the actuary should communicate which documents comprise the report.*
  > *In the actuarial report, the actuary should state the actuarial findings, and identify the methods, procedures, assumptions, and data used by the actuary with sufficient clarity that another actuary qualified in the same practice area could make an objective appraisal"*[32]

- In our May 31, 2011 report document we addressed the fact that our report was intended for CareFirst management, and gave permission for it to be provided to the DISB (collectively, the intended users), as follows: *"Milliman has prepared this report for the specific purpose of providing results and assumptions for our optimal surplus analysis. This report should not be used for any other purpose. This report has been prepared solely for the internal business use of and is only to be relied upon by the management of CareFirst. We understand that GHMSI may wish to share this report with regulators and their professional advisors in the District of Columbia, Maryland and Virginia, or other appropriate regulators. We hereby grant permission, so long as the entire report is provided. We recommend that any party receiving this report have its own actuary or other qualified professional review this report to ensure that the party understands the assumptions and uncertainties inherent in our estimates. Judgments as to the conclusions contained in our report should be made only after studying the report in its entirety.*

[31] *Shaw,* Page 6.

[32] *Actuarial Standard of Practice No. 41, Revised Edition, Actuarial Communications;* Adopted by the Actuarial Standards Board December 2010; Section 3.2, Page 3, *available at* http://www.actuarialstandardsboard.org/pdf/asops/asop041_120.pdf.

Furthermore, conclusions reached by review of a section or sections on an isolated basis may be incorrect. 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."

- In addition to our May 31, 2011 report document, we issued an additional set of documentation materials that included the elements outlined above as required by ASOP 41 to CareFirst management, and communicated that these materials were intended to comprise part of our overall report. We later provided these same materials to the DISB through Rector and FTI Consulting.

In sum, Milliman provided extensive documentation of its model to GHMSI, its client, and to the DISB – i.e., to its intended users – consistent with the requirements of Actuarial Standard of Practice 41. Moreover, it is our understanding that Rector and the DISB provided Mr. Shaw extensive information regarding Milliman's model. That is confirmed by the fact that Mr. Shaw has indicated that he was able to run his own simulations and largely replicate Milliman's analysis.

IV. Limitations and Caveats

This report relates in part to Milliman's 2011 GHMSI report on the Development of an Optimal Surplus Target Range. It should be considered only in conjunction with the 2011 report; applicable terms and concepts are not repeated here. Judgments as to the conclusions contained in this letter should be made only after studying both reports in their entirety. The material in both reports was developed for the exclusive use of CareFirst management, for its internal consideration in connection with surplus targets. We understand that CareFirst, with Milliman's permission, has shared our 2011 report with certain regulators and their professional advisors in the District of Columbia, Maryland and Virginia, or other appropriate regulators, and that CareFirst may wish to share the current report with the same parties. We hereby grant permission, so long as the entire report is provided. We recommend that any party receiving this material have its own actuary or other qualified professional review this material, along with our 2011 report, to ensure that the party understands the assumptions and uncertainties inherent in our estimates. Milliman does not intend to benefit any third party either through this analysis or by granting permission for this material to be shared with other parties.

In developing this material we relied on data and other information provided by CareFirst. We have not audited or verified this data or information. The expectations for CareFirst in the future and the subsequent actual experience of CareFirst may vary materially from the assumptions used in this analysis.

The authors of this material are Consulting Actuaries for Milliman, are members of the American Academy of Actuaries, and meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinions contained herein.

EXHIBIT 3

Council of the District of Columbia
Committee on Public Services and Consumer Affairs

Report

1350 Pennsylvania Avenue, N.W., Washington, DC 20004

To: Members of the Council of the District of Columbia

From: Mary M. Cheh, Chairperson
Committee on Public Services and Consumer Affairs

Date: October 17, 2008

Subject: Bill 17-934, the "Medical Insurance Empowerment Amendment Act of 2008"

The Committee on Public Services and Consumer Affairs, to which B17-934, the "Medical Insurance Empowerment Amendment Act of 2008," reports favorably on the legislation and recommends its adoption by the Council of the District of Columbia.

CONTENTS

STATEMENT OF PURPOSE AND EFFECT

The purpose of B17-934, the "Medical Insurance Empowerment Amendment Act of 2008," is to provide a framework to ensure that non-profit hospital and medical services corporations pursue their public health mission. B17-934 would require the Mayor to determine the percentage of annual premium revenues that non-profit hospital and medical services corporations must spend on community health reinvestment, to establish a sufficient surplus operating range for non-profit hospital and medical services corporations, and to require non-profit hospital and medical services corporations to justify the accumulation of surplus in excess of the upper limit of that range, or divest themselves of the excess surplus through community health investment. The bill would also require non-profit hospital and medical services corporations to continue to offer the open enrollment program to each subscriber as long as the subscriber renews his or her coverage under the program; to set affordability and adequacy standards for the open enrollment program; and to require non-profit hospital and medical services corporations to advertise the availability of the open enrollment program. The legislation would prohibit non-profit hospital and medical services corporations from converting to for-profit status.

LEGISLATIVE HISTORY

September 16, 2008	Introduction of B17-934 by Councilmembers Cheh, Alexander, Barry, Bowser, Brown, Catania, Graham, Mendelson, Thomas, and Wells, and Chairman Gray
September 19, 2008	Referral of B17-934 to the Committee on Public Services and Consumer Affairs
September 26, 2008	Notice of Intent to Act on B17-934 is published in the *District of Columbia Register*
September 26, 2008	Notice of Public Hearing on B17-934 is published in the *District of Columbia Register*
October 10, 2008	Public Hearing on B17-934 held by the Committee on Public Services and Consumer Affairs
October 17, 2008	Consideration and vote on B17-934 by the Committee on Public Services and Consumer Affairs

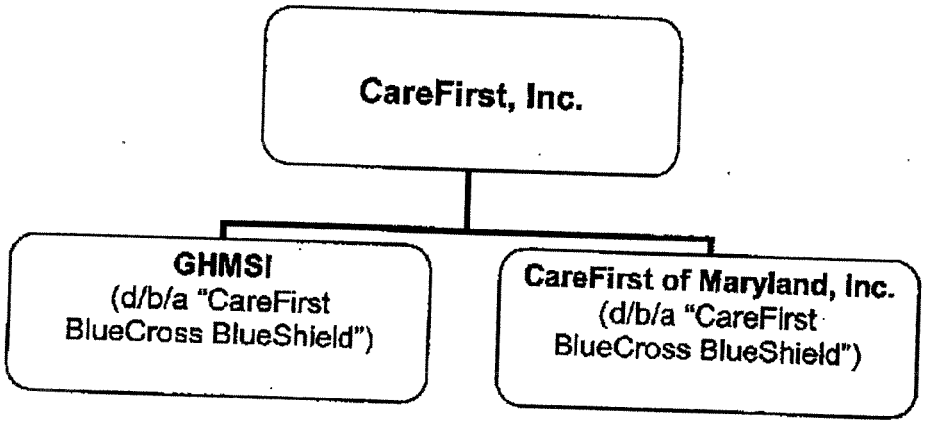
BACKGROUND/COMMITTEE REASONING

A. Background

The central problem addressed by Bill 17-934 is the lack of a framework to ensure that the District's only non-profit hospital and medical services corporation meets its obligations to community health reinvestment.

