1
2 HEARING
3
4 District of Columbia
5 Department of Insurance, Securities and Banking
6
7 Group Hospitalization and Medical Services, Inc.
8 Surplus Review Hearing
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12 Washington, DC
13 Wednesday, June 25, 2014
14
15 Hearing in the above-entitled matter
16 commencing at 9:00 a.m. at the Hilton Garden Inn,
17 1225 First Street NE, Washington, DC, the
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1 A P P E A R A N C E S
2
3 Department of Insurance, Securities and Banking:
4 Chester McPherson, Acting Commissioner
5 Dana Shepperd, Acting Deputy Commissioner
6 Phil Barlow, Associate Commissioner for Insurance
7 Stephanie T. Schmelz, Esquire, Assistant Attorney
8 General, Office of the General Counsel
9 Adam Levi, Esquire, Assistant Attorney General,
10 Office of the General Counsel
11 Robert H. Myers, Jr., Esquire,
12 Morris, Manning & Martin
13
14 Neil K. Rector, Rector & Associates
15 Sarah W. Schroeder, Rector & Associates
16 Jim Toole, FTI Consulting
17 Robert B. Stewart, FTI Consulting
18
19 Chet Burrell, CareFirst
20 G. Mark Chaney, CareFirst
21 Phyllis Doran, Milliman
22 Dominic Perella, Hogan & Lovells
23
24 Walter Smith, DC Appleseed
25 Mark E. Shaw, United Health Actuarial Services

1 APPEARANCES (Continued):

2

3 Cheryl Fish-Parcham, Families USA

4 Margot Aronson, Greater Washington Society for

5 Clinical Social Work

6 Maria Gomez, Mary's Center

7 Vincent Keane, Unity Health Care

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1 P R O C E E D I N G S
2 COMMISSIONER McPHERSON: Good morning,
3 everyone.
4 AUDIENCE: Good morning.
5 COMMISSIONER McPHERSON: Today is
6 Wednesday, June 25, 2014. The time is approximately
7 9:00 a.m. We're located in the Hilton Garden Inn
8 Meeting Room, Astor/Paint Branch, located at 1225
9 First Street, Northwest, Washington, DC. I am
10 Chester McPherson, the acting commissioner for the
11 District of Columbia, the Department of Insurance,
12 Securities and Banking. I will now call this
13 hearing to order.
14 I would like to say good morning again.
15 It's good to meet a number of you for the very first
16 time. I've seen your names in various
17 communications and may have been in a call or two.
18 So it's, again, my pleasure to be here and to meet
19 you here as we get into this very important process.
20 So again, welcome to this public hearing
21 concerning Group Hospitalization and Medical
22 Services, Inc. During the hearing today, we may
23 refer to the company as GHMSI or CareFirst DC.
24 With me today is staff from the
25 Department, including Dana Shepperd, our acting

1 deputy commissioner; we have Phil Barlow, our
2 associate commissioner for insurance; and our agency
3 counsel, Assistant Attorneys General Adam Levi and
4 Stephanie Schmelz.
5 Our outside counsel are also present.
6 They are Robert Myers and Joe Holahan from Morris,
7 Manning & Martin. Also here today are -- are Neil
8 Rector and Sarah Schroeder of Rector & Associates,
9 as well as Jim Toole and Robert Stewart of FTI
10 Consulting. They will be serving as experts for the
11 Department.
12 The law allows the Department to hire
13 outside consultants to assist us in the surplus
14 review because of the complex issues involved. In
15 the interest of openness, transparency and allowing
16 all interested persons to review and comment on the
17 work of our consultants, we have published their
18 work on our website and ask that you give -- and
19 asked them to give a presentation and answer
20 questions today.
21 The purpose of this hearing is to help us
22 determine whether GHMSI's surplus is excessive as
23 defined by law. This surplus review is not a simple
24 exercise. It requires thoughtful analysis of
25 complex facts and laws. We appreciate those who are

