

**Testimony**  
**September 10, 2009**  
**Hearing before the Department of Insurance, Securities and Banking**

**Introduction and Context**

My name is Chet Burrell and I am the CEO of both CareFirst and our Affiliate in the District of Columbia, Group Hospitalization and Medical Services, Inc. (GHMSI). Together, the companies serve 3.4 million members, approximately 1 million of whom are members of GHMSI.

Of the GHMSI members, approximately 10 percent are residents of the District of Columbia. Nearly half live in Maryland, with the balance in Virginia and out of the area. In total, CareFirst serves approximately 45 percent of the insured population living in the Maryland, Northern Virginia and District of Columbia region.

We are here today to talk about GHMSI's surplus. The very word "surplus" seems to imply "extra", "unneeded", "too much". Yet, in the insurance world, it is an essential requirement that represents amounts held for the protection of subscribers to assure that, come what may, their claims will be paid.

Let me observe at the outset that we are not here today for a routine hearing that is part of a regular, long established regulatory process. We are here under a new law in the District of Columbia called the Medical Insurance Empowerment Amendment Act of 2008 (MIEAA), which requires the Commissioner of the Department of Insurance, Securities and Banking to review the portion of GHMSI's surplus "attributable to the District" and to determine if that surplus is "excessive" under the Act. It is important to note that so far as we know, there are only two states in the country that actively seek to monitor the upper surplus limits of an insurer and neither state's approach is even remotely comparable to the District's framework under the MIEAA.

It is apparent that this hearing – indeed, the entire framework established by the MIEAA – is the culmination of nearly a decade's intense work on the part of the DC Appleseed Center for Law and Justice, a Washington-based advocacy group. Appleseed has operated with a theory in mind that lies behind all of its arguments and efforts. To start, I would like to summarize this theory since I believe it illuminates important background and context for the issues that come before you today.

It is Appleseed's view that GHMSI is a "charitable and benevolent" institution that has as its primary mission service to the public to promote the general health of the community. Indeed, Appleseed has said that GHMSI's assets "belong to the public", that GHMSI "exists to serve the public", that "if GHMSI were a for-profit company, its profits and surpluses would benefit its shareholders," and that residents of GHMSI's service area are the company's shareholders. Appleseed argues that this entitles the public to the

equivalent of dividends to be paid out of GHMSI's surplus. It calls these dividends "community health reinvestment".

These elements of Appleseed's theory find expression in its interpretation of the MIEAA. The Act seeks to impose an obligation on GHMSI to engage in "community health reinvestment to the maximum feasible extent consistent with financial soundness and efficiency." According to Appleseed, that means GHMSI must use its resources to promote the general public's health.

In the context of the MIEAA, the Appleseed theory holds that GHMSI should maintain a reserve consistent with "financial soundness" but, Appleseed argues, this is a reserve that is well below where it presently is. It says that, if the company fails to keep reserves to an absolute minimum, it is not doing what it can "to the maximum feasible extent" in meeting its obligations to the public.

There is a clear object of the Appleseed theory: To cause GHMSI to expend as much of its reserves and resources as possible for the public benefit and cause this to happen continuously. To put this in concrete terms, Appleseed has said that GHMSI should be able, on a sustained basis, to provide as much as \$60 to \$100 million per year for the public benefit. And Appleseed claims that GHMSI's current aggregate reserve level is "excessive" by hundreds of millions of dollars. These themes are central to the pre-hearing reports filed by Appleseed a week or so ago.

Naturally, the idea that such sums might be available for District programs - which otherwise cannot be funded out of the District's budget - has caught the eye of some District officials. What government jurisdiction would not be attracted to the idea that such large sums could be raised without having to face the ire of the taxpayer and could be obtained through an esoteric regulatory process few in the public follow? Further, who would rise to the defense of an insurance company - even if it is a local one - that sought to resist this idea?

This creates the real possibility of a dangerous perversion in the regulatory process. The desire to obtain the funds causes a strong incentive to deem GHMSI's surplus "excessive" and to demand a plan for its disposition to the general public. And the political incentives are especially skewed here because the source of the funds is overwhelmingly from residents of other jurisdictions, not District residents themselves (who, as noted earlier, comprise only 10 percent of GHMSI's membership).

Nevertheless, we find ourselves here today to carry out the dictates of the MIEAA - legislation that was crafted to advance Appleseed's theory. So, let me start with the essential facts of the matter and see if they fit the theory.

