**REPORT OF THE DISTRICT OF COLUMBIA**
**DEPARTMENT OF INSURANCE, SECURITIES, AND BANKING**
*Lawrence H. Mirel, Commissioner*

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**In the Matter of: Inquiry into the Charitable Obligations of GHMSI/CareFirst in the District of Columbia**

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## I. PURPOSE

This report sets forth the findings and recommendations of the Department of Insurance, Securities, and Banking ("Department") based on its inquiry into the charitable obligations of Group Hospitalization and Medical Services, Inc. ("GHMSI") in the District of Columbia. Specifically, the report addresses the following issues:

1. Whether GHMSI has a legal obligation to engage in charitable activities.
2. If such an obligation exists, what is the nature and extent of that obligation.
3. If such an obligation exists, is GHMSI adequately meeting that obligation.

The Department initiated this inquiry in large part in response to a December 2004 report of the DC Appleseed Center ("Appleseed"), a non-profit institution located in the District of Columbia.[1] The Appleseed Report argued that: GHMSI was "legally obligated to provide charitable activities within its service area"; GHMSI was "not meeting [its] charitable obligation to the citizens of the National Capital Area"; based on its "significant surpluses", GHMSI could and should commit millions of additional dollars each year to charitable activities; and GHMSI could make these additional charitable commitments while still remaining "viable and competitive".[2]

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[1] *CareFirst: Meeting Its Charitable Obligation to Citizens of the National Capital Area*, DC Appleseed Center for Law and Justice, December 2004 ("Appleseed Report").
[2] Appleseed Report at I-1 and I-9 through I-10.

Even though, as set forth below, the Department does not agree with all of the assertions in the Appleseed Report, it does agree with Appleseed's primary premise: GHMSI, as a strong and responsible provider of health care insurance in its service area, can and should do more to promote and safeguard the public health of the residents of the District of Columbia.

## II. SUMMARY OF FINDINGS

Based on the record before us, the Department finds the following:

- GHMSI has a legal obligation under its charter to operate as a non-profit charitable and benevolent institution.
- GHMSI is meeting its basic obligation as a charitable institution by operating a non-profit health plan that serves residents throughout its service area, including the District of Columbia.
- GHMSI's charter allows the corporation to engage in charitable activity, other than the provision of health insurance, that promotes and safeguards the public health.
- GHMSI, as a major corporation operating in the District of Columbia, has a responsibility to engage in activities which benefit the residents of the District.
- GHMSI can and should engage in additional charitable activities in the District that benefit and promote the health of all District residents.
- It is the obligation of GHMSI's Board of Trustees, in the first instance, to determine the amount of additional charitable activity and the specific beneficiaries of this charitable activity.

## III. BACKGROUND

A. History of GHMSI

GHMSI began its existence in 1934 as a hospital association under the name of Group Hospitalization, Inc. ("GHI").[3] GHI was reconstituted in 1939 as a non-profit corporation through a Congressionally granted charter, and several of the provisions of that charter are at the core of this proceeding.[4] Specifically, the charter contains the following relevant provisions:

> *"Sec. 2. [Group Hospitalization, Inc.] is…authorized and empowered (a) to enter into contracts with individuals or groups of individuals to provide for hospitalization of such individuals, upon payment of specified rates or premiums, and to issue to such individuals appropriate certificates evidencing such contracts; (b) to enter into contracts with hospitals for the care and treatment of such individuals, in accordance with the terms of such certificates; and (c) to cooperate, consolidate, or contract with groups or organizations interested in promoting and safeguarding the public health.*
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> *"Sec. 3. [Group Hospitalization, Inc.] shall not be conducted for profit, but shall be conducted for the benefit of the aforesaid certificate holders.…*
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> *"Sec. 8. [Group Hospitalization, Inc.] is hereby declared to be a charitable and benevolent institution, and all of its funds and property shall be exempt from taxation other than taxes on real estate."*

After the grant of its charter, and through a series of transactions not directly relevant to this proceeding, GHI merged with Medical Services, Inc. to form GHMSI, also known as Blue Cross/Blue Shield of the National Capital Area ("BCBSNCA"). GHMSI provides Blue Cross/Blue Shield health benefits to subscribers in its service area,

[3] *See* "CareFirst History and Timeline", http://www.carefirst.com/company/html/Timeline.html.
[4] *See* An Act providing for the incorporation of certain persons as Group Hospitalization, Inc., 53 Stat. 1412, P.L. 395 (1939) ("GHMSI charter"). The GHMSI charter has been amended by Congress several times since 1939. The Department finds, however, that these amendments are not relevant to the current proceeding.

