

GOVERNMENT  
OF  
THE DISTRICT OF COLUMBIA

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DEPARTMENT OF INSURANCE, SECURITIES,  
AND BANKING

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PUBLIC HEARING ON SURPLUS AND  
REVIEW OF GHMSI

Friday,  
September 11, 2009

Office of Zoning

Hearing Room 220 South  
441 4th Street, N.W.  
Washington, D.C.

The Public Hearing on Surplus and Review  
of GHMSI before the District of Columbia  
Department of Insurance, Securities, and  
Banking convened at 10:00 a.m., Gennet

Purcell, Acting Commissioner, presiding.

DISB COMMISSIONERS PRESENT:

GENNET PURCELL, Acting Commissioner  
PHILIP BARLOW, Associate Commissioner

ALSO PRESENT:

LESLIE JOHNSON, Hearing Officer, DISB  
STEPHEN C. TAYLOR, General Counsel, DISB  
MICHELLE MATHIS, Paralegal Specialist, DISB  
ROBERT H. MYERS JR., Morris, Manning & Martin  
CINDY CHANG, Morris, Manning & Martin

JIM TOOLE, Rector and Associates  
NEIL RECTOR, Rector and Associates  
SARAH SCHROEDER, Rector and Associates

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Adjourn

1 P-R-O-C-E-E-D-I-N-G-S

2 10:13 a.m.

3 COMMISSIONER PURCELL: Good

4 morning.

5 The time is now 10:00 a.m. Well,

6 the time is 10:10 a.m. Welcome back to

7 everyone to this public hearing.

8 I'm just going to take this

9 opportunity to remind everyone to please set

10 your phones to vibrate or silence so as not to

11 interrupt any of the witnesses. Also that

12 there's no eating or drinking in this room so

13 please be mindful of that.

14 If there are any witnesses who

15 would like to testify again and have not

16 already indicated that on a witness card,

17 please do so now and provide it to our

18 transcriber.

19 Before beginning I just want to

20 commemorate the day and request that we have

21 a brief moment of silence in honor of

22 September 11.

1 Thank you.

2 And with that we will proceed.

3 Next on my list I have Mr. Doug Gray, Mr.

4 Wayne McOwen and Mr. Paul Creamy. You can

5 come up in the panel of three if everyone is

6 here.

7 I knew you were going to ask that.

8 In that case is Peter Rosenstein is here or

9 Doreen Hodges will take both of you now as

10 well.

11 Mr. Rosenstein, do you copies of

12 your testimony? Okay. Thank you.

13 Rosenstein, I apologize. Good

14 morning.

15 MS. JOHNSON: Would you both raise

16 your right hands to be sworn in please.

17 Do you swear or affirm to tell the

18 truth, the whole truth and nothing but the

19 truth so help you.

20 Thank you.

21 COMMISSIONER PURCELL: You may

22 proceed, Mr. McOwen.

1 MR. McOWEN: Thank you.

2 Good morning Chairperson Purcell  
3 and members of the panel. My name is Wayne E.  
4 McOwen and I represent the District of  
5 Columbia Insurance Federation, a State  
6 insurance trade association whose members  
7 provide property, casualty and health  
8 insurance products and services to the  
9 residents and businesses of the District of  
10 Columbia.

11 On behalf of the DCIF I am pleased  
12 to offer remarks on matters before this  
13 hearing which has been convened by the  
14 Commissioner pursuant to the Medical Insurance  
15 Empowerment Act of 2008.

16 DCIF member companies have a  
17 history of working together to create  
18 progressive and balanced business and  
19 regulatory climates that enable insurers,  
20 agents and brokers to provide quality  
21 affordable insurance coverage to District  
22 consumers.

1                   A component of that objective is  
2 the avoidance of and the elimination of  
3 onerous or unnecessary laws and regulations  
4 which make it more difficult for insurers to  
5 operate and which may have the potential to  
6 add more cost to the system to the detriment  
7 of all stakeholders. It is in this context  
8 that I offer comments today.

9                   I am not here today to speak to  
10 the adequacy or inadequacy of the reserves at  
11 issue in the debate before this body.  
12 However, as a spokesperson for an organization  
13 representing diverse segments of the insurance  
14 industry in the District, I am here to suggest  
15 that the many and varied mechanisms currently  
16 in place and which follow universally  
17 recognized processes for the protection of  
18 consumers should be given careful  
19 consideration.

20                   These mechanisms include the  
21 following.

22                   The chief regulator in all

1 jurisdictions including the District of  
2 Columbia Insurance Commissioner is required to  
3 review and has inherent authority to approve  
4 or disallow insurer proposed rate levels by a  
5 process which insures the adequacy of capital  
6 reserves held for the protection of  
7 policyholders.

8           That rates are approved by the  
9 chief regulator speaks to the adequacy of  
10 insurer reserves in the District of Columbia.

11           Regulators follow a process which  
12 includes a risk-based capital analysis, a tool  
13 essentially enabling the evaluation of the  
14 potential for financial risk by a mathematical  
15 calculation. These formulas operate as an  
16 early warning system to identify potential  
17 financial pitfalls and benchmark levels  
18 regulatory intervention.

19           In extreme cases, the regulator is  
20 empowered to take over a troubled company and  
21 may initiate rehabilitative processes. But it  
22 is important to note that every company risk

1 profile is different. Thus, meeting the  
2 numbers so to speak is not the same for all  
3 carriers. Similarly, every dollar above risk-  
4 based capital limits may not necessarily be  
5 excessive.

6 Like all corporate entities,  
7 insurers are governed by a board of directors  
8 with the fiduciary responsibility for insuring  
9 financial soundness of their company. They  
10 are charged with making decisions regarding  
11 rates and reserves and how well -- how much of  
12 the company -- how much the company can afford  
13 to contribute in good works to the community.

14 Most importantly the fiduciary  
15 responsibility of directors comes with legal  
16 accountability for insuring the reasonableness  
17 of cost projections and claims trends and for  
18 setting rates sufficient to cover these costs.

19 Annual Yellow Book filings,  
20 documenting financial condition of insurers  
21 require sign off by independent actuaries  
22 attesting to the validity of management

1 recommendations. And most critically that  
2 reserves are adequate, neither understated or  
3 excessive.

4 Public hearing enable multiple  
5 stakeholders to weigh in on prospective rate  
6 change insuring that consumers have a voice in  
7 the process.

8 Of course, there are other factors  
9 to consider. Profit versus not for profit  
10 status influences the above mechanism but like  
11 all companies selling a product or service, a  
12 loading is built into the price. For insurers  
13 this loading enables the accumulation of  
14 reserves over time. For nonprofits this  
15 loading may be the only available avenue by  
16 which to secure future operations to the  
17 extent such companies may not have access to  
18 additional financial resources available for  
19 for-profit entities.