1 presenting today to help us with this analysis.
2 For those who are unfamiliar with the
3 surplus review process, the governing statute is the
4 Hospital and Medical Services Corporation Regulatory
5 Act of 1996 as amended by the Medical Insurance
6 Empowerment Act of 2008. I will refer to the
7 statute as "the Act." The Department has issued
8 regulations and procedures for a surplus review as
9 well.
10 In 2010, as required by the Act, the
11 Department issued a decision and an order concerning
12 GHMSI's 2008 surplus. That decision was affirmed in
13 part and reversed in part by a 2012 decision from
14 the DC Court of Appeals which remanded the matter to
15 us for further proceedings. That hearing is part of
16 these proceedings, but our focus today will be on
17 GHMSI's surplus for the end of 2011.
18 The Department previously made a
19 preliminary determination that GHMSI's 2011 surplus
20 exceeded certain risk-based capital standards. Now
21 we must make a final determination as to whether the
22 surplus is excessive. For this determination, we
23 consider two related -- we must consider two related
24 issues in tandem, whether the surplus attributable
25 to the District is unreasonably large and whether it

1 is inconsistent with GHMSI's obligation under the
2 Act to engage in community health reinvestment to
3 the maximum feasible extent consistent with
4 financial soundness and efficiency. Quite a
5 mouthful.
6 The Act specifically requires us to take
7 into account the company's financial obligations
8 arising in connection with the conduct of its
9 insurance business. The Act also requires that a
10 surplus review be undertaken in coordination with
11 other jurisdictions in which GHMSI conducts
12 business.
13 We therefore have notified Maryland and
14 Virginia of these proceedings. The Maryland
15 Insurance Commissioner has submitted a statement for
16 our consideration. It is our understanding that
17 representatives from other jurisdictions will not be
18 testifying today.
19 Witnesses who are testifying today should
20 feel free to address any aspect of the surplus
21 review. This hearing is to gather information, and
22 we will be trying to gather as much information as
23 possible. There is a lot of ground to cover,
24 however, so the presentations and questions may
25 focus on some aspect of the review more than others.

1 We will provide further opportunity for
2 comment after the hearing. In particular, we will
3 provide further opportunity for comment on the issue
4 on how much of GHMSI's surplus should be attributed
5 to the District before we make any decision in that
6 regard.
7 Also, to be clear, the purpose of the
8 review is to look at the surplus as of 2011. I know
9 that the prehearing briefs have included information
10 from after that date and that testimony today may do
11 so as well. I will review and consider that
12 information for the purpose of making my
13 determination.
14 Now I will spend a few moments going over
15 the procedures for the hearing today. We have
16 issued an agenda and a witness list, which generally
17 describes a person's schedule to make presentations
18 and outline the expected time limits for their
19 presentation. A copy of the agenda and the witness
20 list is available on our website and on the table at
21 the back of the room for anyone who does not have a
22 copy.
23 If you wish to speak today and your name
24 is not on the witness list, please see Mr. Levi or
25 Ms. Schmelz during one of our breaks so we can add

1 you to the agenda. All witnesses must give the
2 court reporter a completed witness card prior to
3 testifying. Witness cards are available on the
4 table in the back of the room.
5 After the court reporter has received
6 your witness card, I will swear in each witness or
7 panel of witnesses. Witnesses, please speak into
8 the microphone and begin your testimony by giving
9 your full name, your affiliation and your title.
10 All testimony should be addressed to me, should be
11 relevant to the issues I have outlined, and should
12 not be of a personal nature. In the interest of
13 time, please be mindful of the time limits allotted
14 for testimony.
15 After each presentation, Department staff
16 or myself or counsel may pose questions to the
17 witnesses. If you have any pre-prepared questions,
18 please submit them now to Mr. Levi or Ms. Schmelz.
19 If you have any questions later today, please
20 clearly print in either a question sheet, which is
21 available at the back of the room or on a piece of
22 paper with your question. You should indicate who's
23 submitting the question and who the question is for.
24 Please give that sheet as well to Mr. Levi and
25 Ms. Schmelz.