which includes the District of Columbia, Prince George's and Montgomery Counties in Maryland, and a portion of Northern Virginia. In 1998 GHMSI joined with Blue Cross/Blue Shield of Maryland, Inc. ("BCBSMD," also known as "CareFirst of Maryland, Inc."), which provides Blue Cross/Blue Shield services to the rest of Maryland, in forming a holding company, CareFirst, Inc., a non-profit Maryland corporation.[5] GHMSI, however, remains a District of Columbia domestic corporation under the primary regulatory authority of the District of Columbia Department of Insurance, Securities and Banking.[6] GHMSI currently has 1.2 million subscribers in its service area. Of those, 132,000 reside in the District, 280,000 live in Northern Virginia, and 746,000 live in Montgomery and Prince George's Counties, Maryland.[7]

B. Appleseed Report

The DC Appleseed Center is a non-profit advocacy organization headquartered in the District of Columbia. The mission of Appleseed is to "identify serious local issues, research and analyze them, develop and publish recommendations for systemic reform, and advocate for appropriate solutions."[8] In December 2004, Appleseed issued a report titled "CareFirst: Meeting Its Charitable Obligation to Citizens of the National Capital Area." In its report Appleseed makes the following core assertions:

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[5] In 2001, CareFirst announced its intention to convert to for-profit status and be acquired by WellPoint Health Networks. The proposed conversion was rejected by the Maryland Insurance Commissioner and the planned merger was later abandoned.

[6] In 2000, Blue Cross Blue Shield of Delaware ("BCBSD") became part of the CareFirst, Inc. holding company. BCBSD remains a separate corporation under the primary regulatory authority of its domestic regulator, the Insurance Commissioner of Delaware.

[7] *See* testimony of William L. Jews, president and chief executive officer of GHMSI and of CareFirst, Inc.. Hearing Transcript at 26-27. Overall, including its programs in Delaware and the remainder of Maryland, CareFirst companies have 3.3 million subscribers. Hearing Transcript at 26.

[8] *See* Appleseed Report at ii.

> "GHMSI's federal charter means what it says: GHMSI is legally obligated to provide charitable activities within its service area.
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> "GHMSI's board of directors has a fiduciary and legal obligation to ensure that GHMSI fulfills its charitable obligation….
>
> "GHMSI's legal obligation is as follows: it must use its revenues and surplus to perform charitable activities to the maximum feasible extent, consistent with its need to remain viable and competitive.
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> "GHMSI is financially capable of engaging in charitable activities at a much higher rate than it is currently doing, and still remain viable and competitive. Specifically, it could spend between 2 and 3 percent of its earned annual premiums to charitable activities and still maintain its current pricing structure, its level of competitiveness, and a high level of surplus.
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> "Using this 2 to 3 percent measurement, GHMSI could spend between 41 and 61 million dollars on charitable activities in 2004. By 2008, assuming as much as 10 percent annual growth in total premium revenues, GHMSI could spend between 67 and 100 million dollars on charitable activities, and still remain viable and competitive."[9]

Appleseed concluded that GHMSI was not meeting its charitable obligation to the residents of the national capital area.

C. Issuance of notice and holding of public hearing

In response to the Appleseed Report, the Department in early 2005 initiated an inquiry into the charitable obligations of GHMSI. On February 15, 2005, the Commissioner announced that the Department would hold a public hearing on March 24, 2005, to receive testimony from GHMSI, Appleseed, and the public on the questions set forth in the first section of this report.[10]

[9] Appleseed Report at I-1.
[10] The hearing notice was published in the District of Columbia Register on February 18, 2005. *See* 52 D.C. Reg. 1579.

The Commissioner convened the public hearing at 10:00 a.m. on Thursday, March 24, 2005, in the First Floor Auditorium at One Judiciary Square (441 Fourth Street, NW). The hearing was adjourned at 4:30 p.m., and the record was left open until April 8, 2005. The Department received oral and written testimony from over 40 witnesses. Portions of the testimony are referenced in this report.[11]

## IV. ANALYSIS

### A. Legal Obligation to Operate as a Charitable Entity

The initial issue before the Department is the following: Does GHMSI have a legal obligation to engage in charitable activities?

Appleseed argued in its testimony to the Commissioner that GHMSI is "legally obligated to provide charitable activities within its service area", and that GHMSI has a specific "obligation to pursue a charitable, public health mission."[12] Appleseed based its argument in large part on the language of section 8 of GHMSI's federal charter, which established GHMSI as a "charitable and benevolent institution".[13] In its testimony, Appleseed sought to refute arguments that GHMSI's charitable obligation was obsolete or had no legal effect and that GHMSI's charitable obligation would be inconsistent with its mandate to operate for the benefit of its certificate holders.[14]

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[11] A complete written transcript of the hearing is available from Miller Reporting Company, Inc., 735 8th Street, S.E., Washington, D.C. 20003, 202-546-6666.
[12] Appleseed Report at I-1. The word "testimony," when used in this report, may refer to either the oral or written testimony of the witness. The specific form of the testimony will be set forth in this report.
[13] Appleseed Report at II-8 through II-17. Appleseed also argued briefly that District law also required GHMSI to "use its assets for the benefit of the public beyond its current policyholders …at least with respect to health education programs. Appleseed Report at II-22
[14] Appleseed Report at II-9 through II-21.