20 In the case of health insurers  
21 this may mean that the accumulation of  
22 reserves through policyholder premiums is the

1 only way to attempt to keep pace with medical  
2 inflation as claims spike up and it maybe the  
3 only way to protect such companies from the  
4 catastrophic exposure of a pandemic. Add the  
5 as-yet-to-be-determined Federal reconstruction  
6 of our nation's health insurance landscape and  
7 you have a surplus mystery worthy of Dr. John  
8 H. Watson and his most famous colleague. With  
9 apologies to Sir Arthur Conan Doyle the myth  
10 of the Case of How Much is not Enough.

11 As we have seen over the past six  
12 months to nine months the fortunes are very  
13 large and in some case industry icons can  
14 change quickly. At a time when financial  
15 markets are challenged because of the lack of  
16 capital it makes sense to consider every  
17 traditional solvency analysis to be certain  
18 that policyholder protections are not  
19 compromised, that the availability of coverage  
20 is not put at risk and that the perception of  
21 D.C. as a less than business friendly  
22 environment does not become an unintended

1 consequence.

2           Ultimately, through the functions  
3 of the Chief Regulator, the fiduciary  
4 responsibility of the company's board of  
5 directors and the consultative oversight of  
6 the actuarial community, reliable mechanisms  
7 are in place to provide appropriate and  
8 critical protections for consumers.

9           We believe it is not in the best  
10 interest of consumers to overlook even one of  
11 these mechanisms as these deliberations go  
12 forward.

13           Thank you for the opportunity to  
14 provide comments and I'd be pleased to answer  
15 any questions.

16           COMMISSIONER PURCELL: Thank you,  
17 Mr. McOwen.

18           Mr. Rosenstein.

19           MR. ROSENSTEIN: Here we go. Is  
20 that better?

21           Good morning, Commissioner Purcell  
22 and the other Commissioners. And by the way

1 congratulations on your recent appointment.

2 COMMISSIONER PURCELL: Thank you.

3 MR. ROSENSTEIN: And I am here

4 testifying as a subscriber of Blue Cross Blue

5 Shield CareFirst.

6 My organization, the American

7 Academy of Orthotists and Prosthetists is a

8 nonprofit headquartered in the District. And

9 CareFirst is our insurance provider.

10 I'm been an association executive

11 for over 25 years and have run a number of

12 associations in the District who also use

13 CareFirst as their insurance provider.

14 Small businesses and small

15 associations located in the District like mine

16 are actually disproportionately covered by

17 CareFirst. I like other association leaders

18 have chosen CareFirst as a health insurer for

19 my employees because CareFirst has provided us

20 with superior service and the rates have been

21 largely competitive with other companies.

22 I understand the reason that

1 CareFirst maintains a sizeable reserve level.  
2 And because of that reserve I can feel assured  
3 that if a catastrophe happens I will be  
4 covered and so will my employees.

5           However, if you and others with a  
6 comprehensive knowledge of the insurance  
7 industry can convince me that these reserves  
8 are actually too high, I would respect your  
9 knowledge. But if that is the case, then the  
10 issue becomes what to do with those reserves.

11           I think it would be highly  
12 inappropriate to do anything other than return  
13 those funds to those who built them to their  
14 current levels and that the subscribers and to  
15 do so either through rebates, lower premiums,  
16 rate reductions. To do anything else is most  
17 defensive to the business community,  
18 nonprofits and associations such as mine who  
19 have paid the premiums with the expectation  
20 they were actually for our benefit.

21           It is important to note who built  
22 up these reserves in question today. It was

1 not so much larger employers many of whom  
2 self-insure. So, CareFirst only administers  
3 their health insurance. They do not contribute  
4 to these reserves. It's not the Federal  
5 employees health program which CareFirst also  
6 administers but those funds are not included  
7 in these reserves. Therefore, Commissioner  
8 Purcell, the reserves you're evaluating today  
9 were paid in by small and medium sized  
10 businesses which are actually the economic  
11 backbone of the District as well as  
12 individuals who had to secure individual  
13 coverage.

14 Further, I would note that many  
15 small businesses and associations are  
16 struggling today to afford quality health care  
17 for our employees. And if we can have our  
18 rates reduced we are more likely to continue  
19 to provide those services to our employees and  
20 to pay as much as possible so they can afford  
21 health insurance.

22 Therefore, if you do not return

1 any excess to the subscribers in the form of  
2 a rate reduction or rebate, you'll be doing  
3 direct and immediate harm. It actually would  
4 be a direct tax on these businesses and their  
5 employees. Confiscating these premiums held  
6 in reserve for other purposes may mean that  
7 the money will eventually have to be made up  
8 by those of us who fund the reserves, small  
9 and medium sized businesses and other  
10 organizations located in the District as well  
11 as individual D.C. residents. So would there  
12 be a catastrophe and would those reserves be  
13 needed they will raise our rates to make up  
14 those reserve while you've taken their reserve  
15 for some other purpose and other individuals.

16 This is not equitable to those  
17 tens of thousands of District residents and  
18 their organizations. And, again, it's  
19 actually a direct tax on people who are  
20 already taxed as it is. And what is worse,  
21 it's a tax on only a select few people in the  
22 District and their employers.

1           I personally would be willing to  
2 pay a small personal tax if we could help get  
3 more people healthcare. But I resent being  
4 taxed andn the city purloining these funds  
5 that are meant for something else, while my  
6 neighbor who happens to subscribe to another  
7 insurance company isn't taxed.

8           There is such a thing as equity  
9 and by purloining these funds and these  
10 reserves only from CareFirst, if I had chosen  
11 to go with another company, I wouldn't be  
12 having my money taken.

13           So, there's a basic equity here  
14 that defies description in a lot of ways.  
15 It's actually contrary to the goal of helping  
16 businesses and organizations in the District  
17 and it's contrary to having them maintain  
18 healthcare access for their employees. In the  
19 long run it could encourage many of us to  
20 locate outside the District. It actually  
21 defies logic for the Districts to do this.

22           The other issue here which I will

1 just add is District employees, as I  
2 understand it aren't even allowed to use  
3 CareFirst as their option for healthcare. So  
4 what you're doing is exempting District  
5 employees from this tax automatically because  
6 they didn't even have the option to go to  
7 CareFirst.

8           So, it just gets compounded as you  
9 look at what's being done here to take this  
10 money which was meant for something else. And  
11 I understand the fact that the District is in  
12 financial trouble as all localities are. But  
13 that doesn't mean raid every available excess  
14 fund meant for something else to pay for  
15 something in the immediate future but will  
16 hurt the District in the long run.

17           I trust as Commissioner of  
18 Insurance for the District of Columbia that  
19 you will protect the interest of those tens of  
20 thousands of D.C. residents who pay their  
21 insurance premiums to CareFirst, myself, my  
22 employees included believing those premiums

1 were fair and for our own healthcare coverage  
2 and not for another purpose. Protecting their  
3 interest means letting CareFirst keep its  
4 current level of reserves if you believe that  
5 level is appropriate, to make sure it can  
6 continue to meet our healthcare needs, if you  
7 deem them too high which I will trust your  
8 judgment on, then you must work with CareFirst  
9 to return them to those of us who have  
10 actually paid them.