1 By the end of the day, I will decide
2 whether to ask any of the questions submitted to me
3 today or whether those questions will be asked in
4 writing after the hearing or to not answer those
5 questions at all. Which questions to ask today or
6 later is entirely within my discretion. All
7 questions submitted today will be made part of the
8 official record.
9 Rector & Associates and FTI will give
10 their presentation first, followed by GHMSI, then
11 Appleseed, each of which will have 60 minutes to
12 present. Then we will hear from other interested
13 parties or members of the public, each of whom may
14 have up to five minutes to speak. Finally, we will
15 hear closing statements from Appleseed and then
16 GHMSI. There will be at least one 15-minute break
17 in the morning, a 60-minute break for lunch, and at
18 least one 15-minute break in the afternoon.
19 The Department will produce a transcript
20 of this hearing which will be part of the official
21 record. Other information received today, such as
22 written statements, will also be a part of the
23 record. The record also will include all
24 surplus-related materials posted to the DISB
25 website, including the record from our 2009

1 proceedings, the prehearing reports and relevant
2 correspondence related to the most recent round of
3 review, including annual statements and any
4 post-hearing submissions made before the record is
5 closed.
6 We will post all the materials in the
7 record to the Department's website except that any
8 confidential or proprietary information will be
9 redacted. In other words, the surplus-related
10 materials posted to DISB's website will be the
11 official record for this proceeding.
12 As for post-hearing submissions, the
13 regulations for the Act anticipate that GHMSI or
14 interested persons may file rebuttal statements. In
15 addition, I may call on our consultants to provide
16 further information and analysis after the hearing.
17 If I do, as we have done previously, the Department
18 will publish their report -- its report and give
19 interested persons a reasonable opportunity to
20 comment on them.
21 I want to emphasize -- and let me repeat
22 that -- I want to emphasize -- and I'll repeat again
23 for emphasis -- I want to emphasize that I am not
24 bound by any analysis submitted by our consultants.
25 In making my decision, I will review and I will

1 weigh all the evidence in the record. I may also
2 request that GHMSI, Appleseed or others provide
3 additional information and analysis following this
4 hearing, in which case we will publish their
5 responses and we will allow reasonable opportunity
6 for comment.
7 So let me conclude by saying that it's
8 hardly worth repeating that the issues surrounding
9 this proceeding are complex. They're not easy.
10 They're difficult. They will require that we
11 analyze a range of 40 financial, actuarial, legal,
12 and regulatory matters. The comments and analysis
13 we have received to date have been very helpful and
14 I am looking forward to the presentations we will
15 receive today as we continue to work towards a final
16 decision in this matter.
17 If there are no other preliminary matters
18 at this time, we will now call Rector & Associates
19 from FTI Consulting to present their report. And
20 again, I will remind each speaker that you should
21 clearly identify yourself and your affiliation
22 before you speak. Thank you. And if you have
23 business cards, if you could give them to the
24 reporter, that will be helpful. Only if you have
25 them. Not mandatory.

1 MR. RECTOR: Good morning.
2 COMMISSIONER McPHERSON: Neil, before you
3 get started, if you could just give me a chance to
4 swear you guys in.
5 Whereupon,
6 NEIL RECTOR, SARAH SCHROEDER,
7 JIM TOOLE and ROBERT B. STEWART,
8 having been duly sworn by Acting Commissioner
9 McPherson, gave testimony as follows:
10 COMMISSIONER McPHERSON: Thank you. You
11 may proceed.
12 MR. RECTOR: Good morning. My name is
13 Neil Rector and I'm a senior consultant with Rector
14 & Associates, Inc., or R&A, an insurance regulatory
15 consulting firm. Our firm is staffed by experts in
16 insurance regulation, in financial solvency matters
17 and provides services to insurance regulators and
18 companies on a wide variety of financial condition
19 issues.
20 I have more than 30 years of experience
21 in the insurance industry, including serving as the
22 deputy director of the Ohio Department of Insurance.
23 Since I founded R&A 23 years ago, the firm and I
24 have worked on a wide variety of projects pertaining
25 to insurance and insurance regulation, including

