Appendix C

Excess Surplus Review hearing of
Group Hospitalization and Medical Services, Inc.

District of Columbia Department of Insurance, Securities, and Banking

Rebuttal Statement and Analysis

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This statement addresses five issues that were raised in the hearings conducted by the Commissioner of Insurance, Securities, and Banking on September 10 and 11, investigating whether GHMSI's surplus is consistent with its obligations under the Medical Insurance Empowerment Amendment Act (MEIAA) of 2008. Specifically:

- Whether GHMSI has sufficiently demonstrated to the Commissioner and the public that GHMSI's level of surplus is consistent with its obligation to devote resources to benefit the community—including but not necessarily limited to its policy holders—to the maximum extent feasible and consistent with the company remaining financially sound.[1]
- Whether GHMSI's surplus in fact exceeds that of comparable companies—in particular, comparable companies in Pennsylvania, where the Commissioner of Insurance also conducts annual surplus review and specifies an efficient surplus range for each of the four regional Blue Cross/Blue Shield companies in the state.
- Whether GHMSI's unusual and substantial increase in nonadmitted assets in 2008, continuing through March 2009, in effect reduce GHMSI's stated surplus.
- Whether GHMSI's rate of charitable giving is comparable to that of other nonprofit insurers.
- How GHMSI might meet both its obligations under MIEAA and its responsibility to policyholders without disrupting the insurance market.

A. GHMSI DISCLOSURE TO THE COMMISSIONER AND THE PUBLIC

Public review and evaluation of the findings that Milliman reached in its analysis of GHMSI's "optimal" surplus level is made difficult by the general nature of Milliman's public documentation. The Milliman report does not make clear all of the assumptions that are used or how key assumptions (such as GHMSI's own experience) are factored into the model and, therefore, embedded in their findings. Moreover, neither the report nor testimony by GHMSI officials address how Milliman's" optimal" surplus range relates to the "maximum feasible" criterion for the company's surplus that the MEIAA establishes.

While more detailed documentation has apparently been made available to regulators in the District and in Maryland (Robert Dobson, September 10 statement, page 56), sufficient

[1] D.C. Code § 31-3505.01. Covington and Burling provides a legal analysis of the "maximum feasible" standard and its application to the surplus review in its Sept. 10, 2009 submission and in the attached memorandum. Notably, GHMSI's actuarial consultant, Milliman, admitted that its study of the company's "optimal surplus" did not consider the maximum feasible obligation required by the MIEAA (see Hearing Transcript Sept. 10 at 197).

information to judge the appropriateness of Milliman's underlying assumptions has not been made available to the public nor to qualified actuaries such as Actuarial Risk Management (ARM), whom DC Appleseed engaged on behalf of the public. Consequently, ARM and I, respectively, have been forced to speculate how Milliman might reasonably have used various assumptions that its report did disclose. We have raised serious concerns about what Milliman actually did, but few of these concerns have been resolved, either in the course of the September hearings or in the very little information that GHMSI or Milliman subsequently have made available to either the public or experts engaged on behalf of the public.

MIEAA anticipates that the Commissioner would engage independent experts to review GHMSI's surplus, and that has occurred. The process that the Commissioner has established in this initial review in compliance with MIEAA, including the high quality of experts she has engaged, is critical to the integrity of the process and the public trust. However, in future years, I would urge the Commissioner to consider broadening this review, providing full information on a confidential basis, as may be needed, to other qualified experts such as ARM, who operate under strict professional ethical standards and have been retained by well-established, credible organizations acting in the public interest.

Finally, legislation under consideration by the City Council (B18-401 "Hospital and Medical Services Corporation Regulatory Amendment Act of 2009") would amend MIEAA's provisions, reducing the frequency of mandatory review of GHMSI's surplus to every third year, with the option of an annual review at the Commissioner's discretion. It is likely that subsequent annual reviews would represent a lower burden for the Department than this initial review—and indeed, the annual surplus determinations made in Pennsylvania are obviously not as costly to the Department of Insurance as the initial process. However, less frequent review of GHMSI's surplus seems likely to entail repeating the same burden for the Department as this initial review, unless the Department requires that GHMSI disclose on an annual basis all of the information that would underlie a full review. Therefore, I would strongly urge the Commissioner to consider regulation requiring annual disclosure of all information material to a full surplus review of GHMSI's surplus, even if MIEAA is amended to permit less frequent full review by the Commissioner.