### **GHMSI's Congressional Charter - What does it say and whose money is it?**

Among the things that make GHMSI unique is the fact that it is the only Blue Cross and Blue Shield Plan established and governed by an enabling Charter from the U.S.

Congress. It is also the single most important Blue Plan in the operation and support of the Federal Employee Health Benefits Program – a role of continuing great interest to the Congress. This causes Congress to have a special concern with (among other things) the financial viability of GHMSI.

GHMSI's Charter, established by an Act of Congress in 1939, sets forth its mission in very succinct, clear terms:

GHMSI “shall not be conducted for profit, but shall be conducted for the benefit of the .....certificate holders.”

GHMSI is “authorized and empowered ... to enter into contracts with individuals or groups of individuals to provide for hospitalization and medical care of such individuals, upon payment of specified rates or premiums and to issue to such individuals appropriate certificates evidencing such contracts.”

The Charter, in other words, says GHMSI's mission is to provide health care coverage to subscribers, and that its duty is to those subscribers. It is as simple and direct as that. To assure the mission would be carried out, the Congress placed the company under a Board of Trustees who would oversee the business of the company. To this day, 70 years later, almost to the month, this is exactly what the company does.

To be sure, the Charter goes on to say that the company: “is hereby declared to be a charitable and benevolent institution, and all of its funds and property shall be exempt from taxation....” But this “charitable and benevolent” language is all about tax status. At the time of its Charter, the idea of health insurance was still novel and the American Hospital Association had drafted model language to guide states who were in the process of setting up organizations like GHMSI.

It was widely believed that there was no commercial market in these services, but that they would do a lot of public good by covering people for hospitalization expenses while ensuring the viability of hospitals. This justified their non-profit status and exemption from taxes. That is, the company's services to subscribers were seen to be of such value to society that by themselves, they justified the company's charitable and benevolent “non-profit, non-taxable status”. Congress drew this section of GHMSI's charter directly from the model act.

What Appleseed has done is take the language applicable to the tax status of the company to justify its view that the company has far broader – indeed, primary – obligations to the public at large. From this, in Appleseed's view, all else is derived – including its concerns with the size and use of surplus.

It is noteworthy if one reads the various reports issued by Appleseed over the years, including the ones prepared for this hearing, that the clear, congressionally intended purpose of the company is rarely cited or even referred to.

It was only a few years ago that the last round of hearings was held here in the District by then Commissioner Larry Mirel on these very issues. Appleseed liberally refers to this in its pre-hearing report in support of its theory. However, Appleseed fails to mention the actual conclusion reached by Commissioner Mirel or the accompanying opinion issued by then Attorney General Robert Spagnoletti. I briefly summarize them here:

Commissioner Mirel wrote: “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.....to engage in charitable activities in the District of Columbia which advance the public health. .... 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. “ [Mirel opinion, May 15, 2005].

Attorney General Spagnoletti, in an opinion issued on March 4, 2005, made a series of important statements. I refer here to just a few:

“...DC Appleseed...fails to recognize that GHMSI can be faithful to its ‘charitable and benevolent’ designation by operating its non-profit health plans for the purpose of promoting better public health. Indeed, by providing or improving non-profit health plan benefits for as many subscribers as possible, GHMSI can do much to promote better health in its service area. GHMSI may even choose to fulfill its ‘charitable’ mission by devoting *all* of its resources – including profits and excess surplus – to maximizing the quality, benefits, affordability, and accessibility of its health plans, while maintaining fiscal soundness.”

“GHMSI may meet its obligations 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.”

“With hundreds of thousands of paying subscribers and the potential to enroll hundreds of thousands more, GHMSI can have a broad and positive impact on the public health if it conducts itself for the benefit of its subscribers, as its charter requires.”

“None of the cases cited by DC Appleseed undermine the conclusions, derived from general charitable trust principles, that GHMSI may fulfill its obligations as a ‘charitable and benevolent institution’ through the provision of health plan services to paying subscribers, and that GHMSI has no obligation to divert the profits generated by its health plan services to other charitable activities”.

In other words, this very agency and the District’s top law enforcement official adopted our understanding of the company’s Charter and rejected Appleseed’s idea that GHMSI has a legal obligation to turn over its subscribers’ premium payments to the public. They also made clear that GHMSI’s Board of Trustees is authorized to make decisions on how much subscriber money should be “diverted” to the general public’s needs. But these

holdings do not fit the Appleseed theory. And, therefore, they were not mentioned in its pre-hearing report.