1. CareFirst's Role in Public Health

Group Hospitalization and Medical Services, Inc. ("GHMSI"), a non-profit entity domiciled in the District of Columbia, is the only non-profit hospital and medical services corporation[1] in the District. Its sole member and parent company is CareFirst, Inc., and it is affiliated with CareFirst of Maryland, Inc. ("CFMI"). Both GHMSI and CareFirst of Maryland, Inc. do business as "CareFirst BlueCross Blue Shield."[2] The relationship is set forth in the following organizational chart[3]:



GHMSI participates in the insurance markets of the District of Columbia, northern Virginia, and Maryland. CFMI markets products in all of Maryland.

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[1] The Hospital and Medical Services Corporation Regulatory Act of 1996 is codified as Chapter 35, "Hospital and Medical Services Corporations Regulation," of Title 31 of the District of Columbia Official Code and defines a "corporation," for purposes of the statute, as "a nonstock, nonprofit corporation which is subject to regulation and licensing under this chapter and which offers subscriber contracts as part of a hospital service plan, a medical service plan, or both." D.C. Official Code § 31-3501.

[2] This report uses the term "CareFirst" in a broad sense to refer to GHMSI, CFMI, and CareFirst, Inc., collectively. When necessary, the report uses the terms "GHMSI," "CFMI," and "CareFirst, Inc." to refer to the respective entities.

[3] This chart excludes a substantial number of CareFirst companies, including CareFirst BlueChoice, a for-profit health maintenance organization ("HMO") and subsidiary of CFMI.

GHMSI's predecessor, Group Hospitalization, Inc., was chartered as a "charitable and benevolent institution" by act of Congress on August 11, 1939.[4] The charter was amended in 1984 to reflect the merger of Group Hospitalization with Medical Services, Inc., creating the entity known as GHMSI.[5]

Congress amended the charter again in 1993, this time to make GHMSI subject to District regulation.[6] In 1997, Congress again acted to amend the charter to allow GHMSI to have a non-profit corporate member[7] – CareFirst Inc., which was established as the holding company for both GHMSI and CFMI.[8] This amendment cleared the way for GHMSI to pursue licensing by the Blue Cross Blue Shield Association ("BCBSA"). GHMSI and CFMI began doing business as "CareFirst BlueCross BlueShield" in 1998.

CareFirst BlueCross BlueShield performed very well in its first year of operation, 1998. GHMSI and CFMI totaled $3.9 billion in revenues, 2.5 million subscribers, $75.7 million in net income, and reserves of $472 million.

In 2002, CareFirst and WellPoint Health Networks, Inc. ("WellPoint") applied for a merger. The corporate transaction, which would require the approval of both the Maryland Insurance Administration ("MIA") and the District's Department of Insurance and Securities Regulation (now known as the Department of Insurance, Securities, and Banking or "DISB"), would result in the acquisition of CareFirst by WellPoint and the conversion of CareFirst to for-profit status.

Following a lengthy process in which over 100 hours of testimony were taken and 85,000 pages of documents were reviewed,[9] Maryland Insurance Commissioner Steven B. Larsen concluded in 2003 that it was "clear that this proposed transaction is not in the public interest."[10] Commissioner Larsen noted that the CareFirst board of directors' "decision to allow [the transfer of $68 million to corporate officers as part of the original proposed transaction], and its subsequent defense of that transfer, is inexcusable."[11] In rejecting the merger application, he also cited "the Board's failure to recognize and abide by the corporate mission of the organization . . . and its failure to consider how a conversion might impact its ability to further that corporate mission."[12] It is evident that

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[4] *See* Pub. L. No. 395, 53 Stat.1412 (1939).
[5] *See* Pub. L. No. 98-493, 98 Stat. 2272 (1984).
[6] *See* Pub. L. No. 103-127, § 138, 107 Stat. 1336, 1349 (1993).
[7] A "member" of a non-profit institution is roughly equivalent to a "shareholder" of a for-profit corporation. *See, e.g.*, D.C. Official Code § 29-301.02 (defining "member" as "one having membership rights in a" non-profit corporation).
[8] *See* Pub. L. No. 105-149, 111 Stat. 2684 (1997).
[9] MARYLAND INSURANCE ADMINISTRATION, REPORT OF THE MARYLAND INSURANCE ADMINISTRATION, STEVEN B. LARSEN, COMMISSIONER, REGARDING THE PROPOSED CONVERSION OF CAREFIRST, INC. TO FOR-PROFIT STATUS AND ACQUISITION BY WELLPOINT HEALTH NETWORKS, INC. 2 (2003).
[10] *Id.* at 198.
[11] *Id.* at 175.
[12] *Id.* at 200.

Commissioner Larsen had serious reservations about CareFirst's credibility.[13] The Commissioner emphasized that, despite CareFirst's non-profit mission, "the weight of the evidence supports the conclusion that the enrichment of the executive team was, if not the primary motivation, an important motivation . . . in selecting the prevailing bidder."[14] In essence, the Commissioner concluded that the board had effectively lost sight of its mission.

Since the MIA's rejection of the proposed for-profit conversion and executive windfall, CareFirst has continued to grow in size and financial security. This growth is reflected in the steady annual increases in GHMSI's surplus (that is, the value of its assets minus its liabilities). The following table shows GHMSI's surplus levels over the last five years:[15]

Year	GHMSI Surplus
2003	$392 million
2004	$501 million
2005	$561 million
2006	$663 million
2007	$754 million

As of 2nd quarter 2008, GHMSI's surplus had reached $761 million.

Another method of calculating the financial health of an insurance company involves a risk-based capital ("RBC") ratio. The ratio is computed by comparing the insurer's total adjusted RBC (also known as "TAC," equivalent to the surplus[16]) to authorized control level RBC ("ACL").[17] A low ratio of TAC to ACL represents a high risk of insolvency. When a company's TAC falls to 200% of ACL, the National Association of Insurance Commissioners ("NAIC") recommends that the state insurance regulator place the insurer under regulatory control. The District's insurance laws codify the NAIC recommendations in this regard.[18]

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[13] *Id.* ("In some cases, CareFirst has in fact misrepresented the nature of the offers from the two bidders. This also calls into question the veracity of other information provided to the MIA in connection with these applications.")

[14] *Id.*

[15] Figures in the table are available in GHMSI's annual financial statements submitted to DISB. Dollar values are rounded to the nearest million.

[16] *See* DC APPLESEED CENTER, CAREFIRST: MEETING ITS CHARITABLE OBLIGATION TO CITIZENS OF THE NATIONAL CAPITAL AREA III-44 (2004). The Appleseed report explains that "[f]or health companies, TAC is usually equal to reported surplus plus other types of capital held. This typically includes capital stock if the insurer is a stock company, as well as surplus notes." GHMSI is not a stock company and has no capital stock or surplus notes.

