GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF INSURANCE, SECURITIES AND BANKING

IN THE MATTER OF	)	
Surplus Review and Determination for Group Hospitalization and Medical Services, Inc.	)	Order No.: 14-MIE-016

DECISION AND ORDER ON GROUP HOSPITALIZATION AND MEDICAL SERVICES, INC. PLAN

In accordance with the Hospital and Medical Services Corporation Regulatory Act of 1996, effective April 9, 1997 (D.C. Law 11-245; D.C. Official Code § 31- 3501 *et seq.* (2012 Repl.)) ("Act"), the Commissioner of the District of Columbia Department of Insurance, Securities and Banking ("Commissioner") has reviewed the plan submitted by Group Hospitalization and Medical Services, Inc. ("GHMSI") on March 16, 2015 pursuant to the Decision and Order, Order No. 14-MIE-012 (Dec. 30, 2014), available at http://disb.dc.gov/node/974472 ("December 30 Order"), which required GHMSI to submit a plan "for dedication of . . . [its] excess [2011 surplus] to community health reinvestment in a fair and equitable manner." *See* D.C. Official Code § 31-3506(g) (2012 Repl.).

The Commissioner rejects the plan after concluding that the plan does not comply with the Act for the reasons described herein.

I. BACKGROUND

A. Procedural History

After a multi-year process involving a full-day hearing and thousands of pages of expert reports, statements, and briefs, former Acting Commissioner Chester A. McPherson ("Acting

Commissioner") concluded, in his December 30 Order, that GHMSI's 2011 surplus attributable to the District of Columbia ("District") was "excessive" as defined by the Act. Specifically, the Acting Commissioner concluded that (a) the appropriate level for GHMSI's 2011 surplus was 721% RBC-ACL (approximately $695.9 million); (b) GHMSI's 2011 surplus was excessive because GHMSI's actual surplus as of December 31, 2011 was $963.5 million (998% RBC-ACL); and (c) 21% of GHMSI's 2011 surplus was attributable to the District. *Id.* at 1. The Acting Commissioner determined that $56,213,088.72 is the amount of GHMSI's 2011 excess surplus attributable to the District ("Excess Surplus"). The Acting Commissioner ordered GHMSI to submit "a plan for dedication of the excess surplus attributable to the District to community health reinvestment in a fair and equitable manner . . . ." *Id.* at 66 (citing D.C. Official Code § 31-3506(g) (2012 Repl.) and 26A DCMR § 4603.2). Accordingly, GHMSI was required to submit a plan to dedicate the Excess Surplus to community health reinvestment.

Both GHMSI and the D.C. Appleseed Center for Law and Justice, Inc. ("Appleseed") filed motions for reconsideration of the December 30 Order. *See* D.C. Appleseed's Motion for Reconsideration (Jan. 9, 2015), available at http://disb.dc.gov/node/979552; Motion for Reconsideration and Coordinated Proceedings with Maryland and Virginia (Jan. 22, 2015), available at http://disb.dc.gov/node/989312 ("GHMSI Motion for Reconsideration"). The Acting Commissioner denied both motions. *See* Order on Appleseed's Motion for Reconsideration and GHMSI Request for Briefing Schedule on Reconsideration, Order No. 14-MIE-013 (Jan. 15, 2015), available at http://disb.dc.gov/node/983352; Order on GHMSI's Motion for Reconsideration and Coordinated Proceedings with Maryland and Virginia, and on D.C. Appleseed's Request for Briefing Schedule, Order No. 14-MIE-014 (Jan. 28, 2015), available at http://disb.dc.gov/node/992412.

On January 29, 2015, GHMSI and Appleseed filed Petitions for Review of the December 30 Order with the District of Columbia Court of Appeals ("Court of Appeals"). GHMSI also petitioned for review of the Order denying its motion for reconsideration. In light of these appeals, GHMSI requested that the Acting Commissioner stay all further proceedings in this matter – including the filing of a plan – until after the appeals' resolution. The Acting Commissioner denied GHMSI's motion. *See* Order on GHMSI's Motion to Stay Further Proceedings and Appleseed's Request for Briefing Schedule, Order No. 14-MIE-015 (Mar. 2, 2015), available at http://disb.dc.gov/node/1019482.