So, in plain language, we believe the surplus and reserves of the company are held for the protection and benefit of subscribers and the GHMSI Board must find a particular community need to be of such value and benefit that it justifies using subscriber funds for other than the subscribers' direct benefit. Indeed, the Board gives generously, but always with this in mind. Simply put, the funds held in reserve by GHMSI are for the benefit of subscribers, not the general public.

Appleseed turns this all on its head and states that the company has repeatedly violated its core obligation by doing the very thing the Charter commands it to do. And, in this regard, it is worth noting that the Charter uses a command in the word "shall" in connection with serving subscribers and never mentions a word about the general public.

Let's now turn to another way to look at it.

### **Affordability – A Crisis in the Making for Subscribers**

As Commissioner Mirel and Attorney General Spagnoletti wrote in 2005, it is up to the Board of Trustees to balance how much GHMSI can afford to invest in the community at large after meeting the needs of subscribers. In doing so, the most important consideration for the Trustees, all of whom are residents of the community, is how affordable premiums are for paying subscribers.

Stated another way, the central question the Trustees must address is: when GHMSI gives a dollar to others, is this a burden our subscribers can bear? Or, is that dollar better spent more directly on their behalf? It would be a contorted reading of the Charter to ask the question the other way around: What is the maximum extent that can be given to the public before considering the needs of subscribers?

Appleseed's and the MIEAA's test for the limit of community health reinvestment is the financial soundness of the company, not the burden on subscribers who contribute the money to make it financially sound. But, in our view, financial soundness must include the concept of affordability to the subscriber, not just consider whether the company can minimally cover its claim costs. Without this focus on subscribers, there is no real meaning in the command that the corporation shall be "conducted for the benefit of the ...certificate holders".

On this issue of affordability, a full fledged crisis is emerging. Indeed, the "un-affordability" of health coverage has reached alarming levels. The signs are everywhere. A few statistics clearly illustrate this:

- DC mirrors national trends in that the number of small employers who offer health coverage is steadily declining and is now at 60 percent. So far in 2009, more than three quarters of small employers who left CareFirst, left because the cost of providing

coverage was no longer affordable. Many just dropped coverage altogether rather than go to a competitor. Together, GHMSI and CareFirst provide coverage to the majority of employer groups in the region, which suggests that small and medium groups see the most value in the companies' offerings. Yet, even these groups have found these offerings increasingly unaffordable;

- More than half of the members in small groups who left GHMSI coverage did so because they lost their job – the highest since we started keeping such records. Substantial numbers of these members go into the ranks of the uninsured because they cannot afford coverage;

- Premiums have been rising in lock step with health care costs at an average rate of over 10 percent per year. At this rate, costs double every seven years. These costs are rising at 3 to 5 times the increase in family income in this region and are consuming an ever larger share of disposable income;

- Small employers who are not dropping coverage are moving with lightning speed to high deductible health plans as a way to lower costs for themselves, but, in the process, shifting huge burdens onto employees and their dependents. From a position of nearly no market penetration for these plans in 2005, now more than half of all small groups in Maryland are covered by these designs with groups in the District rapidly following suit;

- In addition to the cost shift caused by high deductible plan designs, employers are steadily – and more rapidly of late – reducing the portion of premiums they pay for. This decline has reached the point where the portion of premium paid by small and medium employers is now at the 50 percent mark for the first time – an historic low.

These are but some of the indicia of the emerging crisis in the health care/insurance marketplace. It is even worse for individuals who have no employer to arrange and partially pay their premium costs.

In response, GHMSI has re-doubled its efforts at cost containment and has operated at extremely small operating/underwriting margins in its overall product portfolio – averaging a total bottom line from underwriting of between 1 and 2 percent over the entire last decade and a fraction of 1 percent last year. The company's Board of Trustees has laid out a plan to continue with these small margins over the foreseeable future. But, the demographic forces pushing health care cost and usage higher are extremely powerful and we see no sign of abatement.