1 serving as the appointed supervisor for financially
2 troubled insurers on behalf of various departments
3 of insurance. I know firsthand how disruptive it
4 can be to policyholders and others when an insurance
5 company gets into financial trouble.
6 While at R&A, I've also served as the
7 team leader on accreditation review teams on behalf
8 of the National Association of Insurance
9 Commissioners. In that position I've been
10 physically onsite and have reviewed the financial
11 solvency oversight operations of the vast majority
12 of the best insurance regulators.
13 I've testified twice before Congress
14 about the US insurance financial solvency system.
15 I've also traveled internationally to help non-US
16 regulators in China, Poland, Hungary, Slovenia, and
17 Brazil to establish an insurance regulatory agency
18 or train the regulatory staff.
19 I believe it was my broad background in
20 insurance regulation, and particularly in matters
21 pertaining to what constitutes appropriate
22 regulatory oversight of insurance company financial
23 solvency that prompted the DC Department of
24 Insurance, Securities and Banking, or the DISB, to
25 ask me to lead the DISB's examination of the surplus

1 position of Group Hospitalization and Medical
2 Services, Inc., or GHMSI, as required by DC Official
3 Code Section 31-3506(e).
4 Sitting beside me today are several other
5 people who are heavily involved in the review. To
6 my left is Sarah Schroeder, who's a principal of R&A
7 and president. To my right are Jim Toole and Robert
8 Stewart of FTI Consulting, whom I'll introduce a bit
9 later.
10 The scope of our work, as requested by
11 the DISB, consisted of the following items: First,
12 an analysis of the standards to be used when
13 reviewing GHMSI's surplus position in accordance
14 with DC statutes and regulations and with the 2012
15 decision of the DC Court of Appeals and DC Appleseed
16 Center for Law and Justice, Inc. versus DISB,
17 referred to as "the Court of Appeals work." Two,
18 reviewing the projection model used to analyze
19 GHMSI's surplus position. Three, determining the
20 appropriate standards to be used to analyze GHMSI's
21 surplus position. Four, analyzing an appropriate
22 amount of surplus GHMSI should maintain to satisfy
23 the appropriate standards. And five, analyzing
24 GHMSI's community health reinvestment expenditures
25 during 2011 and 2012, its projected community health

1 reinvestment expenditures during 2013, and its
2 anticipated community health reinvestment
3 expenditures for 2014 and future years.
4 At the DISB's request, we also reviewed
5 and considered materials and other input provided by
6 DC Appleseed Center for Law and Justice, Inc.,
7 Appleseed, and by United Health Actuarial Services,
8 UHAS, an actuarial consulting firm engaged by
9 Appleseed to assist in its analysis.
10 To be clear, our role in the
11 consideration of GHMSI's surplus has been to act as
12 an advisor to the DISB by analyzing the standards
13 and methodology to be used in reviewing GHMSI's
14 surplus position. R&A is not the final
15 decisionmaker with respect to whether GHMSI's
16 surplus position satisfies the standards
17 prescribed -- by DC statutes and regulations and the
18 Court of Appeals order.
19 Instead, our task has been to convey to
20 the commissioner our findings and recommendations in
21 the form of a written report and related
22 supplemental responses to questions posed by or
23 through the commissioner or his staff. The
24 commissioner is the final arbiter with respect to
25 whether GHMSI's surplus position meets the required