GHMSI did not dispute that it is legally obligated to engage in charitable activities; rather, GHMSI argued that it fulfills its charitable obligation by operating a non-profit health plan.

The Department finds that GHMSI was established with a charitable obligation, and that GHMSI continues to be bound by that obligation. (This conclusion is supported by a recent opinion of the Attorney General of the District of Columbia.)[15] The plain language of section 8 of GHMSI's charter, which has not been substantively modified in the over 65 years of its existence, makes this clear. Appleseed and GHMSI do not disagree on this point. Where they differ is over the content of that charitable obligation.

B. Content of Legal Obligation

Having determined that GHMSI has a legal obligation to engage in charitable activities, the key issue before the Department then becomes: What is the content of GHMSI's charitable obligation? Does the operation of a non-profit health plan satisfy that obligation? Or is GHMSI required to do more? Specifically is GHMSI required to fund other health-related activities in its service area, as Appleseed claims?

GHMSI argues that Congress "intended that GHMSI would operate specifically for the benefits of its subscribers … not for the benefit of the 'public at large.'"[16] In the words of Andrew H. Marks, attorney for GHMSI:

[15] After the Department initiated this proceeding and announced its hearing, the Attorney General of the District of Columbia issued a memorandum on various issues related to the Appleseed Report. *See* Memorandum from Attorney General Robert Spagnoletti to City Administrator Robert Bobb (dated March 4, 2005) ("AG Opinion"). In that memorandum, the Attorney General stated that GHMSI "was chartered by Congress as a 'charitable and benevolent institution' [and] has an obligation to pursue a public health mission." AG Opinion at 1.

[16] Testimony of Andrew H. Marks, attorney for GHMSI ("Marks Testimony") at 2.

> "GHMSI's revenues, which Appleseed seeks to require GHMSI to donate to public health and other charitable causes, are primarily funds paid by GHMSI's subscribers as premiums. GHMSI's Charter requires the company's trustees to act as responsible stewards of those funds and to use them for the benefit of the subscribers who paid those premiums. There is no principled basis for concluding that Congress, when it originally chartered GHMSI, intended GHMSI's subscribers to provide a general funding source for good works in the community."[17]

GHMSI's position is that the provision of health insurance itself constitutes a charitable activity. GHMSI argues that when it was chartered, plans such as GHMSI's "represented a significant innovation in health care" and that GHMSI, at the time of its formation, "provid[ed] a necessary service to the community, and to the hospitals they also served, that would otherwise go unmet."[18] The key point GHMSI makes is that its intended "'charitable' purpose was precisely the provision of insurance benefits to [its] subscribers."[19]

Appleseed, on the other hand, argues that GHMSI's charitable obligations are much broader. Appleseed claims that under federal case law "a charitable organization may not be operated for the benefit of its subscribers alone" and that "to qualify as a charitable organization, an organization must provide a substantial 'community benefit'."[20] Specifically, Appleseed concludes, "GHMSI's obligation is to foster public health initiatives, by providing services such as health education, health care research, participation in public programs, and subsidized coverage to the public in the National Capital area beyond its policy holders."[21]

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[17] Marks Testimony at 2-3.
[18] Marks Testimony at 5.
[19] Marks Testimony at 5.
[20] Appleseed Report at II-24.
[21] Appleseed Report at I-8.

Based on the record before it, the Department finds that the provision of health insurance by GHMSI constitutes a charitable activity under its charter. As GHMSI has noted, the provision of health insurance during the period in which it was chartered was considered a charitable activity. It therefore seems likely that Congress intended this activity to be considered charitable for the purposes of GHMSI's charter. Moreover, if the Department were to determine that Congress had not intended for the provision of health insurance to be considered a charitable activity, this would lead to the unlikely conclusion that Congress had created GHMSI as a charitable organization but had also mandated that its primary mission be a non-charitable activity (*i.e.*, the provision of health insurance). The Department finds this conclusion untenable.

The Department also finds unpersuasive Appleseed's argument that GHMSI has a charitable obligation to the public at large. In reaching its conclusion, Appleseed relies mainly on federal and state cases finding that organizations must have a general community benefit in order to be considered charitable organizations under the tax laws. That test is inapposite here.[22] The issue before the Department is to determine the definition of "charitable" under GHMSI's charter, not under the tax laws.[23] The evidence

[22] We note that GHMSI is not a tax-exempt charitable organization under the Internal Revenue Code. Congress enacted legislation in 1986 withdrawing the tax exemption of GHMSI and all similar non-profit Blue Cross/Blue Shield plans. Tax Reform Act of 1986, § 1012(a),(b). (100 Stat.2085; 26 U.S.C. §§ 501(m) and 833). Although GHMSI receives some tax advantages because it provides an open enrollment product, it pays substantial taxes to both the District and the Federal Governments. In 2004 it paid $5.7 million in District taxes and $31 million in Federal taxes. *See* testimony of Robert Willis, member of the GHMSI Board of Trustees, Hearing Transcript at 29-30.