11 I thank you for the privilege of  
12 testifying before you today.

13 COMMISSIONER PURCELL: Thank you,  
14 Mr. Rosenstein.

15 I don't have any questions.

16 Thank you very much for your  
17 testimony. It will, as you know, be included  
18 in the record, reviewed and analyzed and we  
19 appreciate your contribution to this hearing.

20 MR. ROSENSTEIN: Thank you.

21 COMMISSIONER PURCELL: Sure.

22 Next if Mr. Doug Gray is in the

1 chamber please approach. Also Mr. Paul  
2 Craney, Ms. Doreen Hodges.

3 MS. JOHNSON: Would you raise your  
4 right hand please.

5 Do you swear or affirm to tell the  
6 truth, the whole truth and nothing but the  
7 truth so help you?

8 Thank you.

9 COMMISSIONER PURCELL: Good  
10 morning, Ms. Hodges.

11 MS. HODGES: Good morning,  
12 Commissioner Purcell and others.

13 Thank you for this opportunity  
14 today to be before all of you. I won't be  
15 before you long.

16 My name is Doreen Hodges. I am  
17 the proud parent of two children with special  
18 healthcare needs and/or disabilities living  
19 here in the District of Columbia.

20 I am also the Executive Director  
21 of Family Voices of the District of Columbia  
22 and my testimony is presented on behalf of

1 that organization and its members.

2           Family Voices of the District of  
3 Columbia is the local 501c3 grassroots  
4 organization which is family funded as the  
5 Family-to-Family Health Information Center by  
6 the Health Resources and Service  
7 Administration Maternal Child Health Bureau.

8           Our organization is affiliated  
9 with the National Family Voices Network whose  
10 mission is to achieve family-central care for  
11 all children with special healthcare needs  
12 and/or disabilities.

13           Through our network which  
14 represents 50,000 families of children with  
15 special healthcare needs and a family-to-  
16 family health and information center in 50  
17 states including the District of Columbia, we  
18 provide families that choose to make informed  
19 decisions about services for their children,  
20 advocate for improved public and private  
21 policies, build partnerships among  
22 professionals and families and serve as a

1 trusted resource on the therapeutic and  
2 healthcare decisions regarding their children  
3 with special healthcare needs and/or  
4 disabilities.

5           Our local organization mission is  
6 to advocate to improve public and private  
7 policies, build partnerships among  
8 professionals and families that serve them.  
9 Our guiding principles that outline the type  
10 of services we work toward in every state are  
11 family centered care partnerships, quality  
12 access, affordability and acceptability,  
13 healthcare systems that work for families and  
14 children, inform families and build strong  
15 communities, self advocacy and empowerment.

16           It is our understanding from the  
17 D.C. Appleseed's analysis that may have an  
18 access surplus of about \$300 million and the  
19 hope is that CareFirst and DISB will work --  
20 will consider investing its surplus dollars to  
21 meet some community healthcare care that are  
22 unmet.

1           I would like to talk about some of  
2 the unmet health needs of the District of  
3 Columbia residents. And I hope that CareFirst  
4 and DISB will consider reinvesting its surplus  
5 to meet those needs again.

6           Just a little background on our  
7 organization's advocacy efforts.

8           Back in 2005/2006 Family Voices of  
9 the District of Columbia participated with  
10 Autism Speaks and other professionals and  
11 organizations with presenting draft  
12 legislation to D.C. Council regarding their  
13 16-711, entitled The Rehabilitated Services  
14 Act.

15           Many of the family members,  
16 including myself have children with extensive  
17 medical needs that are partially covered by  
18 their health insurance. This Bill covered  
19 such services as physical therapy,  
20 occupational therapy, speech and language  
21 therapy for children diagnosed with special  
22 healthcare needs and/or disabilities such as

1 Autism, Down Syndrome, Cerebral Palsy and  
2 other genetic orders to be able to receive  
3 equivalent and same services as another peer  
4 who may not have been born or diagnosed with  
5 a special healthcare need. The limit though  
6 is 60 visits.

7           The Board passed and became law  
8 and now governs all D.C. insurance providers.  
9 Much of this law helps the local D.C. employee  
10 but leaves the Federal employees with the  
11 financial strain due to some of the examples  
12 I will outline.

13           Just one example is when a family  
14 receives a prescription or a treatment of  
15 services to be rendered to their child or  
16 their youth with special healthcare needs or  
17 disabilities it may be looking for physical  
18 therapy, occupational and speech services at  
19 least three times a week.

20           Under the Blue Cross and Blue  
21 Shield plan the co-pay rate for them is about  
22 \$15 t \$20 per visit with a total expense of --

1 weekly expense of about \$60 and a monthly  
2 expense of about \$500. Multiply that by four  
3 to five months which is allotted for the 60  
4 visits and the cost comes out to about \$2,000  
5 to \$2,500.

6           If the child is recommended to  
7 have additional services after those services  
8 are rendered the families could be facing out  
9 of pocket expenses of an additional \$14,000 a  
10 year. The families could appeal for  
11 additional services deemed as a medical  
12 necessity but there's no guarantee that they  
13 will be granted the reimbursement or the  
14 additional services that may be incurred.

15           Just to sum up things. Monies  
16 from the CareFirst surplus could be invested  
17 back into the community under such a program  
18 as the Catastrophic Health Fund. Catastrophic  
19 Relief Fund which has been established in such  
20 states as Massachusetts, Connecticut and New  
21 Jersey and many of those states are where you  
22 find similar demographics and analysis of that

1 which fits the District of Columbia and its  
2 surrounding states here in the greater  
3 Washington metropolitan area.

4           The Catastrophic Illness in  
5 Children Relief Fund helps families bear the  
6 accepted financial burdens associated with the  
7 care of children with special healthcare needs  
8 and disabilities. And that Catastrophic  
9 Relief Fund is that of a payee of a last  
10 resort for those families that do not actually  
11 qualify for Medicaid or also a waiver which  
12 the District of Columbia does not have a  
13 waiver here that serves children for the ages  
14 of zero to 23.

15           So, therefore, it provides  
16 financial assistance for families with  
17 children experiencing a medical conditions  
18 requiring services that are not covered by a  
19 private insurance, Federal or state assistance  
20 or any other financial source.

21           This fund is designed to act as a  
22 safety net for families who had excessive

1 expenses related to a child or a youth's  
2 medical needs and the families may be  
3 responsible for these expenses again due to  
4 the lack of insurance or dependent coverage  
5 and a pre-existing conditions and copays and  
6 so forth.

7                   In most states noted above the  
8 child relief fund, the Catastrophic Relief  
9 Fund, receives monies through an annual  
10 allotment of about a dollar for each employee  
11 whose wages are counted as part of the  
12 employer's contributions for unemployment  
13 health insurance and the State Treasury kind  
14 of manages the funds.

15                   This would be a win situation to  
16 the families who do not have Medicaid or  
17 coverage through an employer or that has a  
18 limit such as what CareFirst has offered to  
19 many of both again local D.C. employees and  
20 then also to Federal employees. And CareFirst  
21 can make prices for its open enrollment and  
22 HIPAA products affordable.

1           I want to thank you for this  
2 opportunity today and welcome any questions or  
3 concerns. But most importantly I look forward  
4 to working with many of you on the  
5 possibilities for the future.