The Court of Appeals dismissed the appeals as having been taken from a non-final and non-appealable order, reasoning that the Commissioner had not yet reviewed GHMSI's plan and thus the "administrative process is not yet complete, and no specific, enforceable obligations regarding the excess assets have been imposed on GHMSI." Order, Appeal Nos. 15-AA-108 and 15-AA-109 (D.C. Ct. App. Apr. 28, 2015), available at http://disb.dc.gov/node/1056192.

B. The Plan and Responses to It

On March 16, 2015, GHMSI submitted a plan "pursuant to the instruction" in the December 30 Order. *See* Plan of Group Hospitalization and Medical Services, Inc. filed with the Department of Insurance, Securities and Banking Pursuant to December 30, 2014 Order No. 14-MIE-012 (Mar. 16, 2015), available at http://disb.dc.gov/node/1028982 ("Plan"). In the Plan, GHMSI argues that no distribution of surplus is required. In brief, GHMSI maintains that no distribution is needed because there was not excess surplus, and alternatively, since 2011, GHMSI has spent more than the excess surplus attributable to the District in community health reinvestment in addition to incurring underwriting losses and experiencing a decline in surplus. GHMSI also argues, among other things, that the Department of Insurance, Securities and

Banking ("Department") did not sufficiently coordinate with Maryland and Virginia before issuing the December 30 Order.

The Department received and considered materials addressing the Plan, including correspondence from Appleseed. *See* Appleseed Letter to Commissioner (March 9, 2015), available at http://disb.dc.gov/node/ 1024882, and Appleseed Letter to Commissioner (May 13, 2015), available at http://disb.dc.gov/node/1064632 (advocating for public hearing);[1] Appleseed Letter to Commissioner (March 25, 2015), available at http://disb.dc.gov/node/1034262 (arguing that the Plan does not comply with the December 30 Order or District law). GHMSI responded to Appleseed by arguing that it has complied with the December 30 Order and that Appleseed mischaracterized the law and misstated the facts. *See* Statement of Group Hospitalization and Medical Services, Inc. in Support of its March 16, 2015 Plan (Apr. 6, 2015), available at http://disb.dc.gov/node/1043412. The Commissioner also considered the Virginia Report to the extent it was relevant to the issues presented by the Plan. Finally, the Commissioner reviewed GHMSI's public rate filings submitted to the Department.

II. STANDARD OF REVIEW

The Act mandates that, if the Commissioner determines that GHMSI's surplus attributable to the District is excessive, then "the Commissioner shall order the corporation to submit a plan for dedication of the excess to community health reinvestment in a fair and equitable manner." D.C. Official Code Section 31-3506(g) (2012 Repl.). The Acting Commissioner determined that GHMSI's 2011 surplus was excessive. Accordingly, the Acting Commissioner instructed GHMSI to "submit to . . . a plan for dedication of the excess surplus

[1]The Commissioner considered the suggestion that he hold a public hearing on GHMSI's Plan. A public hearing is not required by law. The Commissioner determined that a public hearing would not advance or otherwise assist the evaluation of the Plan.

attributable to the District to community health reinvestment in a fair and equitable manner . . . ." December 30 Order at 66. To comply with the Act's mandate as reflected in the December 30 Order, the Plan must satisfy the following criteria:

First, the Plan must address the excess surplus by dedicating it to "community health reinvestment." D.C. Official Code § 31-3506(g)(1). In other words, in light of the Act's definition of "community health reinvestment," the Plan must consist of "expenditures that promote and safeguard the public health or that benefit current or future subscribers, including premium rate reductions."[2] D.C. Official Code § 31-3501(1A).

Second, the Plan must dedicate the excess surplus to community health reinvestment "in a fair and equitable manner." D.C. Official Code § 31-3506(g)(1).