B. GHMSI'S SURPLUS EXCEEDS THAT OF COMPARABLE COMPANIES

GHMSI's surplus is very high compared with comparable companies. In my August 31 statement, I drew four comparison companies from ARM's study conducted for DC Appleseed, based on comparable levels of authorized control level (ACL) risk-based capital. ACL levels for the companies ranged from $77 million to $106 million, compared with $81 million for GHMSI. Their surplus ratios ranged from 384 percent (Horizon Healthcare of New Jersey) to 563 percent, compared with 845 percent for GHMSI.

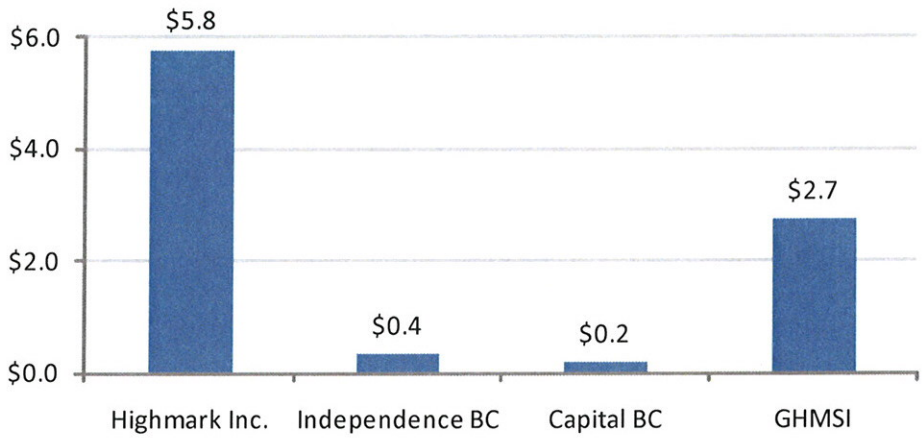
During the surplus review hearing on September 10, Mr. Rector asked me to offer an analysis comparing GHMSI's surplus to the four Blue Cross plans in Pennsylvania (Transcript, Sept. 10 at 352). Mr. Rector's request was pursuant to my expressing under questioning puzzlement about Mr. Chet Burrell's statement in testimony offered to DISB that, in Pennsylvania, Capital Blue Cross is most similar to GHMSI (September 10 transcript page 44, lines 17-21).

In fact, Mr. Burrell's representation is inaccurate:

- Capital Blue Cross serves a largely rural area of central Pennsylvania: the average population density in Capital's 21-county service area is 303 people per square mile, compared with 2,502 persons per square mile in GHMSI's service area. Because there is relatively little competition among providers in rural areas, insurers in these regions have little or no economic advantage in contracting. In contrast, Highmark (which serves the Pittsburgh metropolitan area) and Independence (which serves the Philadelphia metropolitan area) are much more similar to GHMSI in terms of population and provider density, contracting advantages, and market demographics. These differences between rural and urban areas obviously affect carrier risk and therefore bear directly on the levels of surplus necessary for financial soundness and efficiency. Notably, Pennsylvania's Insurance Commissioner grouped Capital Blue Cross with Blue Cross of Northeastern Pennsylvania, which also serves a relatively rural area of the state, in establishing its efficient surplus range. Similarly, Highmark was grouped with Independence—both serving large metropolitan areas similar to the National Capital Area—to establish those companies' efficient surplus range.

- Capital Blue Cross reports net premiums that are a fraction of GHMSI's (Figure 1). Instead, Highmark and Independence bracket GHMSI in terms of both net premiums—a measure of carrier size that is broadly consistent with the level of surplus necessary for financial soundness and efficiency. For both of these companies, Pennsylvania has determined an efficient range of surplus between 550 percent and 750 percent of ACL, compared with GHMSI's 845 percent.