1 standards.
2 As I alluded to earlier, to assist in our
3 work, R&A engaged the services of FTI Consulting, or
4 FTI, and Jim Toole and Robert Stewart of FTI are
5 here today on behalf of their firm. Before I
6 describe our findings and our work, Jim will provide
7 information about his firm and background as well as
8 address some issues that have been raised relating
9 to the work we performed and the documentation of
10 our work.
11 MR. TOOLE: Thank you, Commissioner. And
12 thank you, Neil. Good morning. My name is Jim
13 Toole and I'm a managing director at FTI Consulting,
14 a business advisory firm that provides a full range
15 of actuarial services to insurance companies and
16 regulators. I'm a fellow in the Society of
17 Actuaries, Chartered Enterprise Risk Analyst, and a
18 member of the American Academy of Actuaries. I have
19 over 25 years of experience in the insurance
20 industry, including a variety of roles with leading
21 consulting firms and insurance companies. I acted
22 as the health actuary for the Hawaiian Insurance
23 Division for six years in a contractual relationship
24 with the State of Hawaii. I served as the chair of
25 the health section of the Society of Actuaries,

1 which coordinates and funds research and education
2 activities on behalf of over 3,500 US and Canadian
3 health actuaries.
4 In 2009, I was awarded a Chartered
5 Enterprise Risk Analyst designation as a result of
6 my leadership in the field of enterprise risk
7 management, and I recently completed a three-year
8 term on the Board of Directors of the Society of
9 Actuaries. I'm a frequent speaker at industry
10 meetings, seminars and universities, and have
11 written and/or edited articles for numerous industry
12 publications.
13 I served as lead editor of the textbook
14 Insurance Industry Mergers and Acquisitions that was
15 published by the Society of Actuaries, or SOA, in
16 the spring of 2005. I served as the lead researcher
17 for the Society of Actuaries research project to
18 analyze the potential impact of a pandemic on the US
19 life and health insurance industries, and chaired an
20 SOA research project oversight group estimating the
21 economic measurement of medical errors in the US
22 medical system.
23 FTI was asked by R&A to assist its staff
24 with the analysis of GHMSI's surplus position. We
25 played a similar role in the 2009 review of GHMSI's

1 surplus position. As a result, we were already
2 familiar with the mechanics of and issues relating
3 to the Milliman projection model. But for the
4 purposes of this review, we functioned as an
5 integrated part of the R&A team. Generally, our
6 only communications regarding the project that
7 occurred independently from the rest of the R&A
8 team -- R&A team were with Milliman and GHMSI
9 actuaries to discuss technical aspects of the
10 projection model.
11 At R&A's request, we reviewed the
12 structure of the Milliman projection model and the
13 values and assumptions used to construct the model.
14 We provided R&A with written documentation of our
15 analysis and recommendations. Finally, we reviewed
16 and provided input with respect to the R&A report
17 and related documents prior to finalization and
18 publication of the report and related documents.
19 At the very beginning of the review, a
20 threshold question that had to be addressed was
21 whether to use the Milliman projection model as the
22 base model, subject of course to adjustments, or
23 whether to use a different projection model as a
24 base. There are, of course, other projection models
25 that exist in the market that we could have used or

1 we could have used our own model.
2 After considering the matter and
3 discussing it with R&A and the DISB, we collectively
4 decided to use the Milliman projection model as the
5 base. However, the decision was also made to
6 supplement the work done there by testing it against
7 the results of our own independently constructed
8 model, which we developed for the purpose of
9 validation and testing. We felt that this mix --
10 using the Milliman model as the base, but testing it
11 against the results of our model -- provided the
12 right balance.
13 Now, it's important to emphasize that the
14 decision to use the Milliman projection model as the
15 base did not mean that we were being deferential to
16 Milliman or to GHMSI or that GHMSI was being
17 advantaged. Projection models are essentially
18 calculators and should produce similar results if
19 similar assumptions are used. If a given model is
20 properly constructed, it ultimately isn't all that
21 important whose model you use. Rather, the
22 important decisions pertain to the numbers put into
23 the calculator. In other words, the assumptions
24 selected for the model to run. Our team retained
25 full control over the selection of assumptions and