6           And could I just add one last  
7 thing. And it's many of the organizations  
8 that previously testified maybe at the D.C.  
9 Council earlier this year regarding the  
10 CareFirst surplus money do not have inclusive  
11 settings to include children and youth with  
12 special healthcare needs even though they are  
13 community organizations. So, many of our kids  
14 with special healthcare needs are left out or  
15 segregated with regards to healthcare options  
16 for prevention of obesity and nutrition and  
17 things like that and that could be monies that  
18 could be used to help be preventative  
19 decisions and medications and things like that  
20 in healthcare decisions.

21           I thank you again.

22           COMMISSIONER PURCELL: Thank you,

1 Ms. Hodges. Thank you for taking the time  
2 sitting through yesterday and today to put  
3 your opinions and views on the record. We  
4 appreciate it.

5 Thank you.

6 Any questions from the panel?

7 I don't have any questions.

8 Thank you.

9 Okay. So, again, finally if Mr.  
10 Paul Craney is in the room or Mr. Doug Gray.

11 No.

12 I do have a written report of Mr.  
13 Paul Craney's testimony so that will be  
14 included in the record even though he's not  
15 here.

16 So, prior to calling for Ms.  
17 Ifert's closing statement again I want to give  
18 the opportunity to anyone in the chamber. I  
19 think there's no one new here.

20 Mr. Burrell, in panel, you may  
21 approach. And you, except all for the  
22 exception of Ms. Tilden been sworn in. And so

1 we will swear you in Ms. Tilden and then you  
2 may proceed.

3 MS. JOHNSON: Do you swear or  
4 affirm to tell the truth, the whole truth and  
5 nothing but the truth so help you?

6 MS. TILDEN: I do.

7 MS. JOHNSON: Thank you.

8 MR. BURRELL: Good morning. We  
9 listened and I listened with great interest to  
10 all of the discussion yesterday and I don't  
11 want to attempt this morning to go through a  
12 point by point rebuttal.

13 We hear different pretty  
14 dramatically views of the legal lay of the  
15 land as well as the different views of the  
16 actuarial lay of the land.

17 I'd like to use the time this  
18 morning to just perhaps emphasize a few points  
19 and then make some suggestions. And let me  
20 start with what those points might be.

21 The first point I think I would  
22 emphasize is we are in a severe and worsening

1 crisis with regard to healthcare costs. I  
2 personally have been in this field for 30  
3 years. I formally run a Blue Cross plan in  
4 another state. And I remember at the time  
5 healthcare costs as a percentage of national  
6 GDP was about 9 percent. Today it's  
7 approaching 17 percent.

8           But to put it in concrete terms  
9 healthcare costs in this region have been  
10 rising 9 to 12 percent a year and our costs  
11 for claims have been rising generally in that  
12 range year after year after year.

13           If we look forward to next year in  
14 our product array we see the need for  
15 increases somewhere in the 8 to 18 percent  
16 range that average somewhere in the 10 to 12.  
17 That's what is happening with healthcare  
18 costs. And if you put that in specific terms  
19 I said yesterday just to repeat it today the  
20 average family of four in the District for I  
21 would say one of our most popular products  
22 spends about \$1,800 a month. If costs were to

1 continue to go at the rate they're going then  
2 that \$1,800 a month can be expected to turn  
3 into about \$3,600 a month in about seven years  
4 at which point few can afford it.

5 Let me make a couple of related  
6 points to that.

7 People rightly are concerned and  
8 there was a lot of testimony about this  
9 yesterday with the size of rate increases. So  
10 are we. And they reflect the costs of care by  
11 and large. The margins that the company  
12 operates on, I made the point yesterday. I  
13 just want to make it again is two tenths of a  
14 percent. It isn't as if the rate increases  
15 produce huge bottom line profits. They do  
16 not. And they have not for the last 10 years.

17 The related point is that the rate  
18 increases do not produce ever-increasing  
19 reserves. They do not. The reserves have  
20 been declining in recent years. And we would  
21 expect that potentially to continue and that's  
22 what those charts show.

1           So, I just want to make sure it's  
2 clear that the issue of affordability, we  
3 treat as the central issue and the rising cost  
4 of healthcare is the reason why it is  
5 increasingly unaffordable not because  
6 CareFirst seeks to fatten its reserves or  
7 fatten its profit margins.

8           The second basic point I would  
9 make is that the business of GHMSI is complex  
10 beyond a lay person's imagining. Wish it  
11 wasn't so. We sell to tens of thousands of  
12 employer groups, not just in the District but  
13 throughout the region hundreds of thousands of  
14 individuals in any given months, groups that  
15 we serve, 45 percent of them change their  
16 benefits mostly downward which is disturbing.

17           We have care trends that vary  
18 based on product design, based on geographic  
19 part of the region. All of this creates  
20 incredible complexity which has been complex  
21 in terms of judging what is an adequate  
22 reserve.

1           I want to comment a little bit on  
2 the issue of our market position and our  
3 monopoly or something approaching that. Our  
4 monopoly power. If you sat where we sit or  
5 let me make it more specific. If you sat  
6 where I sit you never feel that ever.

7           What you see is a marketplace so  
8 traumatized by cost that it seeks almost in  
9 the way a person in an overturned boat would  
10 seeks to get up for air. It seeks a better  
11 cost. It seeks lower cost, almost at any  
12 price. What employers are doing is buying  
13 down benefits. Cutting benefits to get to  
14 lower cost.

15           The intensity of that is augmented  
16 by consultants who swarm all over this,  
17 brokers who spreadsheet every possible  
18 offering against every other possible  
19 offering, ours and everyone else's in a search  
20 for what is the best value. Can't blame them.  
21 We completely support that. They ought to go  
22 that on behalf of those they represent.

1           We represent, it is true, a  
2   substantial portion of the market,  
3   particularly for small groups and individuals.  
4   I would offer to you that the reason for that  
5   is the safe harbor that it offers relative to  
6   the alternatives. They sought it based on  
7   value. They sought it because of network,  
8   because of price, because of service, the very  
9   things that we are committed to do. But we  
10   feel in no way secure about that or content  
11   about that. And we are concerned as anyone  
12   else with the rise in cost and the behaviors  
13   that it induces which leads to my next point  
14   which is that what we see in the market today  
15   are what I would call destructive tendencies.  
16   It is understandable but it is worrisome. And  
17   that is employers buying down benefits or  
18   individuals buying down benefits, cutting the  
19   benefits that they have because they can't  
20   afford to have what they used to have.

21           And I gave statistics yesterday  
22   about the degree to which that's happening.

1 In my experience, 30 years in the field, I  
2 have never seen a market move from what is  
3 essentially network-based benefits, PPO  
4 benefits, the things that Blue Cross and Blue  
5 Shield has offered for a long, long time.  
6 Never seen a market move away from that as  
7 quickly as it has to high deductible health  
8 plans. And I mentioned the statistic  
9 yesterday of over 50 percent of small groups  
10 in Maryland rapidly following here in the  
11 District have now moved to these high  
12 deductible designs.