[17] Authorizeed control level is a benchmark determined in accordance with instructions developed by the National Association of Insurance Commissioners.

[18] *See* D.C. Official Code §31-2001.

In addition to meeting statutory the minimum, GHMSI must meet the contractual minimum established by BCBSA as a condition of licensure. The BCBSA requires its licensees to carry a minimum RBC ratio of 375%. According to the Maryland Healthcare Commission, "[m]ost insurance carriers in the United States hold surpluses in the range of 250 to 400 percent [of ACL] even at the low point in the underwriting cycle."[19]

By any measure, GHMSI's RBC ratio is high. The following table illustrates GHMSI's RBC ratio over the last five years:

Year	GHMSI RBC Ratio
2003	787%
2004	951%
2005	893%
2006	955%
2007	916%

GHMSI's 2007 ratio of 916% is more than 4½ times the statutory regulatory standard and almost 2½ times the BCBSA requirement. GHMSI's RBC ratio outpaces those of its affiliates, CFMI (808%) and CareFirst BlueChoice (824%), as well as its regional competitors, Optimum Choice (691%), Kaiser Foundation MidAtlantic (594%), Aetna Health Maryland (545%) and United Healthcare MidAtlantic (430%), and has done so for at least the last five years.

Despite the sustained health of its finances, GHMSI's contributions to community health have not kept pace. While the company gives to a number of deserving community health programs, some of which are described in the "Summary of Public Hearing" *infra*, its community health investments have tapered off.

In 2005, former DISB Commissioner Lawrence Mirel wrote that, "[b]ased upon its financial health, including its significant surplus and net income level, and the breadth of its operations in the District, we believe that GHMSI should be engaging in charitable activity significantly beyond its current activities."[20] He added that, "although GHMSI may meet its legal obligation to engage in charitable activity solely through the provision of health insurance in its service area, GHMSI has *an additional responsibility* – separate

[19] MARYLAND HEALTH CARE COMMISSION, HEALTH INSURANCE PREMIUMS, THE UNDERWRITING CYCLE, AND CARRIER SURPLUSES 2 (March 2005). The "underwriting cycle" is simply "a repeating pattern of gains and losses within the insurance industry. As the cycle plays out, expected trends and the associated premium increases tend to go above or below the actual rate of change in underlying health care costs." MILLIMAN USA, HEALTH INSURANCE UNDERWRITING CYCLE EFFECT OF HEALTH PLAN PREMIUMS AND PROFITABILITY 1 (April 10, 2003).

[20] DISTRICT OF COLUMBIA DEPARTMENT OF INSURANCE, SECURITIES, AND BANKING, IN THE MATTER OF: INQUIRY INTO THE CHARITABLE OBLIGATIONS OF GHMSI/CAREFIRST IN THE DISTRICT OF COLUMBIA 19 (2005).

and apart from the bare legal obligation set forth in its charter – *to engage in charitable activities in the District . . . which advance the public health.*"[21]

The conclusions of Commissioner Mirel dovetail with those of former Attorney General Robert Spagnoletti, who wrote in 2005 that

> [a]s a "charitable and benevolent institution" that seeks to serve a public health mission, GHMSI has an obligation to use its profits and excess surplus to serve the purpose of promoting health in its service area. GHMSI's board may choose to fulfill this obligation in various ways, such as devoting surplus resources to (1) improving the quality, benefits, affordability, or accessibility of its non-profit health plans, (2) providing health plan benefits or other services to the poor at no charge, and/or (3) funding health-related activities that are conducted by other charitable organizations.[22]

Attorney General Spagnoletti followed that statement with another several months later:

> OAG's conclusion is that GHMSI has a legal obligation to devote its entire operation to serving, directly or indirectly, the charitable, public health purposes for which it was chartered. . . .
>
> Until GHMSI acknowledges its obligation as a "charitable and benevolent institution" to operate for the benefit of the public, one cannot presume that its corporate decisions are based on a board determination as to how best to fulfill the corporation's charitable purposes. . . .
>
> [T]he accumulation and maintenance of a surplus is essential if a charitable health insurer is to have the financial solvency necessary to fulfill its public health mission over the long term. But the insurer would be acting contrary to its charitable obligation if it made the accumulation of "surplus" an end in itself, or sought to accumulate surplus for a purpose that was not reasonably related to the company's public health mission. The stronger its current financial position and more secure its future prospects given its current surplus level, the less likely it is that the company has a *bona fide* need, consistent with its public health mission, to accumulate additional surplus.[23]

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[21] *Id.* at 22. (Emphasis added.)

[22] Memorandum from Robert J. Spagnoletti, Attorney General, to Robert Bobb, City Administrator 8 (March 4, 2005).

[23] Memorandum from Robert J. Spagnoletti, Attorney General, to Robert Bobb, City Administrator 1-2 (August 4, 2005).

The positive reaction of GHMSI to the opinions of Commissioner Mirel and Attorney General Spagnoletti was short-lived. The company gave $51 million to charitable activities in 2006 but just $15 million in 2007, while increasing its surplus by over $200 million. CareFirst has stated that it intends to give $40 million in charitable donations in 2008, but this figure is potentially misleading, as it includes giving by both GHMSI *and* CFMI, which has its own surplus of $514 million. It is unclear how much GHMSI plans to contribute to community health programs in its service area.

2. Community Health in the District of Columbia

The RAND Corporation's 2008 study of health and healthcare in the District[24] reveals a number of major issues facing District residents:

- More than 25% of adults have hypertension.
- More than half of adult residents are overweight or obese.
- Despite an overall high level of health insurance coverage, 20% of District residents reported no usual *source* of care.
- Rates of emergency department visits for conditions that could have been handled in a primary-care setting are rising.[26]

The RAND report also highlights a variety of troubling statistics specifically regarding children's health:

- 36% of children between the ages of 6-12 are overweight.
- 9% of District children were reported to have a dental health problem.
- 12% have asthma.

The study also presents data pointing to geographical discrepancies in health and healthcare:

- Wards 7 and 8 have higher rates of chronic disease, poor health status, and premature mortality than the rest of the District.
- Ward 5's rates of hypertension and overweight/obesity exceed the District average.
- Breast and prostate cancer rates are highest in Wards 4 and 8.
- The cervical cancer rate is highest in Ward 7.
- Ward 6 has the highest rate of colon cancer.
- Nearly 1 in 5 children in Ward 7 have asthma.

The report noted that the "availability of providers for vulnerable populations was difficult to measure," but cited residents' assessment that they have "limited options for

[24] Nicole Lurie et al., *Assessing Health and Health Care in the District of Columbia: Phase 2 Report* iv (RAND, Working Paper No. WR-579, 2008).
[26] *Id.* at 3-4.

places to go where they could receive high-quality care."[27] In fact, "[c]urrent ambulatory care capacity is a key factor underlying the problems District residents have accessing care; however, problems with ambulatory care are diverse and extend well beyond just the capacity of the system."[28]

Even the RAND report, which identifies this wide variety of problems, does not fully capture the healthcare issues confronting the District, which faces, among other ills, the worst HIV/AIDS rate in the nation. It is clear, that District residents are fighting an uphill battle in elevating the quality and expectancy of their lives. This struggle is not simply rooted in the number of uninsured residents (approximately 11% of the population), but also in lack of access to adequate primary care, specialist services, preventative care, and health and wellness education.