Given these facts, it is well to remember where GHMSI's reserves come from. They come directly from individuals and small/medium group policyholders – and only from them. Large groups self insure and typically contribute minimally to reserves. To ease the burden, GHMSI targets the earnings on its reserves for the benefit of individuals and small/medium group premium payers in order to help moderate premium increases on

their behalf. In effect, it seeks to target a “dividend” to them as a benefit to those who are most in need among its subscribers.

We know of no individual or employer group that ever paid its premium thinking that the payments they make would be used for anything other than their benefit – particularly in these trying times. If we lose the battle for health care affordability among the working population, no government program can step in to fill the void. Keeping premiums as low as possible is the most essential good we can do for the general community and is certainly the thing most sought after by our premium rate payers – particularly individuals and small groups. Indeed, it is the essential intent of our Congressional Charter.

It is precisely these individuals and groups who will be most harmed if Appleseed’s theory is put into practice. It is they who most built the company’s reserves and they who should benefit from them. In so doing, the whole economy of the region is helped and the greater good is achieved.

If, on the other hand, a large portion of reserves is taken from subscribers – as if their needs were secondary to the general public’s - they not only suffer a loss in the degree of their protection, but also an important source of rate moderation. In effect, Appleseed’s logic is that others in the public – not subscribers - are the real targeted beneficiaries. We do not agree. The reserves of the Company are held for the benefit of subscribers, not others among the public.

To put things in perspective, if \$100 million were “taken”, this equates to \$300 per member (for all individuals and small groups) in the GHMSI service area.

### **Community Health Reinvestment – how much is enough?**

The facts on this question are telling. Let us start with the observation that the level of community health reinvestment that is possible at any point in time by a company such as GHMSI is directly affected by the premium tax policies of the various local and state jurisdictions in which GHMSI operates.

Much attention has been given by Appleseed to the Pennsylvania model which very explicitly uses the concept of Community Health Reinvestment with regard to Blue Cross and Blue Shield Plans. However, Pennsylvania law allows a premium tax offset against any Community Health Reinvestment obligation. The Commonwealth has set the Community Health Reinvestment obligation at 1.6 percent of commercial premiums and 1 percent of Medicare Advantage premiums – but allows a dollar for dollar offset for premium taxes paid. In effect, the Blues Plans in the State pay the difference between these percentages and what they pay in taxes into the Community Health Reinvestment program.

This is not a novel concept to the other jurisdictions in which GHMSI does business. Maryland law establishes a 2 percent premium tax and then waives it to the degree that

the Plans (CareFirst of Maryland, Inc. and GHMSI) contribute to worthy community programs identified by the State. Virginia provides a partial premium tax offset for open enrollment program losses experienced by GHMSI in that state.

Only the District of Columbia imposes premium taxes - at 2 percent of premium revenue - with no offset for community giving. Who pays this tax? The answer is only those who pay premiums – individuals and small groups. This means that all giving by GHMSI in the District is in addition to this tax and on the backs of premium payers.

To get an “apples to apples” comparison among the three jurisdictions GHMSI serves, one needs to add up three categories of payments: premium taxes, community giving and subsidies (planned losses) on open enrollment products. When all three are added up for GHMSI, here is the bottom line:

Approximately 3.3 percent of its total premium revenue is given over by GHMSI for these three purposes combined in the District, while this total is 2.3 percent in Virginia and only 1.7 percent in Maryland. In dollar terms, GHMSI contributes \$14.0 million to the District for these three purposes, while contributing \$6.9 million to Maryland and \$10.3 million to Virginia which account for substantially higher subscriber counts

- Expressed another way, of all that GHMSI expends for these three purposes in its service area, 45 percent goes to the District despite the fact that it has only 10 percent of GHMSI’s membership. The reverse is true for Maryland which has 44 percent of GHMSI’s membership and receives 22 percent of all GHMSI payments for these three purposes combined.

This, however, is not the end of the story. The MIEAA contains an open enrollment program requirement that would cause GHMSI to lose between \$20 and \$30 million annually in each of the next five years. This is due to the fact that this open enrollment product would be required to be sold at well below cost. This provision is now temporarily suspended while GHMSI seeks to work out a public-private partnership with the District. But if it were to take effect, the portion of GHMSI’s premium revenue that would go for the combination of District taxes, giving and subsidies would rise to approximately 7.5 percent of premium income and consume nearly two thirds of all GHMSI contributions for these purposes among the three jurisdictions. This is a level that is at least triple the level in all surrounding jurisdictions. From our members’ perspective, this would mean adding approximately \$100 a month to the average monthly family premium of \$1,800 just for the difference between the 2% average of the other two jurisdictions and 7.5 percent.