III. PLAN EVALUATION

GHMSI's Plan does not comply with statutory requirements. Rather than presenting a plan for dedication of its excess surplus to community health reinvestment, GHMSI argues that it did not have excess surplus in 2011, and even if it did, it need not make any expenditures for community health reinvestment because "no further reduction in GHMSI surplus attributable to the District would be appropriate" in light of developments since 2011 and other factors. *See* Plan at 4. Specifically, GHMSI cites (a) underwriting losses incurred and expenditures made between 2012 and 2014; (b) an allocation theory purportedly resulting in a decline in "District-specific surplus"; and (c) a purported lack of coordination with other jurisdictions which made the December 30 Order defective. The Commissioner cannot accept any of GHMSI's arguments

[2] GHMSI had the option of crafting a plan for excess surplus that "consist entirely of expenditures for the benefit of current subscribers . . . ." D.C. Official Code § 31-3506(g)(2).

as justification for GHMSI's failure to set forth a plan as required by the Act and the December 30 Order for the reasons detailed below.

A. GHMSI's Plan Does Not Fulfill Statutory Criteria.

The "core" of the Plan is GHMSI's argument that it already has reduced its surplus attributable to the District by more than the approximately $56 million required under the December 30 Order based on expenditures and underwriting losses between 2012 and 2014. Specifically, GHMSI claims (a) $62 million in underwriting losses attributable to the District; (b) $50 million in community giving, open enrollment subsidies, and HealthCare Alliance funding; and (c) nearly $30 million in premium rate reductions and moderation. Plan at 4-5. The Commissioner evaluates each of these categories in light of the criteria specified by the Act.

1. Underwriting Losses

To the extent GHMSI contends that its underwriting losses between 2012 and 2014 should be credited to its Plan,[3] the Commissioner must reject that assertion because such losses, by themselves, do not constitute "community health reinvestment." Under the Act, a compliant plan must dedicate excess surplus to community health reinvestment. *See* D.C. Official Code § 31-3506 (g) (2012 Repl.). In this context, the term "community health reinvestment" means "expenditures that promote and safeguard the public health or that benefit current or future subscribers, including premium rate reductions." *Id.* at § 31-3501(1A). Underwriting losses do not promote and safeguard the public health. Nor do they necessarily benefit current or future

[3] GHMSI states that, between 2012 and 2014, it incurred $62 million in underwriting losses attributable to the District. Plan at 4.

subscribers. Thus, underwriting losses, by and of themselves, are not community health reinvestment.[4]

It also is important to recognize that the analysis the Acting Commissioner conducted of GHMSI's 2011 surplus to determine whether it is excessive was based on reasonable projections of GHMSI's post-2011 performance, including the possibility of underwriting losses. *See, e.g.*, December 30 Order at 30, 39 (discussing modeling generally and the rating adequacy and fluctuation risk factor in particular).[5] In other words, the fact that GHMSI experienced underwriting losses does not change the Acting Commissioner's determination that the 2011 surplus was excessive. Nor does it change the Act's mandate that GHMSI submit a plan for the dedication of the excess surplus to community health reinvestment.

If GHMSI were experiencing losses that placed the company's solvency in question and that were not included in the surplus review analysis, the Commissioner could revisit the December 30 Order with respect to the requirement of GHMSI to dedicate the $56 million of excess surplus, or simply address the losses through the enforcement of the Plan . But no such losses have occurred. The company's total net loss between 2012 and 2014 was $15 million. Plan at Table 1. This amount is, to say the least, an extremely small negative margin (0.15%) on GHMSI's total revenues of $9.68 billion over the same period. *See id.* By any reasonable standard, GHMSI has been operating on a break-even basis or very nearly so. Indeed, as GHMSI testified at the surplus review hearing, because the company is a nonprofit entity, it

[4] The Commissioner does, however, recognize that some rate reductions that are intended to result in negative contribution to surplus may constitute community health reinvestment, as discussed further in Section III.A.3 below.

[5] In addition, the Acting Commissioner heard testimony on GHMSI's underwriting losses. Hearing Tr. 175:13-15 (GHMSI representative G. Mark Chaney testified that, since 2009, GHMSI had averaged about $25 to $30 million in underwriting losses).

"[l]argely seek[s] only to break even with a small margin that would keep us financially sound." Hearing Tr. at 109:19-20. GHMSI has essentially met that goal. Accordingly, the Commissioner, based on the information in the Plan, does not view GHMSI's small net loss as a material impediment to preparing and executing a plan.