1 we validated the results generated by the Milliman
2 model by comparing them to the results generated
3 using our own independently developed model.
4 So why did we decide to use the Milliman
5 projection model as the base? Well, even though a
6 projection model is essentially a calculator, it is
7 a very complex calculator and one that needs to be
8 tailored to the task at hand. Since Milliman had
9 already developed its projection model and we were
10 already familiar with it from the 2009 review, using
11 a different model as the base model would have
12 complicated the review without adding commensurate
13 benefit.
14 As I mentioned, what drives the results
15 is the choice of assumptions that go into the
16 calculations, not the projection model itself. So
17 we felt that keeping the model as a constant would
18 allow us and others to focus more clearly on what
19 was important, the assumptions, rather than being
20 drawn into a discussion about this or that aspect of
21 any particular model.
22 However, as I mentioned previously, we
23 supplemented that work by also using a projection
24 model we developed independent of Milliman. Why?
25 The answer again relates to the fact that projection

1 models are very complex. What we didn't want to
2 happen was to be an internal kink in the Milliman
3 model, some aspect of it that wasn't easy to see,
4 but that would have caused the calculations to skew
5 to GHMSI's advantage, even if the assumptions we
6 selected were the correct ones. We felt the best
7 way to detect whether that was happening; i.e., a
8 way to validate the Milliman model, was to run
9 essentially the same assumptions on a model we had
10 constructed independently of Milliman using similar
11 but different forecasting methodology.
12 If we achieved essentially the same
13 results using our model than what was reached using
14 the Milliman model, we knew that the Milliman model
15 was running properly. And in using that approach,
16 we were able to validate the Milliman model and its
17 surplus findings and key assumptions against
18 appropriate historical experience.
19 Now, another topic that we considered
20 before we began our review was whether to evaluate
21 operating results in RBC levels of other health
22 insurers for comparative purposes. In other words,
23 we considered whether it would be helpful to try and
24 identify insurers that might be considered GHMSI's
25 peers and to compare their foundational results and

1 surplus profiles with GHMSI's. We had performed
2 such a peer group analysis in connection with the
3 2009 review and we needed to know whether to perform
4 a similar review this time.
5 Before making a decision regarding this
6 matter, we discussed it with GHMSI, Milliman,
7 Appleseed and UHAS. All of these entities agreed at
8 the beginning of the project that such a comparison
9 would not be helpful because GHMSI's operations and
10 market are different enough from other insurers,
11 even those from other Blue Cross/Blue Shield
12 insurers, that any such comparison would not provide
13 helpful information. The consensus view seemed to
14 be that attempting such a comparison would consist
15 of comparing apples and oranges. Given the views of
16 GHMSI, Milliman, Appleseed, UHAS, and its own views,
17 the DISB told us not to do a comparison at that
18 time.
19 Finally, I'd like to address certain
20 references in Mr. Shaw's report regarding the
21 Actuarial Standards of Practice and Code of Conduct.
22 In his report, Mr. Shaw indicates that in his view
23 the Milliman report and the R&A report are actuarial
24 communications that fail to adhere to the Actuarial
25 Standards of Practice. He claims that Milliman, R&A

1 and FTI did not provide sufficient documentation as
2 required by Actuarial Standards of Practice 41. I
3 have several responses here.
4 First, the Actuarial Standards of
5 Practice apply only to individuals, they do not
6 apply to firms. As a result, contrary to Mr. Shaw's
7 statements, the Actuarial Standards of Practice do
8 not/cannot apply to Milliman, R&A or FTI.
9 Second, the Actuarial Standards of
10 Practice apply only to individual actuaries who are
11 members of one of the five US-based actuarial
12 organizations. The authors of the R&A report, Neil
13 Rector and Sarah Schroeder, are not actuaries, nor
14 do they purport to be actuaries, and they are not
15 members of any actuarial organization.
16 Now, in my opinion, the R&A reports meet
17 the standards of ASOP 41, but the report is not
18 required to do so since the Actuarial Standards of
19 Practice do not apply to the R&A report.
20 Third, contrary to Mr. Shaw's
21 characterizations, ASOP 41 does not set out specific
22 disclosure requirements and certainly not the items
23 claimed by Mr. Shaw in his report. ASOP 41 provides
24 guidance to actuaries with respect to actuarial
25 communications. It's descriptive, not prescriptive.