[23] The Attorney General similarly rejects the application of tax law cases to the determination of what constitutes charitable activities under GHMSI's charter. *See* AG Opinion at 5. The Department also does not agree with the argument in Appleseed's supplemental report that the doctrine of *cy pres* should be applied to the charitable purpose set forth in GHMSI's charter. See "CareFirst is Not Meeting Its Charitable Obligation to Citizens of the National Capital Area," at 9 (citing section 399 of the Restatement Second of Trusts) ("Appleseed Supplemental Comments"). The Department does not find that GHMSI's

before us strongly indicates that the provision of health insurance to its subscribers (and the offering of health insurance on a generalized basis) constitutes charitable activity under GHMSI's charter, and the Department so finds.

The Department's determination is bolstered by the opinion of the Attorney General. The Attorney General found that "GHMSI may meet its obligation under its charter through the operation of non-profit health plans, even if the only direct beneficiaries are the plans' past, current, and future paying subscribers."[24] The Attorney General based his decision largely on the legal principles related to charitable trusts, which he determined would apply to GHMSI.[25]

C. Responsibility of GHMSI to Engage in Additional Charitable Activities

Although GHMSI may satisfy the charitable obligation under its charter solely by providing health insurance in its service area — and although its primary obligation is to its subscribers — that determination does not end the Department's inquiry. The Department finds that GHMSI can and should engage in more charitable activity in the District of Columbia.

i. Authority and responsibility to engage in additional activity

The Department finds that GHMSI has the legal authority to engage in charitable activity beyond the provision of health insurance. First, the charter authorizes GHMSI

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original charitable purpose is now "impractical or impossible," a finding that must be made before this aspect of the *cy pres* doctrine may be invoked. It bears noting, moreover, that if a court were to find that carrying out GHMSI's original charitable purpose is now impractical or impossible (and the application of the *cy pres* doctrine was therefore appropriate) the court might require GHMSI to cease providing health insurance coverage. The Department finds that such a result would not benefit GHMSI's subscribers nor the community at large.

[24] AG Opinion at 2.

[25] AG Opinion at 2-5.

"to cooperate, consolidate, or contract with groups or organizations interested in promoting and safeguarding the public health."[26] Moreover, we agree with the opinion of the Attorney General that GHMSI has a "public health mission" and that GHMSI may support health-related education for the general public, support other charitable organizations in promoting the public health, and engage in cooperative efforts with private entities and the government to promote public health.[27]

Indeed, GHMSI itself recognized in its testimony before the Department that it is empowered to engage in charitable activities beyond its provision of health insurance,[28] and GHMSI stated that it had contributed several hundred thousand dollars to various charitable organizations in the District in 2003 and 2004.[29]

We find that not only does GHMSI have the authority to engage in charitable activity outside of the provision of health insurance, it has the responsibility to engage in such activity. As a major corporate citizen of the District of Columbia, and as the major health insurer in the District, GHMSI has a social responsibility that goes beyond its basic legal obligations; this responsibility includes the requirement to engage in charitable activities beyond GHMSI's primary mission of providing health insurance.

ii. Content of responsibility

The Department finds that GHMSI's additional charitable activities must be confined primarily to the area of public health. The most expansive powers provision in

[26] GHMSI charter § 2.
[27] AG Opinion at 1, 7-8.
[28] *See, e.g.*, testimony of Carol Keehan, member of the GHMSI Board of Trustees, Hearing Transcript at 62 ("[I]f we have surplus that we don't believe we absolutely must have…we can use some of that for the community, to improve the health status of the community" but GHMSI's "first and foremost responsibility" is to subscribers.).
[29] Written testimony of Carol Keehan, member of the GHMSI Board of Trustees, at 2.

GHMSI's charter provides it with the authority to work with organizations to "promot[e] and safeguard[ ] the public health."[30] There is no explicit provision in the charter that grants broader authority to GHMSI. Although the charter does not specifically prohibit non-public health activity, it seems clear that the general purpose of the organization was intended to be the furtherance of the public health. The Department therefore determines that GHMSI's charitable activities must be limited primarily to this area. This conclusion is consistent both with the opinion of the Attorney General and with the arguments put forth by Appleseed.[31]

Within the area of public health, there are many organizations and activities GHMSI might support. In its report, Appleseed provided extensive information on such programs, including "effective education to promote healthy behaviors; greater access to mental health adult and child health services; language and cultural competency; quality of care; and emergency preparedness."[32] The public health needs of the District of Columbia are extensive and diverse.[33]

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[30] GHMSI charter § 2(c).

[31] The Attorney General concluded that GHMSI "has an obligation to pursue a public health mission". AG Opinion at 1. The Appleseed Report also made this determination. *See* Appleseed Report at II-8 ("GHMSI has an obligation to pursue a charitable, public health mission.").

[32] Appleseed Report at III-5.