2. Community Giving, Open Enrollment Subsidies and HealthCare Alliance Funding

According to the Plan, between 2012 and 2014 GHMSI provided $11 million in direct community giving, $24 million in subsidies for the District's open enrollment program and $15 million in funding for the District's HealthCare Alliance Program. Plan at 5-6. GHMSI's reported expenditures in these categories were very consistent from year to year. *See* Plan, Exhibit 3.[6] While GHMSI's continued community giving is commendable; this giving, even when combined with its statutorily mandated support of the open enrollment and HealthCare Alliance programs,[7] does not satisfy the Act's requirement for a plan.

The Act requires that a compliant plan must, among other things, consist of expenditures of excess surplus. D.C. Official Code § 31-3506(g)(2) (2012 Repl.). For two reasons, GHMSI's expenditures for community giving, open enrollment subsidies and HealthCare Alliance funding do not meet this requirement.

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[6] GHMSI's expenditures in 2011 included $3.4 million for community giving, $5 million for the HealthCare Alliance, and $4.5 million for open enrollment subsidies. Between 2012 and 2014, GHMSI's annual community giving varied between $3.4 million and $3.9 million; funding for the HealthCare Alliance was even more consistent, at $5 million per year, each year; and open enrollment subsidies varied between $7.5 million and $10.3 million annually, but also were fairly consistent over time. *See* Plan, Exhibit 3.

[7] *See* D.C. Official Code § 31-3514 (requiring a hospital and medical services corporation to make an open enrollment program available to District citizens); *id.* at § 31-3505(e)(2) (requiring a hospital and medical services corporation to enter into a public-private partnership as a condition of receiving a certificate of authority to operate in the District).

First, as annual, programmatic, and, in the case of open enrollment and the HealthCare Alliance, compulsory, expenses, these GHMSI's expenditures are drawn directly from subscriber premium dollars. Thus, they do not constitute expenditures of excess surplus.

Second, the Acting Commissioner's review of GHMSI's surplus took into account all of the GHMSI's likely and planned obligations, including annual expenditures for community giving, open enrollment subsidies and the HealthCare Alliance. Indeed, the Act required the Acting Commissioner to consider GHMSI's open enrollment subsidies and HealthCare Alliance funding in making his determination. D.C. Official Code § 31-3506(f). In other words, the excess surplus identified by the Acting Commissioner was surplus over and above the amount of surplus necessary to meet these and other obligations of GHMSI. Accordingly, such expenditures cannot constitute expenditures of excess surplus.

3. Rate Reductions and Moderation

In order for rate reductions to be part of a compliant plan, they must constitute "expenditures that promote and safeguard the public health or that benefit current or future subscribers, including premium rate reductions." D.C. Official Code § 31- 3501(1A) (2012 Repl.). This definition thus expressly includes premium rate reductions, so long as such reductions benefit current or future subscribers.

GHMSI's Plan seeks credit for nearly $30 million in claimed rate reductions and moderation since 2011. Plan at 5. Based on the Plan, the Commissioner is unable to credit GHMSI for these rate adjustments towards its community reinvestment obligations under the December 30 Order.

GHMSI states that it undertook these reductions and moderation in rates in an effort to reduce its surplus, which had climbed to 1098% RBC at year-end 2010 due to unanticipated

favorable claims experience that year. Plan at 5. As a practical, mathematical matter, if a company lowers rates when its costs are lower than expected, then there should be little or no impact on the company's surplus – it should be a (close to) zero sum exercise. Thus, while GHMSI may have undertook the adjustments to keep its rates in line with its costs, it offered no evidence that such reductions also served to reduce its surplus for the year end 2011. As such, the reductions cannot constitute community health reinvestment. *See also* December 30 Order at 60-61 (addressing consideration of rate reductions in surplus review).

In more closely reviewing GHMSI's rate filings, however, the Commissioner believes that there may be a portion of rate adjustments that could be quantified and reasonably characterized as expenditures of excess surplus for the benefit of subscribers. In some cases, the rates filed by GHMSI reflected a "negative contribution to surplus." Rate adjustments which are "negative contribution to surplus" appear to be part of a deliberate effort to reduce surplus for the benefit of subscribers and therefore could be credited as community health reinvestment in compliance with the Act. The Commissioner would have been willing to consider "negative contributions to surplus" in the District as community health reinvestment, had GHMSI identified these specific amounts and referenced specific rate filings and/or other supporting documentation.