13 Basically what that does is shift  
14 a huge amount of cost to the member, but it  
15 also from a provider standpoint shifts a huge  
16 collection burden to the provider. Now it's  
17 not a question of getting paid for every  
18 dollar you bill, it's a question of chasing  
19 some of that, a material portion of that from  
20 people who are not in a position to pay it.

21 We're worried that what that might  
22 do is undermine networks, undermine discounts

1 that are actually there for the benefit of  
2 subscribers. We have yet to see the full play  
3 out of this but it's not likely to have a  
4 completely happy ending.

5 All of these dynamics interplay  
6 with each other and create a truly complex  
7 situation for the company and for society and  
8 for anyone that attempts to develop an  
9 appropriate level of reserve or surplus for  
10 the company.

11 Let me take those observations and  
12 add just a couple of other thoughts and then  
13 make a few suggestions and talk about the  
14 consequences here.

15 I mentioned this yesterday that if  
16 you look at GHMSI's business in the District,  
17 in addition to what subscribers have to carry  
18 their own burden in terms of the premiums that  
19 reflect their costs, there is an addition of  
20 premium tax and in addition a community giving  
21 obligation and in addition to that subsidy  
22 where we use company funds to subsidize open

1 enrollment products at very substantial loss  
2 on those products knowingly offering them well  
3 below their cost by design. And ultimately it  
4 is the subscriber that pays that and more  
5 particularly it is the individual and small  
6 groups subscriber that pays that because as we  
7 pointed out, the large groups basically are on  
8 their own experience and self insure and the  
9 FEP program which is a very substantial  
10 portion of our business is on its own  
11 experience. So, the ones that bear the brunt  
12 are the individuals and the small groups and  
13 they are the backbone of the community.

14           So, if you look at the statistics  
15 as I cited yesterday in the District about 3.3  
16 percent is for those factors combined, taxes,  
17 giving and subsidies.

18           We believe based on the  
19 public/private partnership that we have been  
20 discussing with the city council that that  
21 number will go to 5.5. More will be given --  
22 substantially more. And it could go as high

1 as 7.5.

2 I cited yesterday when you look  
3 around the country what you see typically are  
4 in the neighboring states are premium taxes in  
5 the 2 percent range or less or a combination  
6 of giving and taxes in that range. There is  
7 no place that does 3.3 that we could see or  
8 5.5 or 7.5. But that's where we're headed.

9 So, in addition to all of the  
10 other factors of escalating costs these too  
11 must be borne by individuals and small groups,  
12 basically those headquartered here in the  
13 District.

14 And in this connection there's  
15 another things to consider. A whole other set  
16 of things that are about to overtake us all  
17 which is Federal reform and I know one of the  
18 witnesses said yesterday why would we worry  
19 about that. I would only draw everyone's  
20 attention to the fact that the heart of that  
21 reform is individual mandate, no pre-existing  
22 conditions, things that we would absolutely

1 support. We are in every way in tune with  
2 what the President said. We are total  
3 supporters of that.

4 We hope what that does is broaden  
5 out coverage for everyone in the community.  
6 But we are also aware that by doing it it will  
7 have impacts on us and others that neither we  
8 or anyone else can fully see. It will change  
9 our risk profile we hope in productive ways  
10 for society. We will take on all comers.  
11 Think it's sound policy. But it will put  
12 pressure on the company's financial position.  
13 We welcome that but we want to be prepared for  
14 that.

15 So with all of this said I just  
16 want to draw out what I think the implications  
17 are from what I guess we heard or I heard in  
18 the Appleseed presentation yesterday as we see  
19 those consequences.

20 If I understand what Appleseed has  
21 said is that if you look at the company's  
22 surplus in the light of the standard that is

1 in MEIAA that it could be, perhaps is, \$300  
2 million too high in the aggregate.

3 If you connect to that thought the  
4 thought that was expressed that perhaps 60  
5 percent of that is attributable to the  
6 District. And of course we put forward a  
7 different view but take for a moment the  
8 Appleseed view. You're talking about  
9 something in the \$150 million range.

10 If that's the case and just for  
11 the argument sake here, if we were confronted  
12 with a decision from the Commissioner that  
13 says there's \$150 million too much then the  
14 way we would approach it is to say as I said  
15 yesterday, that is the subscribers' money. If  
16 there is excess it is because they paid too  
17 much. Perhaps not in our judgment but in the  
18 judgment of the Commissioner.

19 So, if that were the case there  
20 are a variety of ways to deal with it but  
21 among them would just to not file rate  
22 increases that are needed. Hold rates flat.

1 If the average rate increase year based on  
2 what healthcare costs -- how they are rising,  
3 for argument sake to round it off is 10  
4 percent or 12 percent. Let's just take 10.  
5 We wouldn't do that. We'd hold them flat.  
6 And for awhile, short while, there would be a  
7 benefit to the subscribers. It would start  
8 losses mounting.

9           One of the points I tried to make  
10 yesterday is when you run a business like this  
11 you operate on razor thin margins, a percent.  
12 We fight for a percent or two. And we hope we  
13 can augment that by earnings on our reserves.  
14 But the margins that the business actually  
15 throws off are in those skinny ranges.

16           If we did not file for a 10  
17 percent rate increase that was really needed  
18 we would begin to lose 10 percent on the  
19 policies that we didn't raise. And you could  
20 proceed along those lines until you lost some  
21 specified amount of money. A hundred million,  
22 150 million, pick the point. But what happens

1 at the end of that which is a relatively brief  
2 period, may take 24 months is a spring-back  
3 that will be brutal. Because what it will  
4 require is that the company conform its rates  
5 to reality. Trend if it is going up 10 or 2  
6 percent will have been up 20 to 24 percent.  
7 So, we will have to catch up, maybe with  
8 margin, maybe a little bit, two percent and  
9 the spring back to these groups will be  
10 brutal.

11           There are consequences to that.  
12 First of all, it would be perceived as I think  
13 to some extent a bait and switch. But however  
14 it's perceived the actions that it will evoke  
15 really are mostly likely to result in a mad  
16 dash to find alternatives wherever you can.  
17 And we could expect substantial dis-enrollment  
18 as a result. Whatever desperate nature of the  
19 search for value is today will take on true  
20 intensity then.

21           The dynamic that we would face is  
22 that we know that our rates at that point

1 would be difficult to catch up to the moving  
2 trend and we potentially would face tail  
3 losses on this, meaning the losses would  
4 extend out beyond whatever the period would be  
5 requiring further catch up. It will be  
6 difficult to turn the loss to any kind of  
7 break even or gain is all I am saying as a  
8 practical hard fact. And it will be very  
9 difficult to hold a company on an even keel.

10 I don't even want to mention the  
11 fact that one of the interests that Congress  
12 has in this, GHMSI and our role with the  
13 Federal employee program is in the stability  
14 of the company. And the fact is, the GHMSI  
15 operates the Federal employee operations  
16 center for 4.8 million people U.S. wide not  
17 just in this region.