Figure 1
Net Premiums of the Largest Pennsylvania BCBS Plans and GHMSI, 2008
($ Billions)



Source: National Association of Insurance Commissioners, Consumer Information Source (https://eapps.naic.org/cis/).

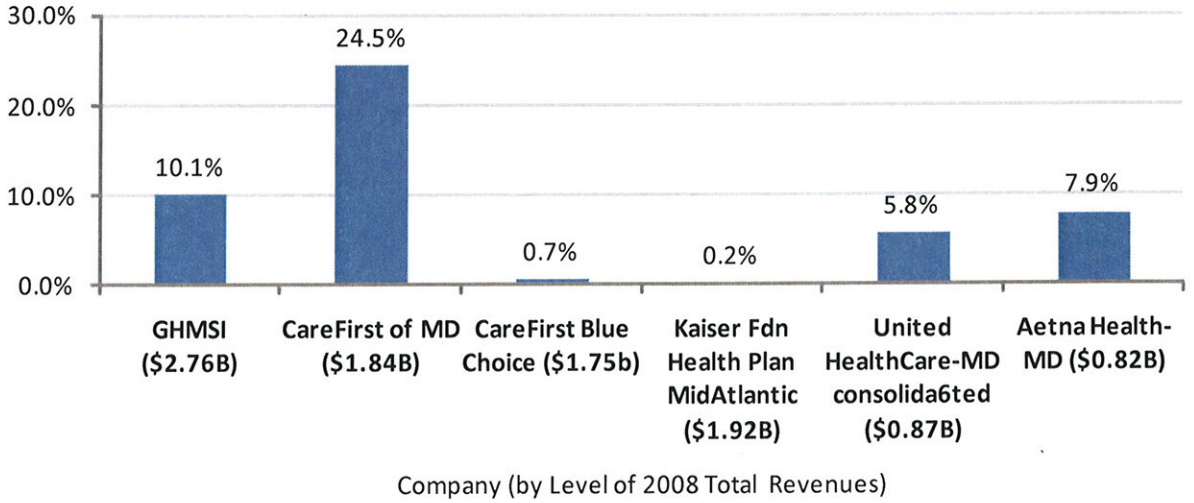
C. GHMSI'S ALLOCATION OF SUBSTANTIAL ASSETS TO NONADMITTED STATUS REDUCED ITS STATED SURPLUS RATIO.

In testimony before DISB on September 10, Mr. Mark Chaney stated that GHMSI's 2008 change in accounting practice, allocating significant assets to nonadmitted status, had "no impact on statutory surplus" but represented a "more comprehensive presentation" of total assets that, Mr. Chaney's statement implies, GHMSI had not reported at all in earlier years (September 10 transcript page 159, lines 13-19).

It is difficult for the public to judge the appropriateness of GHMSI's creating a nonadmitted tax-deferred asset for the purpose of pension funding. However, it is notable that GHMSI's development of nonadmitted assets (and similarly, the creation of new nonadmitted assets by CareFirst of Maryland) is unusual among its competitors. Calculated relative to total revenues (a basis for understanding the company's pension obligations and other potential liabilities), both GHMSI and CareFirst of Maryland held unusually high levels of nonadmitted assets in 2008. Only Aetna showed a similar pattern of high net tax-deferred assets and unspecified nonadmitted assets, but at much lower total levels and still less relative to revenues than either GHMSI or CareFirst of Maryland (Figure 2).

Moreover, only part of GHMSI's net 2008 nonadmitted assets are explained: approximately $70 million are not related to pension funding, but instead are reported as "other unspecified" nonadmitted assets. Because GHMSI has provided no information to support understanding how the formation of these assets did *not* reduce GHMSI's stated 2008 surplus, it is reasonable to presume that they did. At a minimum, therefore, it is important that the Commissioner scrutinize these nonadmitted assets to ensure that GHMSI is compliant with MIEAA. The fact of auditor approval does not at all determine whether these assets should be deemed non-admitted for purposes of applying MIEAA, with its standard of maximum feasible community reinvestment consistent with financial soundness and efficiency.