B. Barriers

There is a deep uncertainty surrounding CareFirst's degree of dedication to its charitable public health mission. The best way to dispel that uncertainty is to enact legislation establishing a framework to ensure that CareFirst meets its public health obligation to the community.

While some parties have suggested that the board of directors is now committed to keeping GHMSI on track toward its public health mission,[29] the board has lost sight of its mission before. Commissioner Larsen's rejection of the proposed merger with WellPoint in 2003 made that adequately clear, but recent events – particularly the issue of former chief executive officer ("CEO") William Jews's severance compensation – have generated heightened skepticism.

William Jews was tapped as the new president and CEO of CareFirst in 1993. By all accounts, he contributed significantly to the improvement of the company's performance, which had suffered in prior years.[30] His tenure was not, however, exemplary, and his departure led to stern criticism of CareFirst's lack of focus on its non-profit mission by its Maryland regulator.

MIA Commissioner Tyler found that Mr. Jews's "record of executive leadership was a decidedly mixed one" and that Mr. Jews cannot "avoid responsibility for the enormous troubles and public wrath visited upon the company" during his tenure (particularly in regard to the failed conversion attempt).[31] The Commissioner also found that it was an "established fact that under [Mr. Jews's] leadership the company strayed significantly from its . . . nonprofit, public purpose mission."[32]

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[27] *Id.* at 6-7.
[28] *Id.* at 13.
[29] *See., e.g.*, testimony of Barbara Lang at the October 10, 2008 hearing on Bill 17-934, *infra* p. 17.
[30] *See Ins. Comm'r for Md. v. CareFirst, Inc.*, Statement of Reasons in Support of Final Order 16, MIA-2007-10-027 (July 14, 2008) [hereinafter MIA Statement of Reasons].
[31] *Id.* at 16-17.
[32] *Id.* at 18.

The reason for the MIA's review of Mr. Jews's record was CareFirst's proposal to pay him nearly $18 million following his termination in 2006. Commissioner Tyler held that the proposed payment was not "fair and reasonable" and that portions of it would not be "for work actually performed" by the former CEO.[33] The Commissioner ruled that the golden parachute payment was unlawful and ordered that it be scaled down to approximately $9 million.[34]

Commissioner Tyler was less than pleased with the board of directors' failure to evaluate Mr. Jews' prior performance in setting his compensation. He wrote that

> the board had little understanding of its role or obligations, starting with its obligations to the [Maryland] General Assembly. Rather than evaluating the CEO, this board of a specially chartered nonprofit health insurer spent time . . . complaining about the "quality" of the Maryland legislature. Those complainants are notable both for their arrogance and their irrelevance because, to state the obvious, the General Assembly directs the CareFirst board, not *vice versa*.[35]

Once again, the board had effectively lost sight of its mission.

CareFirst has also been unable to meet its own expectations for community reinvestment. The Open Enrollment program is a prime example. As part of its response to Commissioner Mirel's 2005 ruling (and at his request), CareFirst filed a report on its charitable donations with DISB. In that report, CareFirst discussed its participation in the Open Enrollment program and its expectations for the program in the following years.

District law requires that non-profit hospital and medical services corporations offer an Open Enrollment program as a way of enhancing the options for health insurance for those who must purchase insurance on the individual market.[36] While many residents receive insurance through their employers or through public programs such as Medicaid or the DC Alliance, the remainder must purchase their coverage individually. Health insurance purchased on this individual market is individually underwritten and tends to be expensive; in some cases, applicants are simply denied coverage because of their medical histories. The statutorily-mandated Open Enrollment program is intended to stabilize – and lower – those high costs and make insurance available to all. The Open Enrollment plan must "provide for the issuance of . . . subscriber contracts without imposition by the corporation of underwriting criteria whereby coverage is denied . . . because of an individual's age, health history, medical history, employment status, or, if employed, industry or job classification."[37] In order to reduce the rates charged to enrollees, CareFirst is required to pay into a rate stabilization fund operated by the

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[33] *Ins. Comm'r for Md. v. CareFirst, Inc.*, Final Order 1-2, MIA-2007-10-027 (July 14, 2008).
[34] *Id.* at 2.
[35] MIA Statement of Reasons, *supra* note 30 , at 25.
[36] D.C. Official Code § 31-3514.
[37] D.C. Official Code § 31-3514(c).

company. The corporation is allowed a tax deduction (capped at $550,000) for the money it places in the fund.[38]

In its 2005 report, CareFirst wrote to Commissioner Mirel that

> [e]nrollment in the program has increased from 255 members in December of 2004 to 319 members as of June 2005 – a 25 percent increase. Although similar open enrollment products offered in other states have typically met with limited success, our goal is to increase OE enrollment to 1,155 by the end of 2005 and to 4,755 by the end of 2009 – which would represent roughly 6 percent of the District's uninsured market.[39]

The company met *none* of those goals. At the end of 2007, there were roughly 1,100 enrollees in the program, and the national healthcare advocacy organization Families USA was complaining to GHMSI about the "barriers consumers face in accessing information on CareFirst's open enrollment insurance option."[40]

The Committee concludes that CareFirst's history of straying from its public health mission, combined with unmet expectations and a lack of a clear framework for accountability to its mission, call for a legislative response.

C. Legislative Action: Description

Bill 17-934 would amend the Hospital and Medical Services Corporation Regulatory Act of 1996 in three key ways.

The first is a requirement that GHMSI engage in community health reinvestment. "Community health reinvestment" is defined in the bill as health coverage for low-income, uninsured, or underinsured persons; operating subsidies for public health provider programs; and other community healthcare-related expenditures reasonably approved by the Mayor.[41] Under the legislation, the Mayor would conduct a thorough review before issuing an annual order to the corporation to expend a specified percentage of its gross premium revenues on community health reinvestment. The annual review would allow the Mayor to establish an appropriate figure that is consistent with financial soundness and efficiency.

The Mayor would also make an annual determination of the appropriate surplus range for GHMSI. Again, this range would be determined after a thorough review and set to be consistent with financial soundness and efficiency.

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[38] D.C. Official Code § 31-3514(j)(1).
[39] Letter from CareFirst BlueCross BlueShield to Lawrence H. Mirel, Commissioner, DISB 11 (Sept. 1, 2005).
[40] Letter from David Tian and Cheryl Fish-Parcham, Families USA, to Chester Burrell and Natalie O. Ludaway, CareFirst BlueCross BlueShield (June 25, 2008).
[41] It is expected that the Mayor will delegate his responsibilities under the legislation to DISB, the agency that regulates insurance companies in the District.