18 If there were concerns over the  
19 viability and the stability of the company, it  
20 certainly doesn't have to be with us. They  
21 don't have to administer through us. There  
22 are many, many jobs associated with that here

1 in the District. It's a role the company has  
2 had since its inception virtually.

3           You received I think as part of  
4 your written or at least from us a letter from  
5 Scott Serota, the President of the National  
6 Association, the Blue Cross and Blue Shield  
7 Association, in which he expressed concerns.  
8 What you can't know and don't know is that I  
9 probably had between 10 and 20 calls with  
10 Scott Serota leading up to this hearing  
11 concerned about what was going on and what was  
12 the direction of the District and where was  
13 this going to end. I just note that. Other  
14 effects beyond the ones I've just mentioned  
15 could occur.

16           So, I left thinking yesterday that  
17 I don't envy the place that the Commissioner  
18 is in to make this decision. I guess I would  
19 make a couple of suggestions.

20           One is to be very, very careful.  
21 The -- Walter Smith yesterday made a right  
22 point I believe. He said that this is about

1 the range and in some ways and many ways it  
2 is. What is the range of reserve that the  
3 company ought to have?

4 Obviously, the company I would  
5 tell you has tried to do it right. It has  
6 sought the best advice it could and it has  
7 listened to that advice after probing that  
8 advice. But it is true that the range is  
9 critical.

10 My suggestion would be this. We  
11 have retained Milliman. If there is more  
12 discussion that is needed with Milliman and  
13 more access to Milliman from our point of view  
14 you have it.

15 We are going to ask Lewin to do a  
16 full-fledged review, not just the second  
17 opinion that they did. And we're going to ask  
18 them to do that promptly. We think Milliman  
19 and Lewin are both credible sources but the  
20 centrality of this issue and the importance of  
21 this issue, not only to us but to the District  
22 as a whole, the community as a whole justifies

1 being very careful.

2 We envision perhaps a four way  
3 here. Milliman, Lewis, Invotex and Rector.  
4 Certainly between four actuaries, actuarial  
5 reviews, some judgment can be made about what  
6 is the right range, the appropriate range for  
7 the company to have.

8 We're concerned about the  
9 timetable that you are under as a Commissioner  
10 and the deadline to make a decision by the  
11 30th of September. We would ask that you  
12 consider taking a little bit longer if that is  
13 possible, even if it took asking the city  
14 council to grant a modest additional time  
15 perhaps another 30 days to get it right.

16 You heard yesterday from  
17 Commissioner Tyler. He expects to have his  
18 work completed in that period of time. I'm  
19 sure he is prepared to share all of that work  
20 and said so yesterday. And given the  
21 importance of the issue and the complexity of  
22 the issue we would hope it would be possible

1 to bring all that insight to bear.

2           If at the end of all of that there  
3 is a conclusion that we indeed do have excess  
4 which means we overcharged our subscribers  
5 then we would file a plan to give it back to  
6 them. And most likely give it to them in the  
7 form of rate moderation going forward.

8           I don't want to overly prescribe  
9 right this minute what the plan might be but  
10 I want to give you a firm understanding of the  
11 direction we would pursue.

12           I've been in the field a long  
13 time. I don't know that I have ever been as  
14 worried as I am right now about what the  
15 consequences of something like this could be.

16           I came to the company really only  
17 for one reason. I know it has an interesting  
18 and colorful and troubled perhaps in some  
19 respects history. And to me that a curious  
20 artifact. I wasn't here. I learned about it  
21 but it's history.

22           And so what I would say is that

1 yesterday I urged a long view. We've been in  
2 this community for 70 years. Everything about  
3 a business with as narrow margins as this  
4 suggests a long view. Keep a moderate steady  
5 course and keep financially sound.

6           We don't want to look for  
7 situations where rates are stabilized and then  
8 shoot up to such a degree it causes trauma in  
9 the marketplace nor do we want to in any way  
10 overcharge any of our subscribers who are  
11 desperately trying to make ends meet. It is  
12 why our Board has decided to keep margins at  
13 one percent or less. And when you take as  
14 much risk in as complex an environment as we  
15 do with trends moving and benefits moving and  
16 groups moving doesn't feel so comfortable to  
17 try to preside over all of that and make that  
18 all come out at a half a percent or a percent.

19           If we misjudge medical trends by  
20 one percent for us it's \$50 million. We do  
21 not aspire, I want to make it very clear, to  
22 fatten our margins in anyway and we do not

1 seek and aspire to increase our reserves in  
2 anyway. But what we do want to do is strike  
3 a modern long-term course that is the best for  
4 the market. I think the hope that the  
5 President was expressing in co-ops I was  
6 struck with it. A co-op in some ways is a  
7 very close clone to what we already are.

8           The hope would be that what the  
9 co-op could do is develop good networks --  
10 good provider networks with good contracts,  
11 with good service and offer good value.  
12 That's the hope and it would do it at skinny  
13 margins, perhaps margins of a half a percent.  
14 That would be the hope. We live that hope.  
15 We are that hope today.

16           So, I guess our strongest point of  
17 all is to be careful with what is done from  
18 here and to gather all of the advice.  
19 Whatever we can do to help you in that regard  
20 you have our assurance. And if there needs to  
21 be more understanding of what Milliman did or  
22 in this case as we add Lewin to it further,

1 you have that.

2           And I would hope you would take  
3 into account also Invotex results and what  
4 Maryland is doing. We live in both  
5 jurisdictions and to think that we could come  
6 out with two different conclusions by two  
7 different regulators on the same subject  
8 within a month is not a particularly welcome  
9 thought.

10           I guess that would conclude my  
11 remarks.

12           Thank you.

13           COMMISSIONER PURCELL: Thank you,  
14 Mr. Burrell.

15           We do have a few follow-up  
16 questions. One I will start with, not for my  
17 benefit, for the benefit of the public  
18 witnesses who you heard from yesterday and  
19 those who are following and paying attention.

20           As an additional footnote perhaps  
21 to your statement that rate increases are not  
22 a reflection of that you're charging too much

1 or that your gouging your subscribers but that  
2 it's reflective of the increases in healthcare  
3 costs. How do you -- could you just expand on  
4 that then and for this lay person watching and  
5 listening, explain then how the surplus got to  
6 the level that it's at and how it is that if  
7 it, you know, if it is excessive it belongs to  
8 the subscribers because you charged them too  
9 much? Because I've heard you say all those  
10 things but it seems a little inconsistent.

11 So, if you could just clarify for  
12 the public lay person who may not understand  
13 how those all work together.

14 MR. BURRELL: I think the -- with  
15 regard to your -- the first part of your  
16 question. There's really only two ways that  
17 the reserves can grow and have grown.

18 Number one, it is the difference  
19 between the premiums and the expenses. The  
20 most significant portion of which are medical  
21 claims. Nearly 90 percent of all costs is  
22 medical claims. The rest is administration

1 and related matters. But the cost that's  
2 driving it is the claims.

3 And it is that difference. That  
4 difference is on that chart for the last 10  
5 years. And on average the underwriting  
6 results have been one to two percent. So, one  
7 way the reserve gets built is from that thin  
8 margin.