Figure 2
Nonadmitted Assets as a Percent of Total Revenues:
Major Companies in the National Capital Area, 2008



Source: Company annual statements.

D. GHMSI'S RATE OF GIVING IS LOWER THAN COMPARABLE COMPANIES.

In its 2008 Community Benefit Report, Kaiser Permanente (which includes Kaiser Foundation Health Plan) reported expenditures of more than $28.9 million in the Mid-Atlantic States in 2008—equal to more than 1.5 percent of Kaiser Foundation Health Plan's total revenues. Kaiser Foundation Health Plan does not pay premium taxes in the District.

In contrast, CareFirst reported contributing $40 million to community benefit in 2008, across all affiliates and across all locations—in Maryland, the District, and northern Virginia. Of this amount, $14 million was attributed to the National Capital Area and, therefore, GHMSI. While GHMSI's community benefit expenditures included voluntary support of various programs and donations, a significant share was required in lieu of premium taxation, including GHMSI's support of the individual open enrollment product in DC (as was required in 2008) net of assets that GHMSI had accumulated for this purpose over the years in lieu of paying the DC premium tax. CareFirst's community benefit (as indicated in its CareFirst Commitment document, available on line) also included corporate memberships and sponsorships (including a House of Representatives Christmas Party; see Burrell, written testimony at 9).

In 2008, GHMSI's community benefit effort across all three jurisdictions in its service area, inclusive of premium taxes and subsidies was just 1 percent of Schedule T total premiums, the frame of reference that Pennsylvania adopted for community reinvestment by Blue Cross and Blue Shield plans and that Mr. Burrell cited in written testimony on Sept. 10. This was substantially less than either Kaiser Foundation Health Plan (1.57 percent) paid, or the 1.6 percent that the Pennsylvania Blues plans contribute (Table 1).

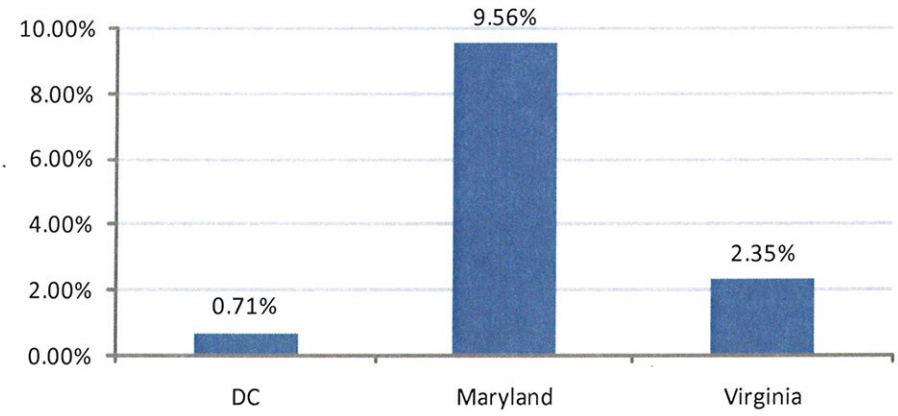
Table 1
GHMSI Community Benefit Inclusive of Tax Payments and Comparison to Kaiser Foundation Health Plan, 2008

	Schedule T Premiums				Community Benefit (including subsidies and premium tax, if any)	(Community Benefit + State & Local Taxes)/ Schedule T premiums
	Total	DC	MD	VA		
Kaiser Fdn Health Plan	$1,838,466,161	$872,886,446	$537,563,514	$428,016,201	$28,930,000	1.57%
GHMSI	$3,126,829,036	$1,966,714,108	$721,455,267	$438,659,661	$31,200,000	1.00%

Source: Company Key Annual Statements, 2008.