If the corporation fails to meet the specified percentage of revenues, or if its surplus exceeds the maximum established by the Mayor, it has the opportunity to demonstrate, by clear and convincing evidence, that the failure was appropriate under the circumstances. If the corporation does not make that showing, it may not increase its premium rates for 12 months, and it must implement a plan to divest the appropriate amount and allocate it toward community health reinvestment. The Mayor is given the authority to issue appropriate orders for the enforcement of the act.

Part two of the legislation deals with the Open Enrollment program. Under current law, CareFirst is permitted to terminate the program as of December 31, 2010.[42] Bill 17-934 would require CareFirst to maintain the program indefinitely. The program must be offered to each subscriber as long as she renews her coverage under the program.

The bill also sets the following affordability and adequacy criteria for the program:

- Annual premiums shall not exceed 125% of the standard individual market rates.
- Deductibles and co-pays shall not exceed the standard commercial policy available to employers in the District.
- No lifetime or annual caps on benefits.
- No exclusions or riders applied to applicants with pre-existing medical conditions.

The third key change made by Bill 17-934 is a ban on conversion to a for-profit entity or mutual insurance company. GHMSI has maintained that it has no interest in converting to for-profit status. When directly asked at the October 10, 2008 hearing, CEO Chet Burrell reiterated this stance. Other states, such as New Jersey, Arizona, and New Mexico, prohibit their non-profit hospital and medical services corporations from converting.[43] This provision provides assurance that GHMSI will remain focused on its public health mission and forecloses the possibility of another conversion fiasco.

D. Legislative Action: Analysis

Bill 17-934 establishes a framework for GHMSI to meet its public health mission. The legislation prescribes standards for the executive branch to follow in determining whether GHMSI is accumulating too high a surplus or spending too little on community health benefits.

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[42] D.C. Official Code § 31-3514(k)(3).

[43] *See* N.J. Stat. Ann. § 17:48A-2.; N.M. Stat. Ann. § 59A-47-4; Ariz. Rev. Stat. Ann. §§ 10-1003(1-2), 10-2302(1-2). Following the failure of CareFirst's conversion attempt in 2003, Maryland enacted a 5-year ban on conversion, which has since expired. *See* Md. House Bill 1179 § 7 (2003).

The Committee emphasizes that these standards are flexible.[44] Rather than designate a specific percentage of premium revenues that must go to community health reinvestment or a specific cap on surplus, the legislation would require the Mayor to revisit the figures every year. The Mayor must also take into account the need to keep the company financially sound and efficient. The intent of the legislation is that the company maintain reserves adequate to pay its subscribers' claims, fund capital improvements, meet contingencies, and remain a healthy participant in the market. This flexibility will allow the operation of the framework to adjust to the underwriting cycle and any incidents which may have an impact on GHMSI's financial viability in the future. It is in the public interest for GHMSI to continue in its role as a robust non-profit health insurer, and nothing in this bill compromises that objective. It is *excess* funds that will go to community health reinvestments.

Because GHMSI plays that important role in its *entire* service area, the committee print for Bill 17-934 includes a new provision requiring the Mayor to give due consideration to the interests of the other jurisdictions within the service area. The bill also consistently refers to community health reinvestments for the entire service area. GHMSI's current giving is not restricted to the District; nor should it be. The Committee expects that GHMSI will continue to engage in charitable activity in the District, northern Virginia, and Maryland. Community heath reinvestments *anywhere* in GHMSI's service area would be credited against its obligation.

Finally, the bill also removes the permissive sunset for open enrollment. By setting affordability and adequacy standards for the program, Bill 17-934 ensures that the product will be a meaningful piece of the healthcare coverage offered to District residents. Requirements for advertising the program help to make sure that residents will actually be aware of the program. Most importantly, the open enrollment provisions of Bill 17-934 will guarantee the availability of relatively affordable health insurance to those unable to secure coverage from their employers or public programs.

E. Cost-Benefit Analysis

This is not the first time that the Council has considered establishing a framework for ensuring that CareFirst meets its obligations to the public health. Similar legislation (Bill 16-190) was introduced by Councilmember Graham in 2005 but was not brought forth to the full Council. Community activists, particularly the DC Appleseed Center, have continued to press CareFirst to increase its charitable activity or, at least, consent to some independent oversight of its surplus and community health reinvestment practices.

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[44] Bill 17-934 may be contrasted in this regard with the agreement that Pennsylvania entered into with its non-profit health plans. The Pennsylvania agreement "committed the Plans to annually contributing 1.6 percent of their health care premiums plus 1 percent of their Medicare and Medicaid premiums, less certain state taxes, . . . to support community health programs." CAROL PRYOR & CATHERINE DUNHAM, THE ACCESS PROJECT, THE PENNSYLVANIA COMMUNITY HEALTH REINVESTMENT AGREEMENT: ESTABLISHING NON-PROFIT INSURERS' COMMUNITY BENEFIT OBLIGATIONS 3 (2006).

Despite negotiations convened by the chairperson of this Committee, no such agreement was reached.

Bill 17-934 represents a chance to achieve a measure of finality on this issue, with a neutral party – the Mayor and, by delegation, DISB – following legislatively-prescribed standards to determine the appropriate surplus and community health reinvestment levels for GHMSI, consistent with financial soundness and efficiency. The health needs of the community are acute and extensive and would be well-served by a non-profit hospital and medical services corporation that is held accountable to its non-profit, public health mission.

For the reasons listed above, the Committee has determined that the enactment of Bill 17-934 by the Council would greatly benefit District residents.

SECTION-BY-SECTION ANALYSIS[45]

Section 1 provides the long and short title of Bill 17-934.

Section 2 amends the Hospital and Medical Services Corporation Regulatory Act of 1996 as follows:

Subsection (a) defines the term "community health reinvestment."

Subsection (b) requires the corporation to comply with the Risk-Based Capital Act of 1996 by filing an annual risk-based capital report with the Mayor.

Subsection (c) contains findings and requires the Mayor to issue an annual order to the corporation to expend a specified percentage of its gross premium revenues on community health reinvestment. The subsection further establishes a rebuttable presumption when the corporation fails to meet this percentage that it is not engaging in community health reinvestment to the maximum feasible extent consistent with financial soundness and efficiency.

Subsection (d) requires the Mayor to make an annual determination of the appropriate surplus range for GHMSI, consistent with financial soundness and efficiency. The subsection also establishes a rebuttable presumption when a corporation exceeds this permissible surplus range that it is not engaging in community health reinvestment to the maximum feasible extent consistent with financial soundness and efficiency.

This subsection also requires the Mayor to determine annually whether the corporation has satisfied its community health reinvestment obligation. If he determines that it has not, the corporation has 90 days to file a report justifying its failure by clear and convincing evidence, as well as a plan to divest itself of excess surplus and spend the specified percentage of revenues in the event the Mayor rejects the proposed justification.

[45] This analysis addresses the committee print of Bill 17-934.

If the corporation fails to meet its burden of justification, the Mayor must reject for 12 months all premium rate increases ought by the corporation and issue such orders as are necessary to enforce the legislation.