B. GHMSI's Arguments Concerning Attribution of Surplus are Irrelevant to the Evaluation of the Plan.

In the Plan, GHMSI also argues that no further surplus reduction is needed because, according to its newly-presented calculations, its surplus attributable to the District would have been reduced by more than $56 million by the end of 2015. To reach this conclusion, GHMSI disregards its surplus as a whole and offers its own, new calculations of what it characterizes as "District-specific surplus" and "District-specific RBC." Plan at 4-5. In light of its calculations,

GHMSI suggests that there no longer is any excess surplus attributable to the District. *See* Plan at 5.

This line of reasoning is based on the argument, first articulated in the GHMSI Motion for Reconsideration, that the Commissioner must first attribute surplus to the District and only then determine whether the District-specific surplus is excessive. *See* GHMSI Motion for Reconsideration at 3-4, 10-13. Essentially, GHMSI argues that the Acting Commissioner erred in his finding of excess surplus as result of his failure to properly attribute surplus and risk to the District. This argument is irrelevant to the determination of whether GHMSI has filed a plan that complies with the Act and the December 30 Order.

In addition to its irrelevance to the Plan, the Acting Commissioner rejected this argument with respect to his finding of excess surplus. First, as the Acting Commissioner explained in his Order denying the GHMSI Motion for Reconsideration, GHMSI could have made this argument at any time during the lengthy proceedings preceding the December 30 Order but chose not do so. Order No. 14-MIE-014 at 2. Accordingly, the Acting Commissioner determined that it was not in the public interest or an efficient use of public resources to reconsider the excess surplus determination in light of arguments GHMSI had every opportunity to present previously but did not.

Second, the Acting Commissioner rejected GHMSI's contention that he must first attribute surplus to the District and then evaluate the District-specific surplus to determine whether it is excessive because it was directly contrary to the position GHMSI has repeatedly advocated throughout the surplus review proceedings. The Department's regulations implementing the Act require GHMSI to file an annual financial report with the Commissioner "which details the company's surplus and examines whether the company's surplus is considered

excessive under the Act." 26A DCMR § 4601.1. On June 1, 2012, GHMSI filed the required report with respect to its 2011 surplus, concluding that the surplus was not "excessive" under the test required by Act. CareFirst BlueCross BlueShield, Report on GHMSI Surplus, at 11 (June 1, 2012), available at http://disb.dc.gov/node/311302. In support of this conclusion, GHMSI cited a number of actuarial studies, every one of which, including those commissioned by GHMSI, evaluated the company's surplus *as a whole*.

GHMSI's pre-hearing brief and its testimony at the surplus review hearing similarly reflect GHMSI's view that the proper way to determine whether the company's surplus is excessive under the Act is to evaluate it as a whole. For example, a central subject of inquiry during the hearing was the report prepared for the Acting Commissioner by Rector & Associates evaluating whether GHMSI's 2011 surplus was excessive. Rector & Associates, Inc., Report to the D.C. Department of Insurance, Securities and Banking – Group Hospitalization and Medical Services, Inc. (Dec. 9, 2013), available at http://disb.dc.gov/node/756762 (the "Rector Report"). The Rector Report reviewed GHMSI's surplus as a whole. At the hearing, GHMSI endorsed the Rector Report, calling it "essentially a creditable piece of work" which "represents a sound set of conclusions." Hearing Tr. 101:13-15.

Perhaps the clearest statement of GHMSI's position on this issue is found in its response to a question posed by the Acting Commissioner: "Please provide your recommendations regarding how the Commissioner should determine the amount of GHMSI's surplus that is attributable to the District." Third Scheduling Order, Order No. 14-MIE-005 (Aug. 7, 2015), available at http://disb.dc.gov/node/878702. In response, GHMSI stated,

> GHMSI recommends that the Commissioner not address the attribution of GHMSI's surplus at this time. *The Commissioner is not required to address attribution unless he concludes that GHMSI's surplus, as a whole, is excessive*. Both Rector and Milliman have determined that GHMSI's

> year-end 2011 surplus was not excessive as a whole, based on detailed analyses that follow sound actuarial practice. The Commissioner should make the same finding for all the reasons set forth in GHMSI's testimony, Pre-Hearing Report, and other filings.