9 The second way the reserve gets  
10 built is from earnings on the invested funds  
11 that are in the reserve. And we invest those  
12 extremely conservatively by law and by choice.  
13 And they are there as they earn for the  
14 benefit of the subscribers because we use  
15 those earnings to help moderate rate  
16 increases. Everything that we can get from  
17 earnings on the portfolio we don't have to get  
18 from subscribers through premium rate  
19 increases. So, that's how the reserve got  
20 built. it got built slowly by these small  
21 additions every year and by the earnings on  
22 the reserve. That's the way it got built.

1           On the care cost side it's a  
2 complicated situation as everyone knows. Our  
3 -- we work very, very hard on provider  
4 networks, the adequacy of those networks and  
5 the pricing of those networks. It's not  
6 generally widely known, but the discounts that  
7 we obtain from providers are in the order of  
8 65 percent of billed charges, all of which  
9 gets passed back in value to the subscribers.

10           If you were to go out in the  
11 marketplace and just go privately to a doctor  
12 you would not enjoy those discounts. There  
13 are a series of other things that we tried to  
14 do to restrain cost. I would say that there  
15 is a check on those things in the sense that  
16 what people most object to in insurance  
17 companies is them intersecting in the cost of  
18 their care, or in telling them what care they  
19 can and can't get. We are very respectful of  
20 that.

21           What's driving cost is not the  
22 unit cost of care. Physician fees as we pay

1 fees at our discounted levels are not rising.  
2 That value is passed on directly in our  
3 premiums. And what we pay to hospitals is  
4 rising a single digit per year in terms of  
5 inflationary increases.

6           What is rising and where most of  
7 this comes from on cost is use. We see every  
8 year ever more use of service, a lot of it  
9 associated with American lifestyles, meaning  
10 the rise of obesity in the population, the  
11 correlation of that with diabetes, with heart  
12 disease and a series of other chronic  
13 conditions. And when you take those powerful  
14 forces that are pushing up cost through higher  
15 use together with fee for service medicine  
16 which the President mentioned the other night,  
17 the idea that we pay by unit of service. You  
18 put those two forces together and you have why  
19 medical inflation is what it is in this  
20 country. What's going on in this region is  
21 not different.

22           Counteracting those forces as I

1 said yesterday is the single most important  
2 challenge we and the Government face and every  
3 other payer faces.

4 So, it's a long-winded answer to  
5 your question but the reserve was built the  
6 way I described and it was built year b y year  
7 by year only in that way b y these small  
8 margins and by the earnings.

9 COMMISSIONER PURCELL: Thank you.

10 Jim.

11 MR. TOOLE: Are there margins that  
12 derive from the administrative services  
13 business and the FEP business and they do  
14 those margins occur to surplus?

15 MR. BURRELL: Generally on the  
16 administrative services only business we  
17 operate virtually without margin because of  
18 price pressures. It is so competitive and it  
19 is consultant driven as I've said. And they  
20 prove every cost and every item to the point  
21 where there's virtually nothing left.

22 It is the reality we deal with and

1 everybody else deals with. The rest of their  
2 cost is claims of course on the large group  
3 side of things.

4           On FEP it's essentially cost with  
5 one exception for us. And this is by the  
6 design of the Federal program which is that we  
7 can win as a plan what is called a service  
8 award, meaning if we provide truly outstanding  
9 service we can win an award for that. So, you  
10 get your cost covered but then you can get  
11 this award.

12           Just as a matter of interest,  
13 GHMSI got that award for the 12th straight  
14 year this past year. No one in the country  
15 has ever done that. That award produces to us  
16 a financial award of between \$15 and 20  
17 million a year. And so it's welcome. But  
18 it's certainly not in the scheme of things on  
19 a multi-billion company any major additive  
20 factor to our bottom line.

21           If it does contribute to the  
22 bottom line as it does, it goes to the

1     reserve.  So, in that sense, yes.  It would  
2     build to the reserve.

3                 I would say one other thing about  
4     FEP.  Because of its importance to us, because  
5     of its size, it is helpful even though it is  
6     based on cost, it helps us cover cost  
7     overhead.  It's very favorable in that regard.  
8     In other words, if we had to have all the  
9     administration cost only on small groups and  
10    only on individuals it would be higher but we  
11    are able fortunately because of the  
12    materiality of the FEP program to allocate to  
13    them their share of it and get them to pay for  
14    it which is what they do under their contract.

15                It is why I am concerned that if  
16    there was a concern at the Federal level or  
17    there was a concern at the National  
18    Association level about the stability of this  
19    plan they have options.  We are not the only  
20    ones that could administer that program.  And  
21    in deed there is a back-up to us within the  
22    blue system that could be rather promptly

1 triggered if they ever had any concerns. And  
2 that would cause job loss and everything else  
3 here and it would splash back on local,  
4 individual and small group premium payers  
5 because then there would be no ability to  
6 spread the administrative costs over FEP.

7 My point is there are as always in  
8 this field unintended consequences, hidden  
9 consequences down the line of things that on  
10 the surface seem so clear and easy and when in  
11 reality are not at all. That's why I say be  
12 careful.

13 COMMISSIONER PURCELL: Neil.

14 MR. RECTOR: I had just two very  
15 quick clarification questions.

16 You talked a lot about the margin,  
17 the thinness of the margin.

18 Is that the margin for all  
19 products combined? So, if the FEP and the  
20 administered services are basically near zero,  
21 then the individual and small group would need  
22 to be higher so that it averages down to that?

1 MR. BURRELL: Yes.

2 MR. RECTOR: Okay.

3 And then the second question I had  
4 is I think in your testimony today you talked  
5 about the reserves declining year to year to  
6 year. And I didn't know if you --

7 MR. BURRELL: I'm sorry, I meant  
8 RBC if I said reserve.

9 MR. RECTOR: Okay. Thanks.

10 That's all I had.

11 MR. BURRELL: The reserve actually  
12 did not. The dollars did not.

13 MR. RECTOR: Yes.

14 MR. BURRELL: The RBC did.

15 MR. RECTOR: Yes. Thanks.

16 COMMISSIONER PURCELL: Skip.

17 MR. MYERS: I have a couple of  
18 questions for you, sir.

19 First of all, we heard testimony  
20 earlier from Mr. Rosenstein and he said that  
21 he felt that any surplus, any excess surplus  
22 should be attributable to individuals or small

1 groups.

2 What's your view on that?

3 MR. BURRELL: I have already  
4 answered that many times. That is my view.

5 MR. MYERS: Okay.

6 MR. BURRELL: If there is an  
7 excess it goes back to them.

8 MR. MYERS: Okay.

9 I wanted to ask -- talk a little  
10 bit about the test for determining excess and  
11 maybe this is a question for you or maybe for  
12 Mr. Hogan.

13 But in any event I wanted to walk  
14 through this with you in the statute because  
15 there was testimony -- it seems to me there's  
16 some conflicting testimony or inconsistent  
17 testimony yesterday about this question.