The City Council has deliberately left the open enrollment provision in the MIEAA as an “assurance” that GHMSI would be more inclined to a favorable – from their perspective - outcome in the negotiations on the public-private partnership. GHMSI has been explicitly informed by the City Council that the MIEAA Open Enrollment requirement will be a feature in any permanent legislation going forward for this purpose.

It should be noted that while more modest in comparison, the proposed public-private partnership would still cause the combined total of GHMSI contributions for taxes, giving and subsidies to be in the 5.5 percent range, or approximately 57 percent of all GHMSI payments for these purposes in the three jurisdictions. This level is well more than double the rate of surrounding jurisdictions and would cause GHMSI's spending for these three purposes to exceed \$23 million annually

I would ask a disinterested observer: Is this too little in the way of "Community Health Reinvestment" on GHMSI's part? Compare these percentages to what GHMSI seeks to put away in reserves for its subscribers each year – an average of 1 to 2 percent annually. How much is enough?

To further put these numbers in perspective, we researched other jurisdictions around the country. Only a handful – most notably those in neighboring jurisdictions – even require or measure community giving, and the combined burden is usually 2 percent or less after tax offset (as in the case of Pennsylvania). The District is a distinct anomaly in this regard – substantially higher than any other jurisdiction we could find and heading to sharply higher levels yet.

Further, since these burdens are borne only by GHMSI's premium payers - no other insurer operating in the District has this mandated burden - they force up rates to cover the cost. This includes rates paid by the 90 percent of members who reside in Maryland and Virginia or elsewhere. Hence, the interest of these other jurisdictions in this proceeding and its outcome is high.

If Appleseed gets its way, and its theory were to prevail – meaning that GHMSI is ordered to payout a portion of its reserves to the public - then a "taking" of reserves will have occurred in addition to the 5-7 percent annual contribution for taxes, subsidies and giving, and there will be harm to premium payers. Further, the means to moderate future premiums – through earnings on reserves – will be sharply reduced. There could scarcely be worse news for premium payers if that should come to pass.

In a broader sense, there could scarcely be a more discouraging message to the business community in the District and the region at a time of deep and prolonged financial and economic distress.

And, all of this is occurring before the outlines, contours and demands of federal health reform are known. It appears likely that these reforms will place additional taxes and fees on insurers, further adding to the burdens on subscribers.

### **A Further Perspective on GHMSI Reserves**

In its reports of July 31 and August 31 to the Commissioner, GHMSI presented how it determines overall reserve ranges and how it believes the requirement in the MIEAA to

“attribute” a portion of the reserves should be carried out. There is no need to repeat the key points of those reports.

But, we wish it understood that we have carefully reviewed the statements made regarding GHMSI reserves by Appleseed, ARM and Mathematica and find them replete with error, mischaracterization and misunderstanding. Just a few examples are offered now to point this out. Milliman will speak to this further in its testimony and a more complete listing in a separate submission will be made following this hearing.

With regard to the statements made about the RBC reserve ranges used in Pennsylvania, it is not fair or correct to say, as the Appleseed family of reports do, that the Commonwealth approved RBC ranges that are far below GHMSI’s current range. The Pennsylvania legislature adopted ranges for a different purpose and did, indeed, assign a lower range to the largest Plan in the State. However, for the Plan that is most like GHMSI in size – Capital Blue Cross and Blue Shield – it approved a range that is virtually identical to the range GHMSI currently uses on the advice of Milliman.

Nor, among a long list of criticisms of Milliman’s work, is it fair or correct to say that the Milliman report excluded FEP and administrative services lines of business that have a low risk profile and investment income. It did not. This is flat wrong.

The ARM report states that GHMSI surplus was reduced by a large amount due to a large increase in non-admitted assets, implying that without this, the company would have much larger reserves. As a matter of fact, the change had no impact on surplus and was agreed to by GHMSI’s external auditors and by the DISB in their separate audit of GHMSI financial filings.