[33] Several of the witnesses at the hearing proposed specific activities GHMSI could support, including the following:

- Mark Ouellette, director of the D.C. Children and Youth Investment Trust Corporation, suggested that charitable funds from GHMSI could be used to address the issue of childhood obesity. (Hearing Transcript at 191-192).
- Frances Gemmill, president of the D.C. League of Women Voters, recommended that GHMSI: support the expansion of the "D.C. [Healthcare] Alliance to include everybody below 200 to 400 percent of the federal poverty level"; assist "low-income residents, especially children, get dental care"; and offer "affordable individual insurance policies to members with pre-existing conditions". (Hearing Transcript at 234-235).
- Cheryl Fish-Parcham, representing Families USA, suggested that GHMSI implement a "high-risk pool coupled with a sliding fee scale public insurance program"; "subsidize care through the

Each of these suggestions (and other presented at the hearing and in written testimony) merit consideration by GHMSI.[34] The Department finds, however, that is the

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Alliance for an additional number of people"; and/or provide resources for prescription drug assistance. (Hearing Transcript at 247-248).

- Mary McCall, representing the Metropolitan Washington Public Health Association, suggested that GHMSI could: provide "higher-risk persons and small busineses with more advantageous rates"; expand the reach of the DC Healthcare Alliance; "subsidize oral health services for Medicaid, Alliance, and other under-insured persons"; and fund "a full-time nurse [for] each of the District's public schools". (Hearing Transcript at 240-241).
- Victor Freeman, president of the Medical Society of the District of Columbia, suggested that GHMSI provide "direct support to primary care clinics and/or fund neighborhood wellness and health promotion programs in those clinics."(Hearing Transcript at 260).
- N. Thomas Connally, medical director of the Arlington Virginia Free Clinic, suggested that the money be spent on "preventive health care measures" and "volunteer organizations that can leverage volunteer help." (Hearing Transcript at 293).
- Margot Aronson, president of the Greater Washington Society for Clinical Social Work, "urge[d] that the mental health needs of the community be considered in any public conversation about what health services might be supported by charitable activity from CareFirst." (Hearing Transcript at 311).
- Sharon Baskerville, executive director of the D.C. Primary Care Association, suggested that GHMSI's charitable funds be used to: "create a medically vulnerable facilities fund, for expanding primary care clinics, special medical needs, housing including seniors, mental health facilities, community residential facilities, which could be tied into the overall Medical Homes D.C. initiative." Ms. Baskerville also suggested that a loan repayment or scholarship program be created "for health professionals that agree to locate and practice in designated primary care shortage areas for a set number of years." Ms. Baskerville further suggested that funds be used to expand the D.C. Healthcare Alliance or to create a buy-in program "to include all residents between 200 and 400 percent of poverty." (Hearing Transcript at 337-338).

[34] Several witnesses at the hearing provided positive testimony on current GHMSI community activities:

- Anthony Evans, president of the D.C. Black Church Initiative, stated that he "[stood] up to be counted among those who are willing to testify publicly to the great outreach that CareFirst is doing." Mr. Evans spoke of CareFirst's funding for his initiative to provide public information on diabetes to the District's African American population, and added that he "believe[s] that the findings of the Appleseed report are misleading, erroneous, and do not reflect the generosity and contributions that CareFirst has made to the Distict of Columbia and the metropolitan area." (Hearing Transcript at 206-210).
- Vincent Keane, chief executive officer of Unity Health Care, spoke of his organization's "positive experience with CareFirst," which provides funding for Unity's "Health Care for the Homeless" program. (Hearing Transcript at 224-226).
- Anthony Owens, communications director for United Way of the National Capital Area, testified that he believes that "CareFirst shares the essence of the same values and vision as United Way," and added that CareFirst made a "corporate match donation of $177,000" to the United Way's 2004 fundraising campaign. (Tr. 280).
- Pam Katz, executive director of the Juvenile Diabetes Research Foundation/Capital Chapter ("JDRF") said that JDRF was "pleased to have CareFirst as a very generous donor. (Hearing Transcript at 274-276 )
- Nancy Rosen, chief executive officer of Sister to Sister Foundation, said that CareFirst-GHMSI "generously donated and actively participated in our National Women's Heart Day campaign in

responsibility of GHMSI's Board of Trustees to determine the public health initiatives to which GHMSI will provide contributions or assistance, and the Department therefore declines to make recommendations on specific charitable activities.

The Department does note, however, that it continues to be critical of GHMSI's administration of the open enrollment program it is required to maintain by law.[35] Under that statute GHMSI is permitted to pay the 1% premium tax that would ordinarily go to the District's general fund into a separate Rate Stabilization Fund, the monies to be used to subsidize open enrollment contracts to assure competitive rates. Although the Rate Stabilization Fund has built up a balance of more than $4 million, subscribers to the open enrollment program have been few. As of the date of the hearing there were only 275 persons enrolled.[36] Accordingly the Department has required that GHMSI pay its premium tax for 2004 to the general fund instead of to the Rate Stabilization Fund and has told GHMSI that it will do the same in future years unless and until GHMSI has properly advertised the availability of the open enrollment program and spent down the funds already committed to that program. [37]

iii. Extent of responsibility

The remaining question before the Department is GHMSI's capacity — in terms of dollars — to make charitable donations to the community at large. Appleseed argues

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Washington, D.C.," and had "responsibly worked to help collaborate with the community to advance health care and to support public and private efforts to meet the needs of persons lacking health insurance." (Hearing Transcript at 215-216 ).