Group Hospitalization and Medical Services, Inc.'s Further Response to Questions in the Third Scheduling Order and Statement Regarding Attribution, at 1 (Oct. 10, 2014) (emphasis added), available at http://disb.dc.gov/node/920962. GHMSI's Plan now turns this statement on its head.

The Acting Commissioner also declined to adopt the unprecedented approach to surplus attribution and review urged in the GHMSI Motion for Reconsideration because it would be contrary to the Act and any sound analysis of the company's surplus. The Act states: "In determining whether the surplus of the corporation that is attributable to the District is excessive, the Commissioner shall take into account all of the corporation's financial obligations arising in connection with the conduct of the corporation's insurance business . . . ." D.C. Official Code § 31-3506(f) (2012 Repl.). Thus, the Acting Commissioner found that the Act itself therefore requires an examination of the surplus as a whole.

Moreover, the concepts of financial soundness and efficiency that underpin the surplus review reasonably require an examination of the surplus as a whole in the first instance. Following guidance from the Court of Appeals, the Acting Commissioner interpreted the Act to require him to evaluate GHMSI's surplus by determining the amount of surplus that is large enough to be consistent with financial soundness and efficiency, but no larger. December 30 Order at 15-16. It makes no sense to evaluate the company's surplus for financial soundness on any basis other than as a whole. GHMSI's surplus is maintained against all risks and contingencies the company may encounter, regardless of origin. Accordingly, any risk or contingency, if incurred, will affect the company's surplus as a whole. Thus, the Acting

Commissioner determined that the only rational way to evaluate the surplus for solvency is to review it as a whole.

Similarly, the only reasonable way to evaluate the surplus for efficiency – *i.e.*, whether it is neither so high as to be wasteful of a company's resources nor so low as to render the company unable to respond to reasonable risks and contingencies – is as a whole. *See* December 30 Order at 20-21 (discussing role of efficiency in evaluating surplus). Because the concepts of financial soundness and efficiency only have meaning when applied to the surplus as a whole, any other interpretation would lead to unreasonable and absurd results.

In short, the Acting Commissioner, in his review and evaluation of GHMSI's surplus, concluded that the Act requires that GHMSI's surplus first be evaluated as a whole to determine whether it is excessive and only if any excess is found, then evaluated to determine how much of the excess is attributable to the District. This is not to say that if and when the surplus is determined to be excessive, as the December 30 Order has done, the excess cannot be apportioned in a reasonable way by jurisdiction to determine how much excess surplus must be devoted to community health reinvestment. Indeed, the Act requires that this be done. For the reasons stated in the December 30 Order, the Acting Commissioner believed the allocation methodology he adopted – allocating GHMSI's excess surplus based on the geographic location of the business generating the surplus, December 30 Order at 52 – was reasonable and consistent with the letter and spirit of the Act.

As a final matter, the Commissioner acknowledges that GHMSI's surplus as a whole has declined modestly – falling by 0.35% – since 2011, from $964 million at year-end 2011 to $960 million at the end of 2015. As with underwriting results, the possibility that GHMSI's surplus might decline was factored into the Acting Commissioner's surplus review. The small reduction

in surplus experienced by GHMSI does not change the Acting Commissioner's determination that the 2011 surplus was excessive. Moreover, the reduction in surplus does not relieve GHMSI of its obligation to submit a plan for dedication of the excess to community health reinvestment.[8]

C. GHMSI's Argument that the December 30 Order was Erroneous Because the Acting Commissioner Failed to Coordinate His Surplus Review is Irrelevant to the Evaluation of the Plan.

GHMSI's Plan seeks to revisit an issue previously raised in challenging the December 30 Order, which required GHMSI to submit a plan as required by the Act. Specifically, GHMSI asserts that the Commissioner did not properly coordinate with Maryland and Virginia in reviewing GHMSI's surplus and arriving at the determination that it is excessive. *See* Plan at 6-7; *see also* GHMSI Motion for Reconsideration at 2-3. Similar to its attribution argument referenced in Section III.B above, this argument is not relevant to the single question at hand: Has GHMSI submitted a plan to dedicate its excess surplus to community health reinvestment in a fair and equitable manner? Whether the Acting Commissioner failed to appropriately coordinated with other regulators does not relieve GHMSI from submitting the required plan or prevent the Commissioner from determining whether the Plan complies with the Act and December 30 Order.