Subsection (e) requires the Mayor to order an annual audit of the rate stabilization fund for open enrollment; requires the corporation to continue to offer the open enrollment program indefinitely; establishes affordability and adequacy criteria for the program; and mandates advertisement of the program.

Subsection (f) prohibits the corporation from converting to a for-profit entity.

Subsection (g) prohibits the corporation from converting to a mutual insurance company.

Subsection (h) requires the Mayor to issue rules to implement the legislation; requires the corporation to furnish such information to the Mayor as he may require; and requires the Mayor to take into account the needs and interests of other jurisdictions in the corporation's service area when implementing the legislation.

Section 3 adopts the fiscal impact statement included in this report.

Section 4 states that the bill shall take effect following the approval of the Council and the standard periods of Mayoral and Congressional review.

SUMMARY OF PUBLIC HEARING

On Friday, October 10, 2008, the Committee on Public Services and Consumer Affairs held a hearing on Bill 17-934, the "Medical Insurance Empowerment Amendment Act of 2008." **Councilmember Mary M. Cheh**, chairperson of the Committee, called the hearing to order at 9:00 a.m. in room 120 of the John A. Wilson Building.

Chairperson Cheh provided background on the question of CareFirst's community obligations. She then explained the structure and goals of Bill 17-934. Chairperson Cheh acknowledged that CareFirst does currently give to the community and that many of the programs it supports are deserving and effective. She noted, however, that CareFirst should have nothing to fear from the bill if, as it asserts, it is already giving sufficiently to community health investment.

Councilmember David Catania made an opening statement, noting at the outset that the subject matter of Bill 17-934 intersects the responsibilities of the Committee on Health, which he chairs. Councilmember Catania detailed his concerns with the leadership of CareFirst, including the pecuniary gain that executives were to receive under the company's original plan for conversion to for-profit status. He also explained his experience in negotiating with CareFirst to arrive at the original proposal for the

Healthy DC program. Those negotiations led to an apparent agreement between CareFirst and his office, until CareFirst decided at the last minute to pull out of the deal. Councilmember Catania noted that the more that CareFirst adds to its reserves, the more attractive a target it becomes for conversion to for-profit status.

Chester "Chet" Burrell, President and CEO of CareFirst BlueCross BlueShield, testified in opposition to the legislation.[46] Mr. Burrell stated that CareFirst already gives generously to the community, more so than all other commercial insurers in the region. He added that it seems self-evident that the principal obligation of CareFirst is to work for the benefit of its policyholders. Mr. Burrell stated that he accepted his job at CareFirst because he saw the potential role that CareFirst could play in addressing the unmet health care needs of the community.

Mr. Burrell stated that CareFirst has no intention of converting to a for-profit company. He added that CareFirst follows its public-health mission and voiced his personal support for a legislative ban on conversion by CareFirst to for-profit status.[47]

Mr. Burrell testified that CareFirst BlueCross BlueShield's risk-based capital would be between 700-750% by the end of the 2008, in part because of the nationwide economic downturn and in part because of a widespread trend of rising healthcare costs. Councilmember Cheh asked whether the ratio was dropping in response to the Council's consideration of Bill 17-934 and suggested that, while the legislation has not been enacted, we may be seeing its effects already. Mr. Burrell stated that CareFirst does not manipulate its surplus and that any change is a result of the business process.

Councilmember Cheh asked Mr. Burrell whether he considered Bill 17-934 to be qualitatively different from extant laws governing insurance, as the industry is already highly regulated. Mr. Burrell responded that he believed this legislation to be different. He contrasted the bill's framework to the authority granted to the Insurance Commissioner of Maryland, who has the ability to review a company's reserves and, if he concludes that they are excessive, can return the excess to policyholders by rate reduction. Councilmember Cheh stated that her concern was whether insurance departments in other jurisdictions review companies' surpluses. Mr. Burrell stated that some states do look at excess surplus.

Mr. Burrell stated that CareFirst does not offer a Medicaid product in the District. In response to questioning by Councilmember Catania, Mr. Burrell testified that he would be happy to discuss with the Councilmember the possibility of providing $4 million to fill the "doughnut hole" in Medicare Part D.[48] Councilmember Catania asked if Mr. Burrell

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[46] Witnesses Burrell, Lang, Gleason, Smith, Chollet, and Calia provided their testimony under oath.

[47] Due in part to Mr. Burrell's testimony, the Committee Print of Bill 17-934 includes provisions, not included in the introduced version, that would prohibit a non-profitmedical and hospital services corporation from converting to for-profit status.

[48] An explanation of the Medicare Part D "doughnut hole" is provided in HENRY J. KAISER FAMILY FOUNDATION, THE MEDICARE PART D COVERAGE GAP: COSTS AND CONSEQUENCES IN 2007 i (2008) ("A unique feature of the Medicare Part D drug benefit is the so-called "doughnut hole", the gap in coverage in which Part D enrollees are required to pay the full cost of their drugs until they qualify for catastrophic

could point to the last time that CareFirst filed for a premium rate increase that was ultimately rejected by DISB. Mr. Burrell said that he could not but noted that DISB has the power to reject proposed increases.

Councilmember Cheh asked why CareFirst had not met its target enrollment rates for Open Enrollment program. Mr. Burrell responded that CareFirst had hoped for wider industry participation in the program, so that CareFirst would not be alone in contributing to covering the target population. Councilmember Cheh remarked that CareFirst has a history of making assurances that it is ultimately unable to meet.

Barbara Lang, President and CEO of the DC Chamber of Commerce, testified in opposition to the bill. Ms. Lang recognized that Bill 17-934 has been narrowly drafted to apply to one corporate entity in the District (namely, CareFirst)[49], but she voiced concern that the legislation could encroach upon a board of director's duty to steer a company. Ms. Lang stated that the bill could set a public policy precedent for governmental interference with the management of for-profit and not-for-profit companies. She added that no one could have foreseen the recent failure of companies such as AIG and Bear Stearns, which emphasizes how hard it would be for the Mayor to "draw down" GHMSI's reserves without damaging the company's financial health.

Councilmember Cheh noted that comparing this legislation to the collapse of major financial companies is not appropriate, as the federal government had to bail out greed, excess, and lack of good leadership by the executives and boards of those companies. She pointed out that Bill 17-934 would not draw down reserves; rather, it establishes a framework. Ms. Lang responded that she respectfully disagreed as to that analysis of recent corporate failures, and that the point of her testimony was that, in her view, Bill 17-934 usurps the corporate board's role and duty. She added that all companies need reserves to get through hard times. Councilmember Cheh agreed that companies need reserves and suggested that Bill 17-934 was wholly consistent with that necessity.

Sharon Gleason, Director of Development for the Girl Scout Council of the Nation's Capital, testified in opposition to any attempt to harm CareFirst's finances, because of its charitable giving. Ms. Gleason testified that CareFirst supports the Girl Scouts' Grow Strong program, which has served 2000 girls in the metropolitan area since 2007. Ms. Gleason detailed the Girl Scouts' efforts, with CareFirst's financial support, to help District girls develop. In response to a question from Councilmember Catania, Ms. Gleason testified that she was unaware that CareFirst has not provided a Medicaid product in a generation.