[35] *See* § 15 of the Hospital and Medical Services Corporation Regulatory Act of 1996 (D.C. Law 11-245; D.C. Official Code § 31-3514).
[36] *See* testimony of William L. Jews, Hearing Transcript at 67.
[37] On May 2, 2005, GHMSI filed an amended tax return with the District of Columbia Government along with a check in the amount of $2,776,258.

that GHMSI "must use its revenues and surplus to perform charitable activities to the maximum feasible extent, consistent with its need to remain viable and competitive."[38] Under these standards, Appleseed argues, GHMSI "could spend between 41 and 61 million dollars on charitable activities in 2004" and between "67 and 100 million dollars on charitable activities" by 2008.[39] Several of the witnesses at the hearing also argued for contributions in this range.[40]

In its testimony CareFirst stated that in 2004 it provided $2.6 million to support local charitable and non-profit organizations in its entire service area, which includes Delaware, Maryland and Northern Virginia, as well as the District of Columbia. That figure represents 2% of its net operating income in that year.[41] Of this amount $1.3 million, or 49%, went to District of Columbia organizations.[42] In 2005 CareFirst says it intends to increase its annual giving to $8.7 million, or 7.3% of its expected net operating income for the year.[43] Assuming the same ratio of spending in the current year, approximately half of that total, or $4.35 million, would go to District of Columbia organizations.

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[38] Appleseed Report at I-1.
[39] Appleseed Report at I-1.
[40] *See*, *e.g.*, testimony of: Frances Gemmill, president of the D.C. League of Women Voters, Hearing Transcript at 229 ($50 million to $100 million); Mary McCall, Metropolitan Washington Public Health Association, Hearing Transcript at 240 ($100 million); Sharon Baskerville, executive director, D.C. Primary Care Association, Hearing Transcript at 335 ($40 million to $61 million for 2004).
[41] *See* testimony of William L. Jews, Hearing Transcript at 54.
[42] GHMSI's testimony indicates that only approximately 11% of GHMSI's members are District residents, and of CareFirst's total members only 4% are District residents. *See* written testimony of GHMSI, at second exhibit. Appleseed, on the other hand, states that in 2003, 68.8% of GHMSI's total enrollees were enrolled in the District, 17.7% were enrolled in Maryland, and 13.5% were enrolled in Virginia. We believe that that both sets of figures are probably correct. The Appleseed figures are based on where policyholders were *enrolled*, and includes Federal Government employees, while the CareFirst figures show where policyholders *live*. Since insurance is typically sold at the workplace, it is not surprising that a high proportion of those enrolled by CareFirst at their District workplace live in the suburbs.
[43] *See* testimony of William L. Jews, Hearing Transcript at 53.

The gulf, then, between what GHMSI is contributing to community organizations and what Appleseed believes it could and should be contributing, is wide. CareFirst points to the $2.6 million it donated to community organizations in 2004, of which $1.3 million was donated by GHMSI directly,[44] while saying it plans to increase this amount significantly in coming years. Appleseed believes that GHMSI alone could make contributions of between $41million and $61 million a year without damage to its financial viability or competitiveness.

Appleseed bases its estimate of the amount GHMSI could safely contribute to community organizations on the ratio of surplus to premium volume.[45] It believes that GHMSI has too much surplus and that it should divest itself of much of that surplus by donating the money to community charities. Specifically Appleseed believes that GHMSI should make community contributions equal to 2% ($41 million) to 3% ($61 million) of its *premium volume*, using 2003 figures.

GHMSI testified that while it is currently in good financial health, with an A+ rating from the financial rating organizations,[46] that was not always the case. In the late 1980s, GHMSI was close to bankruptcy. Currently it has a ratio of capital (reserves and surplus) to risk of 950%. Testimony presented on behalf of GHMSI defended that ratio as approximately correct, given competitive pressures and the uncertainties of the

[44] The Department believes that $537,000 of that amount represents expenditures from the Rate Stabilization Fund.
[45] *See* testimony of Dr. Deborah Chollet, Senior Fellow, Mathematica Policy Research, expert witness for Appleseed, Hearing Transcript at 178.
[46] *See* testimony of William L. Jews, Hearing Transcript at 59.

future.[47] That is substantially higher than the minimum ratio of 200% mandated by District of Columbia law or the 375% minimum ratio required by the Blue Cross Blue Shield Association of its members, but well within prudent operating standards for a company with the size and scope of GHMSI, according to its expert.[48] At the upper end of the scale, the Blue Cross Blue Shield Association has established 800% as the surplus level at which it "makes the 'presumption…that the [insurer] is sufficiently strong to meet its obligation to its insureds well into the future.'"[49] The Pennsylvania Insurance Department recently held that the maximum level of surplus that that state's BlueCross BlueShield plans should maintain varied between 750% and 950%.[50] Finally, in an analysis commissioned by GHMSI, the Milliman Group concluded that "a reasonable target for GHMSI's surplus ratio is 800-1100%…under normal operating conditions."[51]