In addition to being irrelevant, the Acting Commissioner considered and rejected this argument challenging his finding of excess surplus under the Act and upheld the determinations he made in his December 30 Order. The Acting Commissioner concluded that he fully complied with the statutory mandate to coordinate with the other jurisdictions in which GHMSI conducts business and to "consider the interests and needs of the jurisdictions in the corporation's service area." D.C. Official Code §§ 31-3506(e), 31-3506.01(b) (2012 Repl.).

[8] While GHMSI is mandated to file a plan, it could have fashioned its plan to factor-in any reduction in surplus with respect to is community health reinvestments.

The Acting Commissioner and his staff communicated with the Maryland and Virginia insurance commissioners and their staff, including through correspondence advising them of the surplus review hearing and soliciting their participation. The Acting Commissioner would have welcomed live testimony from other regulators, but they chose instead to submit written statements. The Acting Commissioner specifically solicited input from the Maryland and Virginia insurance commissioners after the hearing, and carefully considered the written statements that they submitted in response. *See also* December 30 Order at 62-65 (describing coordination efforts). The Acting Commissioner's staff responded to all inquiries from Maryland and Virginia insurance regulators. Virginia regulators reported not that the Department failed to coordinate with them in the surplus review process, but rather that they did not take full advantage of the opportunities presented (and intend to participate more fully in future surplus reviews). *See* Virginia Report at 7.

GHMSI's argument that the Acting Commissioner failed to coordinate seems to rest on an erroneous interpretation of the Act. GHMSI conflates "coordination" with "agreement." *See, e.g.*, GHMSI Motion for Reconsideration at 2 (asserting that "coordination" under the Act "requires Maryland, Virginia and the District to come to agreement regarding the many multi-jurisdictional issues relating to GHMSI's surplus."); Plan at 6-9.[9] However, nothing in the Act suggests that the Commissioner must come to agreement with regulators in Maryland and Virginia in determining whether GHMSI's surplus is excessive or in determining the proper attribution of surplus among jurisdictions. To the contrary, the Act vests sole authority in the Commissioner to make these determinations. The Act states GHMSI's "surplus may be

[9] GHMSI appeared to recognize the weakness in its own legal argument when it sought an amendment to GHMSI's congressional charter requiring agreement among the jurisdictions for any distribution of surplus.

considered excessive only if . . . *the Commissioner* determines that the surplus is unreasonably large and inconsistent with corporation's obligation" to engage in community health reinvestment. D.C. Official Code § 31-3506(e) (emphasis added). Similarly, the Act entrusts to the Commissioner alone the determination of how much surplus is attributable to the District. *Id.* at § 31-3506(f), (h). The Commissioner may not cede authority to other jurisdictions in making these determinations.

Furthermore, the notion that all affected jurisdictions must come to agreement on the determinations required by the Act is directly contrary to the Act's purpose and intent. The Act requires the Commissioner to apply a specific standard to determine whether GHMSI's surplus is excessive. This standard is unique to the District and provides that the surplus may be considered excessive only if it is "unreasonably large and inconsistent with the corporation's obligation" to engage in community health reinvestment to the maximum feasible extent consistent with financial soundness and efficiency. D.C. Official Code § 31-3506(e). The Act does not permit the Commissioner to employ any other standard, as likely would be required to reach agreement with Maryland and Virginia.[10] The Commissioner has no authority under the Act to substitute Maryland's standard, or any standard Virginia may adopt, for the District's own.