18 If you look at the statute under  
19 E1 and 2, it establishes the determination of  
20 when -- when the surplus is excessive. It  
21 says that the surplus must be greater than the  
22 appropriate risk based capital requirements as

1 determined by the Commissioner for the  
2 immediate preceding calendar year. And it  
3 must be determined that the surplus is  
4 unreasonably large and inconsistent with the  
5 corporation's obligation under Section 6A  
6 which is its charitable exempt purpose.

7 Presumably because it says "and"  
8 and not "or" arguably there could be a  
9 circumstance under which it was unreasonably  
10 large but consistent with the corporate  
11 corporation's obligation. And I wanted to see  
12 what your views were on that.

13 MR. HOGAN: That's true. As a  
14 matter of statutory construction there has to  
15 be -- as you've pointed out it says after a  
16 hearing and E(2). There's has to be two  
17 findings.

18 One, and if both findings are not  
19 made then there is no remedy. There is -- the  
20 Commissioner has to stand back and there can  
21 be no remedy, no finding of excess.

22 So, if there is not an

1 unreasonably large finding, then and if our  
2 reserves are not unreasonably large, then  
3 there is no excess. Likewise, if -- even if  
4 they were unreasonably large, if -- if  
5 managing the reserves in some way was  
6 inconsistent with the corporate obligation  
7 which includes financial soundness and  
8 efficiency. If there was some contingency out  
9 there, I'm not saying there is. We don't know  
10 the fact. But if there was some contingency  
11 out there where management of the reserves at  
12 that point would be inappropriate because of  
13 financial soundness and efficiency concerns,  
14 that issue would need to be considered.

15 MR. MYERS: Can you imagine a  
16 circumstance under which the -- the surplus is  
17 considered to be unreasonably large but it is  
18 also consistent with the corporation's  
19 obligation? I'm thinking there in terms of  
20 what the corporation does with its excess --  
21 excess money.

22 MR. HOGAN: Well, I don't think

1 there's been testimony or any facts about that  
2 kind of circumstance. But I think that, you  
3 know, you're asking me to speculate about a  
4 hypothetical situation. Is it possible in the  
5 future? The statute was written so there were  
6 two requirements. The drafters of the statute  
7 apparently intended it to be a two-step  
8 inquiry. And so although I don't have an  
9 example for you, yes. There is a possible,  
10 let's say for instance there was a management  
11 based on an upcoming, you know, concern about  
12 known but not rated for public health crisis  
13 that is to be expected.

14 At that point you may say that  
15 right now standing here today even if we are  
16 outside the range we know something is coming,  
17 we're not rated for it. So consistent with  
18 financial soundness and efficiency we -- we  
19 aren't going to act now because reserves are  
20 going to lead back naturally into the  
21 appropriate range.

22 So, that's the kind of situation

1 where I think, you know, to get to the answer  
2 to your question.

3 MR. MYERS: Okay. Okay.

4 Just to move on then to the next  
5 part. Sub-part F. It says -- the statute  
6 says, in determining whether the surplus of  
7 the corporation that is attributable to the  
8 District is excessive. In other words, it's  
9 giving the Commissioner advice as to or a  
10 mandate as to how to make this determination.  
11 The Commissioner shall which is a mandate,  
12 take into account all of the corporation's  
13 financial obligations arising in connection  
14 with the corporation's insurance business.  
15 And that's what we've been talking about.  
16 Including and then it specifies two things.  
17 And therefore places emphasis upon these two  
18 things.

19 Premium tax and the corporation's  
20 contribution to the open enrollment program.

21 My question to you, sir, is would  
22 you agree that the city council in passing

1 this intended to emphasize these two criteria  
2 as part of the overall or -- the overall issue  
3 of the conduct of the corporation's insurance  
4 business?

5 MR. HOGAN: Well, the city council  
6 is a matter of statutory construction clearly  
7 laid out these two as two of many factors,  
8 undefined factors. Many factors that the  
9 insurance commissioner should look at. So,  
10 certainly, those two factors should be looked  
11 at. Mr. Burrell has testified about those two  
12 factors in this hearing. But in no way is  
13 that limiting.

14 So, yes. I agree with you that  
15 the council passed the statute and noted those  
16 two factors. They expressed nothing -- no  
17 limitation on other factors to be looked at,  
18 however.

19 MR. MYERS: Okay. Thanks.

20 COMMISSIONER PURCELL: Thank you.

21 If there are no further questions,  
22 I think this will conclude out formal hearing

1 proceedings.

2 I want to thank all of you. Thank  
3 you too GHMSI for your closing statement.

4 I want to thank everyone who  
5 participated as witnesses. I think we've  
6 shown by the sheer numbers that were here  
7 yesterday and the large number of witness  
8 testimony that we've received that there is  
9 substantial public interest in this issue and  
10 rightfully so.

11 The Department would like to  
12 acknowledge GHMSI and D.C. Appleseed Center  
13 for Law and Justice. We are aware that you  
14 two have dedicated a lot of time and effort to  
15 developing the information arguments that were  
16 set forth in the last two days and in support  
17 of your views and these efforts along with the  
18 time and attention also spent by our  
19 department I think has contributed to what I  
20 would say has been a successful airing of the  
21 issues.

22 So, thank you once again.

1           As I stated in the opening  
2 statement a complete transcript of this  
3 hearing will be made available we believe.  
4 We're confirming that. We would like to place  
5 it on our website. We want to make sure that  
6 legally we can do so and so we will update the  
7 site to the extent that's not the case.

8           And that update will be later than  
9 September 16th of this year.

10           Our website is [www.disb.dc.gov](http://www.disb.dc.gov).  
11 The public and anyone here may call our office  
12 for any additional information or copies of  
13 any of the hearing materials.

14           All of the testimony that was  
15 received today will be posted to our site as  
16 well and no later than September the 16th.

17           Once again, the official record in  
18 this matter will remain open until close of  
19 business on September 25th of 2009. Anyone  
20 wishing to submit a written testimony or a  
21 rebuttal statement and those witnesses who  
22 have been requested to submit additional

1 information please do so by that date. And  
2 please make it to the attention of Ms. Leslie  
3 Johnson, our Hearing Examiner and Carmenita  
4 Snowden my executive assistant.

5           As I stated in my opening, as  
6 required pursuant to the HSMCR Act as amended  
7 by the MEIAA Act of 2008 after a final review  
8 and analysis of all the submissions,  
9 consideration of the entire record and  
10 application of the relevant laws and  
11 regulations, I will seek to make a final  
12 determination as to whether GHMSI's surplus  
13 which is attributable to the District is  
14 excessively -- is excessive and unreasonably  
15 large.

16           The final determination is  
17 presently required to be issued in writing no  
18 later than September 30th. If I determine  
19 that the surplus is excessive and unreasonably  
20 large pursuant to the statute, I will require  
21 GHMSI to submit a plan for my approval for  
22 dedication of the excess to community health

1 reinvestment pursuant to the statute.

2           So, thank you all again.

3           If there are no further issues,  
4 this will formally adjourn our hearing at  
5 11:22 a.m., September 11, 2009.

6           Thank you.

7           (Whereupon, the above matter was  
8 concluded at 11:25 a.m.)

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