The use of the term "surplus" in the insurance context is often misunderstood. To a layman "surplus" implies "extra;" that is, not needed. In insurance terms, however, "surplus" is that margin of reserves that can protect against unforeseen losses, as could arise from an epidemic, a terrorist attack, or simply from business reverses. According to Robert H. Dobson, a consulting actuary with Milliman who testified on behalf of GHMSI, "surplus" has a precise definition; it is the difference between assets and liabilities, known in other contexts as "net worth" or "equity capital" or "contingency

[47] *See* testimony of Robert H. Dobson, F.S.A., Milliman Actuarial Consultants, Hearing Transcript at 93-95.
[48] *See* Appleseed Report at III-45; Robert H. Dobson et al., "Need for Statutory Surplus and Development of Optimal Surplus Target Range" ("Milliman Report"); In re Application of Capital Blue Cross et al., Penn. Ins. Dept. Misc. Docket No. MS05-02-006, at 22 (February 9, 2005) ("Penn. Ins. Dept. Order").
[49] *See* Penn. Ins. Dept. Order at 22.
[50] *See* Penn. Ins. Dept. Order at 35. The Pennsylvania Insurance Commissioner state that "[t]he difference between the ranges is due to considerations of size and level of diversification, as well as distinctions in underwriting risk volatility and underwriting risk leverage." *Id.* at 37.
[51] *See* Milliman Report at 18.

reserves."[52] Another witness for GHMSI, former Pennsylvania Insurance Commissioner Constance B. Foster, testified that health insurers need "a strong surplus…to meet their obligations to their policy holders."[53]

All parties agreed that surplus is necessary and also that it is possible to have more surplus than is reasonably required. But how much surplus is too much? Surplus is a measure of the health of a company, and to ask how much is necessary is essentially to ask: "How healthy should the company be?" We believe it is not wise or feasible to establish a "bright line" test for making such a determination. The testimony presented at the hearing, however, was enlightening and helpful in dealing with this question.

The Department is unpersuaded that the proper measure of the capacity of an insurance company to safely make contributions to community charities should be the ratio of surplus to *premium volume*, which is the standard proposed by Appleseed.[54] "Premium volume" is simply a reflection of the amount of business (i.e., the amount of risk assumed) by the insurance company. An insurance company could have a very large premium volume (as indeed GHMSI does) and be teetering on the brink of bankruptcy, (which fortunately GHMSI is not).[55] We believe a better measure for considering whether the amount of charitable contributions is reasonable is the relationship between surplus and *earned income* or *net operating income*. That is the measure CareFirst uses

[52] *See* testimony of Robert H. Dobson, Hearing Transcript at 93.
[53] *See* testimony of Constance B. Foster, former Insurance Commissioner of Pennsylvania and now a partner with Saul Ewing LLP. Hearing Transcript at 79.
[54] *See* testimony of Dr. Deborah Chollet, senior fellow at Mathematica Policy Research, Hearing Transcript at 178. *See* also criticism of Dr. Chollet's methodology, testimony of Dr. Gregory S. Vistnes, Charles River Associates, a witness for GHMSI, Hearing Transcript at 102-111.
[55] *See* colloquy on this subject between Commissioner Mirel and Dr. Chollet, Hearing Transcript at 179-180.

when it says its community charitable program was 2% of earned income in 2004 and will rise to 7.3% of earned income in 2005.[56]

We find that the $41 million to $61 million that Appleseed asserts GHMSI could safely divest itself of, based on its current premium volume, is not reasonable, and we reject the use of a surplus-to-premium-volume measure as unsound and potentially dangerous.

At the same time we believe that the ability of CareFirst and of GHMSI to do more for the community than it is doing currently is beyond doubt.

In 2003, CareFirst had revenues of $7.3 billion and net income of $171.3 million.[57] Furthermore, GHMSI has total adjusted capital levels that are generally well above industry standards and above the levels of other providers in the District and Maryland.[58]

Based on 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.

By finding that GHMSI should engage in significant additional charitable activity, the Department does not mean to diminish the importance of GHMSI's and CareFirst's current charitable activities. Moreover, by finding that GHMSI can and should engage in significant additional charitable activity, the Department also does not mean to diminish the importance of maintaining a large level of surplus.

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[56] *See* testimony of William L. Jews, Hearing Transcript at 53.
[57] CareFirst 2003 Annual Report at 11.
[58] *See* Appleseed Report at III-42 through III-46; Appleseed Supplemental Report at 14-15. According to Appleseed, GHMSI's surplus was 951% of authorized control level risk-based capital.