The combined criticisms of the Milliman report are virtually all unfounded and we – and they – intend to respond to this on a point-by-point basis. We do not wish to let stand the misleading impression that Appleseed’s reports seek to create – namely, that there is no credible basis for the range Milliman developed. The Lewin Group’s review came to essentially the same conclusion as Milliman using a different analytical approach. Lewin, it should be noted, was the advisor to the Pennsylvania General Assembly’s Legislative Budget and Finance Committee in reviewing the surplus levels and community benefit activities of the four Blues plans, including a review of the Pennsylvania Insurance Department’s Order which established surplus ranges for the Blue Plans. Additionally, as a Lewin representative will tell you, Lewin has served as an adviser to the District on a variety of health-related issues.

It is also worth emphasizing that the mandate to the Commissioner under the MIEAA is not ultimately to judge whether GHMSI’s total reserves are “excessive” or “unreasonably large”, but just that portion of the reserves “attributable” to the District. We re-iterate our position that it is the residents of the other jurisdictions who mostly built GHMSI’s reserves by incurring over time less in claims where they live than they paid in premiums. The portion left to the District is essentially proportionate to its share of total membership.

## **Conclusion**

The facts do not fit Appleseed's theory. Yet, the theory has shaped much of the perception and unfortunately, the law, in the District.

GHMSI, by the command of its Congressional Charter, exists to serve its subscribers. It best fulfills this command – to conduct its business for their benefit - by offering the best possible value to its subscribers. To succeed in this purpose – which, at its heart, means providing affordable access to health care for subscribers – is to serve the whole community well. We believe no other interpretation of the Charter can be made. Nor do we believe that District law can modify or over-ride the mandate in the Charter.

GHMSI's subscribers are struggling greatly to pay premiums that are escalating faster than their incomes and their ability to pay for them. This is made worse by the shift of cost to them by the advent of high deductible health plans and lower contributions from employers who find themselves struggling to offer coverage at all. Our subscribers are the working backbone of this community, of the District and of the larger region. If Appleseed's approach is adopted and premiums are driven up still further, more and more of our subscribers will be unable to afford their premium payments. This does no one any good, and no local government program will be able to offset the harm that results.

The reserves that GHMSI maintains are in a range that is appropriate for a Plan of its size and characteristics. The Pennsylvania approach validates this. The company, by its own policy and track record, has never exceeded this range nor even risen above the mid point of this range. And the company's subscribers already bear a community health reinvestment obligation that is, by far, the highest in the nation - and that under any foreseeable scenario will increase given actions pending with the City Council. Certainly, this burden is already far higher than the neighboring jurisdictions GHMSI serves and far higher than that imposed in Pennsylvania, the jurisdiction held up by Appleseed as a model.

GHMSI has never sought a confrontation over the issues raised by Appleseed's theory, nor does it now. It believes that the opinions rendered four years ago by both the Commissioner and the Attorney General were essentially on the mark and the company has acted in accordance with this belief.

But according to what theory and in what context will the requirements of MIEAA now be carried out? We seek an implementation of the MIEAA that is consistent with our Charter – one that recognizes that by doing right by our subscribers, we do right by our whole community. We intend to continue our community giving which has consistently exceeded all other non-profit organizations combined on a regional basis. But, we wish to do so under the guidance and oversight of our Board of Trustees, as charged by Congress - not have community giving determined by a District only regulatory process.

We believe the company holds no excess in its reserves – particularly with regard to any portion that is “attributable” to the District – and any order to GHMSI by the

Commissioner to expend any portion of its reserves to other than subscribers is nothing more than a government "taking" of subscriber money for District purposes. Worse, it is a taking of subscriber money from neighboring jurisdictions.

**Our view in closing can be stated simply:**

If any legitimate excess is ever found on a different set of facts than those present here, it can mean only one thing: that subscribers were overcharged and are due a return of excess. It does not mean they should have their funds taken based on a theory not supported by the Charter or the facts. In such a circumstance, the only remedy the company can and would pursue is to do what its Charter commands: to return the excess to its subscribers.

We hope the MIEAA will be implemented in a way that allows us to carry out the central command of our Charter, and we are deeply concerned with the regional consequences if this is not to be the case.

Commissioner Purcell, we recognize and respect your new responsibilities to reach a decision on these critical issues in but a few weeks. For the sake of all involved, mostly for our subscribers – including those in other jurisdictions - we urge you to take great care in your decision, and we stand ready to offer any assistance you may need in doing so. In this connection, we would strongly suggest that you coordinate your review and decision on the surplus with the Insurance Commissioner of Maryland, who is currently engaged in an in-depth review of GHMSI's surplus.