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coverage. In 2007, the first full year of enrollment in Part D plans for many beneficiaries, the coverage gap began when a beneficiary incurred $2,400 in total drug spending and ended after out-of-pocket spending reached $3,850, equivalent to $5,451 in total drug spending. Once through the gap, beneficiaries become eligible for catastrophic coverage where most of the costs of . . . drugs are covered.").

[49] The Committee notes that Bill 17-934 addresses not a single entity *per se*, but rather a class of one, as GHMSI is the only non-profit hospital and medical services corporation that has been granted a certificate of authority under the Hospital and Medical Services Corporation Regulatory Act of 1996. Were another corporation to fall under the ambit of that act, it too would be subject to the provisions of Bill 17-934.

Walter Smith, Executive Director of the DC Appleseed Center, testified in support of the legislation. He listed four reasons why his organization supports Bill 17-934: 1) it puts in place a "fair, transparent process to ensure that GHMSI meets its public health mission"; 2) such a process is "particularly appropriate" given the uncertainty of public officials regarding whether CareFirst is meeting its obligation to the public; 3) GHMSI's failure to meet its obligations would have a substantial, negative impact on the community; and 4) the framework established by the legislation protects the public's interest in the company and is in keeping with actions taken by other jurisdictions.

Mr. Smith stated that, in implementing the bill, the Mayor would take all potential effects on CareFirst's finances into account as part of the requirement to be consistent with financial soundness and efficiency. He testified that Bill 17-934 could be positive for local businesses, as their employees' healthcare costs would be lowered as a result of enhanced community health reinvestment.

Deborah Chollet, Senior Fellow at Mathematica Policy Research, Inc., testified in support of Bill 17-934.[50] Ms. Chollet, an economist, described the financial situation of GHMSI. She noted in particular that GHMSI's surplus continues to exceed that of its competitors in the metropolitan area; that there is precedent for this legislation in Pennsylvania, which entered into an agreement with its Blue Cross Blue Shield plans to give 1.6% of their gross premiums to community benefits; and that GHMSI could afford to spend more on community health reinvestments. Ms. Chollet stated that, based on her analysis, the gap between what CareFirst gives and what it could (and should) be giving is "enormous." She added that Bill 17-934 provides flexibility where the Pennsylvania agreement is rigid, and that this bill benefits from that flexibility.

Ms. Chollet noted that there is any number of needs to which community health reinvestments could be applied, offering electronic medical records, quality of care, cost of care, health education, and preparedness as examples.

Kurt Calia, Partner at Covington and Burling LLP, testified in support of the legislation. Mr. Calia provided an overview of the legal foundation for the bill. He noted that the Bill 17-934 finds ample basis in GHMSI's charter, in the ability of the District to govern its own affairs, and in relevant case law concerning charitable and benevolent entities. Mr. Calia reiterated that GHMSI has obligations as a charitable and benevolent institutions and that the company refuses to acknowledge these obligations. He added that the business community could see many of its healthcare concerns resolved by increased giving by CareFirst to preventative care and other community health reinvestments.

Mr. Calia explained that even if CareFirst's obligations were only to its present and future subscribers, that group is nearly synonymous with the community at large.

[50] Ms. Chollet indicated that her testimony reflects her own opinions and not those of her employer.

JoAnn Lamphere, Director of State Government Relations for Health and Long-Term Care at AARP, testified in support of Bill 17-934. Ms. Lamphere stated that AARP endorses the reinvestment of excess surplus in community health reinvestment. Her organization particularly lauds the continuation of Open Enrollment and the establishment of adequacy and affordability criteria for the program. Ms. Lamphere noted that Bill 17-934 would provide improved assurances of health coverage and care to needful members of the community.

Cheryl Fish-Parcham, Deputy Director of Health Policy for Families USA, testified in support of the legislation. Ms. Fish-Parcham explained that she receives calls from residents of states that have no program similar to Open Enrollment, and that these residents face direct medical costs that are "totally impossible" for them to handle. Ms. Fish-Parcham stated that CareFirst began information about the Open Enrollment program on the Internet in August of 2008 and that Bill 17-934's requirement that the program continue to be advertised will increase awareness of its availability. She noted that the current $1500 annual drug cap in the Open Enrollment plan is woefully insufficient to meet the needs of the high-risk individuals who tend to purchase coverage under the program. She added that states that keep premiums within the caps imposed by Bill 17-934 (such as Maryland and Minnesota) do a better job of covering high-risk individuals. Ms. Fish-Parcham concluded by pointing to the many unmet health care needs in the District, some of which could be fulfilled by greater community health reinvestment by GHMSI.

Robert F. Van Dyke, an employee of RealMed, a healthcare technology company, testified in opposition to the legislation. Mr. Van Dyke testified that CareFirst has demonstrated its commitment to the community. He stated that he supports the need to increase access to health care but is worried that this bill could cause lead to higher premium costs. Mr. Van Dyke noted that his concerns were based less on questions about the structure of the legislation and more in the need to share costs among all insurers.

Sharon Baskerville, CEO of the District of Columbia Primary Care Association ("DCPCA"), testified in support of the legislation. Ms. Baskerville stated that her organization, which represents clinics throughout the District, recognized the legislation as "a strong bill in the right direction" but had questions about its implementation. In particular, she was concerned about the government's ability to effectively manage investments – including community health reinvestments – for District residents.[51] Ms. Baskerville testified that she believes it is "critical" to have legislation to put an end to the question of CareFirst's community obligations. She pointed out how difficult it is for a clinic or community health program to raise funds and that District residents "should not have to depend on their healthcare based on how good a fundraiser I am."

Vera Waltman Mayer, Senior Advocate for IONA Senior Services and Coordinator for the DC Coalition on Long Term Care, testified in support of Bill 17-934.

[51] Chairperson Cheh clarified that this bill does not authorize the Mayor to receive or invest any funds; instead, CareFirst would be required to spend down the money itself. The government would simply ensure that the funds are spent on actual community health reinvestments.

Ms. Mayer stated that CareFirst could be of great assistance in meeting the health needs of the District. She described the difficulty that home care workers face in obtaining affordable health insurance and the ripple effect that their clients must deal with as a result. Because persons without insurance often wait until an emergency to seek medical care, their conditions require longer, more involved treatments, and a home care worker cannot take care of his or her clients when he or she is receiving such treatment. Ms. Mayer concluded by explaining that GHMSI could contribute to the availability of affordable health insurance by supporting the Alliance or Healthy DC.

Theodore A. Burkett, a private citizen, appeared with Ms. Mayer and testified about his experience as a CareFirst subscriber. Formerly covered by CareFirst in connection with his employment, Mr. Burkett was laid off when the store at which he worked was closed. He stated that he was forced to switch to an individual policy with high co-payments and benefit caps that does him more financial harm than good. While he pays over $7000 in premiums annually, CareFirst contributes no more than $5000 to his medical bills.