1 Beyond these somewhat technical responses, it is
2 also clear to me that as a substantive matter,
3 Mr. Shaw has been given information sufficient to
4 allow him to analyze and understand our work
5 consistent with the intent of ASOP 41.
6 Mr. Shaw's 61-page report sets out in
7 detail his analysis of the structure of the model,
8 the assumptions used by both Milliman and R&A, and
9 his own conclusions with respect to GHMSI's surplus
10 and their needs using different assumptions. It
11 seems clear to me that any material differences
12 between Mr. Shaw's conclusions and ours pertain to
13 the assumptions selected rather than because
14 Mr. Shaw did not have sufficient information to
15 understand the model or the work that we did.
16 And at this point I'd like to just turn
17 the discussion back to Neil so he can further
18 describe an analysis done by R&A and FTI.
19 MR. RECTOR: Thanks, Jim.
20 As a part of our examination and as
21 requested by the DISB, we analyzed the projection
22 model used by Milliman in its work as GHMSI's
23 consultant. Milliman documented its work in a May
24 31, 2011 public report titled, "Need for statutory
25 surplus and development of optimal surplus target

1 range." In addition, Milliman provided us with
2 technical materials related to its May 31, 2011
3 report.
4 We also received from Milliman and GHMSI
5 additional written materials concerning the model,
6 and we also reviewed and considered materials
7 provided by Appleseed and by Mark Shaw, consulting
8 actuarial from UHAS. At the outset, staff from our
9 firm and FTI met on two separate occasions with key
10 staff from GHMSI, Milliman, Appleseed, UHAS and
11 others to discuss the structure of our work, the
12 Milliman model and the standards to be used by the
13 DISB and R&A in the analysis of GHMSI's surplus.
14 During those meetings, Appleseed and UHAS provided
15 input into the appropriate structure and standards
16 to be used in the examination. We listened
17 carefully to that input and took that input into
18 account.
19 Based on those meetings, we had
20 subsequent discussions with Milliman and GHMSI
21 during which we requested and received additional
22 information regarding GHMSI's surplus and the
23 Milliman model. Upon completing our analysis, we
24 issued our report dated December 9, 2013.
25 Subsequent to the issuance of the report, Appleseed

1 and UHAS submitted a series of questions to the DISB
2 regarding our analysis and recommendations.
3 To gain a better understanding of the
4 questions, we participated in several conference
5 calls with their representatives and with
6 representatives from the DISB, GHMSI, and Milliman.
7 Through the DISB, we provided over 30 pages of
8 written responses to Appleseed's and UHAS's
9 information requests. DISB's responses to those
10 questions appear on the DISB's website and will be
11 made a part of the record for this hearing.
12 Before getting into a more detailed
13 discussion of our particular findings, I'd like to
14 provide an overview of the projection modeling
15 methodologies much of our work is based on. At its
16 core, the Milliman projection model uses a
17 statistical approach to determine how much surplus
18 GHMSI needs to start with to stay above a certain
19 RBC threshold level at a certain degree of
20 probability over a three-year period of time.
21 For example, the model could determine
22 how much surplus GHMSI would need to start with in
23 order to have no more than a 2 percent chance of
24 falling below a 200 percent RB threshold level
25 within three years. The model involves a complex