In the District, if GHMSI's community reinvestment had been at Kaiser's 1.5 percent level or the 1.6 percent level as is required of the Pennsylvania Blues, its total community benefit (including taxes paid) would have been more than twice what it actually spent in 2008 (Figure 3). In other words, GHMSI would have spent $31.5 million in community benefit and taxes paid, versus the $14.0 million that it actually spent (See Burrell written testimony, Sept 10, at 8).

Figure 3
GHMSI Community Benefit and Tax Payments as a Percent of Schedule T Premiums by Jurisdiction, 2008



Sources: GHMSI Key Annual Statement and Burrell written testimony, September 10, 2009.

E. REMEDY PHASE OF THE COMMISSIONER'S RESPONSIBILITY UNDER LAW

In his statement before the Commissioner on September 11, Mr. Burrell described the only remedy he sees available to GHMSI to reduce surplus in compliance with MIEAA as rate

reduction to current or new subscribers below the level that would meet actual medical and administrative costs. He envisions a "spring back" in premiums, following a short period of below-cost premiums, which he describes as "brutal" (Burrell, Hearing Transcript, September 11, page 42).

However, the strategy to bring excessive surplus into compliance with MEIAA that Mr. Burrell describes would not comply with the standing obligation of the Department of Insurance, Securities, and Banking (DISB) to review and approve rates that are adequate, not excessive, and not unfairly discriminatory. It seems obvious that whatever remedy GHMSI settles on must meet both MIEAA's standard of "maximum feasible" and DISB's standing rules regarding adequate rates. To do otherwise would disrupt competition in the insurance market to an extent that potentially would harm both policy holders and the community.

Moreover, based in large part on Mr. Burrell's own dire predictions, the spend-down plan that Mr. Burrell has imagined arguably would not meet MIEAA's requirement that GHMSI's plan for bringing its surplus into compliance be "fair and equitable." This criterion suggests that a targeted and sustainable rate reduction is more likely to comply with MIEAA's requirement than setting temporary, across-the-board, inadequate rates.[2]

In any case, GHMSI has many alternative, less simplistic remedies at its disposal that would avoid the disruption that Mr. Burrell envisions. For example, assuming that GHMSI could reduce premium growth to a sustainable level for all enrollees, it could reduce premium growth for specific, vulnerable populations—such as enrollees in a guaranteed-issue individual product. Neither would present the disruption that Mr. Burrell envisions. Alternatively or in addition, GHMSI could reduce its surplus by investing in strategies to reduce medical cost—certainly for policy holders but potentially also benefiting the community more broadly. Such strategies might include proactive disease management—establishing best-practice care protocols and 24-hour advice and counseling lines for high-risk diagnoses.

GHMSI also could invest more extensively in disease avoidance—for example, proactively urging policy holders to seek diagnosis, primary care, and counseling for conditions ranging from hypertension to HIV. In addition, it could commission high-quality, scientifically valid "formative" evaluations of its initiatives to reduce medical cost, aimed at both understanding what works and modifying programs to work better. Such initiatives certainly would offer greater benefit to policy holders for the same premium. Moreover, and other payers to understand what initiatives can be successful in reducing cost, with sufficient speed and detail to emulate the initiative quickly, would benefit the community more broadly—including past policyholders, whose premiums contributed to GHMSI's current extraordinary surplus.

However, if GHMSI is looking for a simple "quick fix" to comply with its obligations under MIEAA, it could consider a strategy that would be less disruptive of markets—specifically, offering current (but not prospective) policyholders a premium "holiday", during which they would pay no premiums at all. The subsequent "spring back" would, then, be merely a

[2]In 2005, GHMSI claimed much higher community benefit than in either prior or subsequent years. Nearly all of the increase was due to restrained rate increases. However, GHMSI's relatively low rate increases appeared to be more a marketing strategy than community benefit, as other carriers similarly reduced their rates that year.

resumption of paying premiums in accordance with DISB's standing rules for approving rates. This strategy may not be optimal, as past (but not current) policy holders arguably would be treated unfairly. Nevertheless, it would offer current policyholders immediate and welcome relief as GHMSI begins to meet its obligations under MIEAA.