A major responsibility of the Department is to ensure that the company that collects premiums from its policyholders today will be around and able to pay legitimate claims that may be filed by those policyholders in the future. We expect—indeed we require—that insurance companies maintain sufficient surplus to be able to assure us that they can meet their commitments to their policyholders. We do not want to see a situation where at the very time when an unforeseen event causes substantial losses, such as would happen in the event of an Asian flu epidemic or another anthrax attack, our major health insurer is unable to pay claims because it has insufficient surplus. Furthermore we recognize that in the current health insurance market even our largest insurer, CareFirst/GHMSI, is a small player on the national scene and will be under increasing pressure from much larger for-profit insurers with access to the capital markets that are not available to a non-profit, and that because of these competitive factors it is prudent for CareFirst/GHMSI to have the resources needed to constantly modernize and up-grade to meet the competition. We agree with CareFirst/GHMSI that its major obligation is to its policyholders.

The importance of maintaining a significant level of surplus is highlighted by GHMSI's relatively recent history. Just over a decade ago, GHMSI was in such poor financial condition that it needed to borrow $60 million from other BlueCross/Blue Shield plans in order to remain solvent.[59] It is the responsibility of the GHMSI Board of Trustees—and of this Department — to ensure that this type of situation does not occur again.

[59] *See* testimony of Robert M. Willis, member of the Board of Trustees of GHMSI, Hearing Transcript at 19.

The Department believes that it is possible for a non-profit insurer to maintain too large a surplus. In fact, even the actuarial consultant for GHMSI acknowledged this point at the Department's hearing.[60] There is not sufficient evidence before the Department, however, for us to establish a maximum level of surplus. Moreover, the Department finds that it is the responsibility of the Board (in the first instance) to determine this level, and therefore the additional amount of community charitable activity that GHMSI can safely engage in.[61]

Based on the evidence before the Department, it appears that GHMSI may reduce its surplus level without negatively impacting its financial strength and viability, and the Department believes that could be achieved by increasing financial contributions to organizations, activities, or joint efforts that will advance the public health in the District of Columbia.

CareFirst may already be recognizing its responsibility. Earlier this year, CareFirst announced a multiyear $92 million "CareFirst Commitment" initiative that is "designed to further [CareFirst's] mission of maximizing access to and the affordability of health care coverage, while at the same time facilitating [CareFirst's] social commitments to the communities we serve."[62] The result of the initiative will be to

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[60] *See* testimony of Robert H. Dobson, Hearing Transcript at 98 ("There is an actuarial principle…that states that it's not reasonable nor prudent, nor even possible, to set aside enough money to prepare for any conceivable contingency. So I guess that, by itself, acknowledges that there is some amount [of surplus] which would not be considered reasonable.")

[61] Many witnesses agreed on this point. *See*, for example, testimony of Walter Smith, executive director of Apleseed, Hearing Transcript at 143. ("[T]he GHMSI board should determine in the first instance and exercise its discretion in the first instance…to decide how much they can afford …to spend and what the programs will be…"). *See* also testimony of Frances Gemmill, president of the D.C. League of Women Voters, Hearing Transcript at 236. ("I think the CareFirst board has to decide" how additional charitable contributions are spent.)

[62] Written testimony of Carol Keehan, Member, GHMSI Board of Trustees, at 2.

reduce the growth in surplus, both directly and indirectly. The initiative is comprised of a commitment to lower CareFirst's earnings (i.e. its growth in "surplus") target by $60 million; $24 million "to fund public-private programs that provide prescription drugs for low-income seniors in Maryland and to offer coverage for difficult-to-insure individuals in the District of Columbia"; and $8.7 million in 2005 "to launch new initiatives to encourage excellent physician care, improve patient safety, enhance hospital intensive care, partner with community organizations to address health care needs, and reduce racial and ethnic health disparities."[63]

## V. CONCLUSION

The Department finds 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 and apart from the bare legal obligation set forth in its charter — to engage in charitable activities in the District of Columbia which advance the public health. The Department believes that it is possible for GHMSI to make these additional charitable contributions while maintaining a financially strong health insurance program for its subscribers, but declines to determine the amount or kinds of additional community contributions GHMSI should make. The Department finds that it is the responsibility of the Board of Trustees (in the first instance) to determine the amount of additional charitable contributions which will be made, and the manner in which the contributions will be made.

[63] CareFirst News Release, "CareFirst BlueCross BlueShield Announces $92 Million Plan to Fulfill Not-for-Profit Mission", January 18, 2005. Of the $35 million in rate relief, GHMSI stated that "$10.5 million [is] in the District itself;" written testimony of William L. Jews, at 8.

The Commissioner requests that the Board of Trustees of GHMSI submit to the Department a detailed report by September 1, 2005, reporting on the charitable activities of both GHMSI and CareFirst for 2004 and 2005, and the planned activities of GHMSI and CareFirst for 2006 and beyond. The report should include a location-specific listing of the organizational recipients of charitable contributions and an analysis of the expected benefits of the charitable activities and contributions of GHMSI and CareFirst.