Rather than requiring agreement, the Act directs the Commissioner to coordinate with Maryland and Virginia and consider their interests and needs, which is what the Acting Commissioner determined that he did. As detailed above, the Acting Commissioner solicited the advice and consultation of insurance regulators in Maryland and Virginia before, during and after

[10] Indeed, Maryland has a different standard for surplus review. Under Maryland law, GHMSI's surplus may be considered excessive only if the Maryland Insurance Commissioner determines it is "unreasonably large." Md. Code, Ins. § 14-117(e)(1).

the surplus review hearing. The Acting Commissioner stated that he carefully considered all input received from Maryland and Virginia insurance regulators in reaching the decisions reflected in the December 30 Order. Throughout these proceedings, the Acting Commissioner sought to balance the interests and needs of Maryland and Virginia, as articulated by their regulators and evaluated by the Acting Commissioner, with the interests and needs of the District and the requirements of the Act. Notably, Virginia regulators acknowledged that the December 30 Order "was thorough and deliberative" and they did *not* recommend taking action against distribution of GHMSI's excess surplus attributable to the District. Virginia Report at 7. Virginia regulators also recommended "taking a more active role in coordinating with the Department as well as the Maryland Insurance Administration on future actions related to GHMSI's surplus. In particular, participating in the next surplus review of GHMSI, either as a party or participant, would be beneficial." *Id.* The Commissioner welcomes greater input and participation by the Virginia and Maryland insurance regulators in future surplus reviews.[11]

IV. CONCLUSIONS AND ORDER

For the reasons detailed above, the Commissioner concludes that GHMSI's Plan does not comply with the Act because it does not dedicate to community health reinvestment the company's excess surplus attributable to the District. The Commissioner therefore finds that GHMSI failed to submit a plan as ordered by the Acting Commissioner under D.C. Official Code § 31-3506(g) (2012 Repl.).

[11] Any future surplus review process may be impacted by the amendment to GHMSI's corporate charter that was enacted by Section 747 of the Consolidated Appropriations Act, 2016 (Pub. Law 114-113). That amendment provided in part that with respect to GHMSI's surplus for any year after 2011, "[t]he corporation shall not divide, attribute, distribute, or reduce its surplus . . . without the express agreement of the District of Columbia, Maryland, and Virginia . . . that the entire surplus of the corporation is excessive . . . and . . . to any plan for reduction or distribution of surplus.''

Under these circumstances, the Act provides:

> If the Commissioner determines that the corporation failed to submit a plan as ordered under subsection (g) of this section within a reasonable period or failed to execute within a reasonable period a plan already submitted . . . the Commissioner shall deny for 12 months all premium rate increases for subscriber policies written in the District . . . and may issue such orders as are necessary to enforce the purposes of this chapter.

D.C. Official Code § 31-3506(i). *See also* 26A DCMR § 4603.3 (allowing denial of rate increase "until the company complies with the order" to submit a plan in accord with the statute).

Accordingly, the Commissioner ORDERS:

1. Effective immediately, all requests for premium rate increases for subscriber policies written by GHMSI in the District are hereby denied for 12 months from the date of this Order, or until the Commissioner develops and approves a plan pursuant to this Order, whichever occurs first;
2. Pursuant to his authority to issue such orders as are necessary to enforce the purposes of the Act, the Commissioner shall develop and approve a plan for GHMSI to dedicate the excess surplus determined by the December 30 Order in a fair and equitable manner after providing a 30-day period of public comment beginning on the date of this Order;
3. There shall be a 30-day period of public comment beginning on the date of this Order for the public to provide written comments on the plan to be developed by the Commissioner pursuant to this Order, and persons providing comments are asked to include comments that specifically address the following issues:

    a. Length of time for the dedication of the excess surplus;

    b. Whether the Patient Protection and Affordable Care Act, 42 U.S.C. §§ 18001 *et seq.* should impact the timing of the dedication of the excess surplus;

c. Whether the amount of excess surplus to be dedicated should be offset by any reduction in surplus between December 31, 2011 and December 31, 2015;

d. Whether the dedication of excess surplus should be suspended or modified in the event that adverse conditions reduce GHMSI's surplus. If yes, describe the types of adverse conditions that should be considered;

e. Whether the dedication of excess surplus could be modified pursuant to future reviews of GHMSI's surplus;

f. Whether rebates to current or past policyholders would be an appropriate expenditure for community health reinvestment;

g. Whether there were any negative contributions to surplus made by GHMSI that should be taken into account for the plan; and

4. No later than 30 days after the expiration of the public comment period set forth in this Order, the Commissioner shall issue and approve a plan to dedicate the excess surplus to community health reinvestment in a fair and equitable manner.

Dated: June 14, 2016

Stephen C. Taylor
Commissioner
Department of Insurance, Securities and Banking

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