Margot Aronson, Vice President for Legislation and Advocacy at the Greater Washington Society for Clinical Social Work, testified in support of the legislation. Ms. Aronson stated that social workers see first-hand the impact of lack of access to affordable healthcare and mental health care in the District. She added that Bill 17-934 would provide "clear direction" for CareFirst to meet its obligations as a charitable and benevolent institution. Ms. Aronson noted that the Open Enrollment program should be affordable, with reasonable deductibles and no pre-existing condition exclusions. She also urged the Council to consider addressing the problem of low reimbursement rates for mental health providers; providers are leaving CareFirst's network because they cannot afford to practice at CareFirst's rates.

Kim Alphonso, a private citizen, testified about the healthcare needs of her family, which includes a child with special needs. Ms. Alphonso praised CareFirst for providing the best coverage she has had and asked the Committee not to "make CareFirst's revenue an additional source for DC's budget."[52]

Father Mario Dorsonville, of the Spanish Catholic Center, Catholic Charities, testified to his organization's experience in working with CareFirst. Father Dorsonville stated that CareFirst has been an important partner for the Center's medical and dental clinics, providing $100,000 a year in support.

Paul Alegero, representing the Boys and Girls Club of Greater Washington, testified in opposition to the legislation. He noted that CareFirst supports the Boys and Girls Club's efforts to fight the District's high teen pregnancy rate.

[52] Chairperson Cheh pointed out that the bill would not appropriate any of CareFirst's funds for government use.

Wayne McOwen, representing the District of Columbia Insurance Federation ("DCIF"), testified in opposition to the legislation.[53] Mr. McOwen stated that Bill 17-934 is onerous and unnecessary, since DISB already has authority to regulate premiums. He opined that the bill would abandon traditional solvency analyses to set arbitrary limits on insurers' reserves. Mr. McOwen testified that satisfactory processes are already in place to provide protections for consumers.

Alan Nessman, Special Counsel with the Practice Directorate of the American Psychological Association ("APA"), testified in support of Bill 17-934.[54] Mr. Nessman stated that his organization's support is based on its extensive experience with the mental health needs of the District as well as the APA's experience with CareFirst in particular. He urged the distribution of a portion of any community health reinvestment to mental health needs. Mr. Nessman testified that CareFirst could help provide mental health coverage in the DC Alliance; coordinate data about mental health needs and services in order to better target services; or coordinate services more effectively between the providers and other persons serving the District's mental health needs. Mr. Nessman voiced support for the legislation's Open Enrollment provisions and the addition of a prohibition of pre-existing condition exclusions.

James F. Brown, Director of Health Services at The Actors Fund, testified in support of the legislation. Mr. Brown explained that Bill 17-934 would speak directly to the needs of the artists that seek assistance from The Actors Fund. Mr. Brown noted that the rate of lack of health insurance among artists is twice the national average and that many rely on programs such as Open Enrollment for coverage. He testified that it is essential for community health reinvestments to expand coverage and maintain a widespread community health system.

Janice Williams, Executive Vice President of Programming for the YMCA of Metropolitan Washington, testified to CareFirst's financial support of YMCA programs. Ms. Williams noted that District's childhood obesity statistics are troubling and that CareFirst helps fund the YMCA's efforts to engage children in more exercise. She noted that CareFirst employees often volunteer their time in furtherance of the YMCA's work.

Gabrielle Urghart, Executive Director of the American Heart Association ("AHA"), Greater Washington Region, testified to CareFirst's financial contributions to the AHA's work. She noted that CareFirst asks for results from the programs they support and added that CareFirst employees are engaged in community volunteering.

Jeff Franco, Executive Director of City Year Washington, DC, testified to CareFirst's support of City Year's efforts to fight HIV in the District. He expressed his gratitude to CareFirst for its contributions to City Year's work.

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[53] Mr. McOwen indicated that DCIF is a trade association of which GHMSI is a significant member.
[54] Mr. Nessman indicated that he was presenting the testimony of Katherine Nordal, the Executive Director for Professional Practice at the APA.

Stephen J. Ackerman, a self-employed writer testifying on behalf of the DC Chapter of the Nation Writers Union, Local 1981 of the United Auto Workers, testified in support of the legislation. Mr. Ackerman described his difficult experiences trying to obtain health insurance as an individual. He noted that the Open Enrollment provisions of Bill 17-934 would be a positive step toward addressing the problems of the individual market.

Colleen Dermody, Vice President of Witeck-Combs Communications, a small business with a staff of 5, testified to her satisfaction with CareFirst as an insurer. Ms. Dermody requested that the Committee consider the needs of subscribers first, though she acknowledged the positive nature of community health reinvestment.

Irwin Royster, Director for Community Outreach at Planned Parenthood of Metropolitan Washington DC, Inc., testified to CareFirst's support of Planned Parenthood's efforts to provide free health services for at-risk teens.

Doreen Hodges, Executive Director of Family Voices of the District of Columbia, Inc. and a mother of special-needs children, testified in support of Bill 17-934. Ms. Hodges noted that the legislation could assist many families with special-needs individuals. She offered the concept of a "catastrophic relief fund," which would provide support for families bearing the burden of high costs associated with special-needs children, as an example of an appropriate community health reinvestment.

Chairperson Cheh thanked the witnesses for their testimony, and called the hearing to a close at 1:40 p.m.

FISCAL IMPACT

The Committee on Public Services and Consumer Affairs finds that approval of Bill 17-934 will have no fiscal impact. A fiscal impact statement has been requested from the Office of the Chief Financial Officer and will be delivered by second reading.

ANALYSIS OF IMPACT ON EXISTING LAW

Bill 17-934 would have a minimal impact on existing law. The bill would authorize the Mayor to establish appropriate operating surplus ranges for non-profit hospital and medical service corporations, direct excess surplus to be invested in the health of the community, and order a percentage of premiums to be spent on community health reinvestment. Bill 17-934 would also set adequacy and affordability criteria for open enrollment, remove the permissive sunset for open enrollment, and prohibit non-profit hospital and medical services corporations from converting to for-profit status.

COMMITTEE ACTION

On Friday, October 10, 2008, the Committee on Public Services and Consumer Affairs met to consider the Committee Print and Committee Report on Bill 17-934. Chairperson Cheh convened a quorum with Councilmembers Brown and Wells joining her in attendance.

Chairperson Cheh moved for approval of the Committee Print and Report on Bill 17-934, with leave for staff and the General Counsel to make technical corrections and conforming changes. The Committee Print and Report on Bill 17-934 were approved by voice vote, 3-0.

LIST OF ATTACHMENTS

(A) Bill 17-934, as introduced
(B) Notice of Intent to Act, published in the *District of Columbia Register*
(C) Public Hearing Notice, published in the *District of Columbia Register*
(D) Public Hearing Agenda and Witness List
(E) Committee Print of Bill 17-934
(F) Fiscal Impact Statement on Bill 17-934
(G) Testimony submitted to the Committee