1 statistical modeling process called "stochastic
2 testing." It calculates 500,000 gain and loss
3 possibilities based on combinations and permutations
4 of various assumptions and then ranks those
5 possibilities from the most favorable gain outcome
6 to the least favorable loss outcome.
7 From that, it's possible to determine the
8 amount of money GHMSI has a given chance of losing.
9 The loss amount determined as a result of this
10 process is then used to calculate how much money
11 GHMSI would need to start with in order to stay
12 above the selected RBC threshold levels at the
13 selected degree of probability during the model
14 three-year period.
15 As Jim mentioned earlier, the result is
16 really driven by the assumptions selected. Because
17 the model generates the calculations automatically,
18 it's important to get the key assumptions right.
19 Consequently, a significant part of our work
20 consisted of carefully reviewing and adjusting the
21 key assumptions underlying the projection modeling
22 process, including the probability and severity
23 distributions assigned to the key assumptions. Our
24 work in this area was time consuming and difficult.
25 There was almost never a clear right or wrong

1 answer. It was a matter of judgment.
2 In using our judgment to select
3 assumptions, we selected assumptions based on what
4 we believed are the risks and opportunities inherent
5 in GHMSI's future operations, including the possible
6 effects of health reform. In some instances, our
7 choices were consistent with GHMSI's historical
8 results. However, in many instances, and
9 particularly those impacted by the risks of health
10 reform, the assumptions selected were quite
11 different from GHMSI's historical experience because
12 we anticipate health care reform will cause certain
13 aspects of GHMSI's operations to be different in the
14 future than they have been in the past.
15 It's also important to emphasize that the
16 assumptions were selected based on what was known
17 regarding health care reform at the time our review
18 was performed. Any future analysis of GHMSI's
19 surplus will, of course, need to update those
20 assumptions based on the most current understanding
21 of how health care reform will impact GHMSI.
22 Further detail about the financial projection
23 modeling process and about our work were set out in
24 our report and in responses to Appleseed's and
25 UHAS's questions I refer to above.

1 To summarize, the projection model uses a
2 statistical approach to determine how much surplus
3 GHMSI needs to start with to stay above a certain
4 RBC threshold level and a certain degree of
5 probability. I mentioned a few minutes ago the
6 example how much surplus GHMSI would need not to
7 have more than a 2 percent chance of falling below a
8 200 percent RBC threshold level. However, the model
9 could calculate how much surplus GHMSI needs
10 relative to RBC threshold levels other than 200
11 percent and degrees of probability other than 2
12 percent. So we also had to make determinations
13 regarding which RBC threshold levels to measure and
14 the degree of probability of crossing those
15 thresholds.
16 In making those decisions, we focused on
17 the statutory standards as interpreted by the 2012
18 Court of Appeals order. In that order the Court of
19 Appeals indicated that there are two determinations
20 the DISB must make in connection with the surplus
21 review. One, whether GHMSI has engaged in community
22 health reinvestment to the maximum feasible extent
23 consistent with financial soundness and efficiency;
24 and two, whether GHMSI's surplus exceeds appropriate
25 RBC requirements and is unreasonably large,

1 inconsistent with GHMSI's community health
2 reinvestment mandate.
3 The Court of Appeals also indicated that,
4 as a matter of law, the two determinations must be
5 made in tandem, not seriatim, to give full effect to
6 the statute. Our understanding is that the first
7 determination, whether GHMSI has engaged in
8 community health reinvestment to the maximum
9 feasible extent consistent with financial soundness
10 and efficiency, requires GHMSI to engage in
11 community health reinvestment right up to the edge
12 of where doing more would present an inappropriate
13 risk of GHMSI becoming financially unsound or
14 inefficient. In other words, could GHMSI give more
15 in community health reinvestment expenditures
16 without becoming financially unsound or inefficient.
17 Our understanding is that the second
18 determination, whether GHMSI's surplus exceeds
19 appropriate RBC requirements and is unreasonably
20 large and inconsistent with GHMSI's community health
21 reinvestment mandate, goes to whether GHMSI has
22 excess funds; in other words, an unreasonably large
23 surplus, more than it needs, so that such excess
24 funds could be used to fund community health
25 reinvestment.

1 As I indicated, the Court of Appeals
2 order made clear that, as a matter of law, the two
3 determinations must be made in tandem rather than in
4 seriatim. The two determinations therefore have to
5 be read together. In other words, excess surplus
6 under determination number 2 is any surplus
7 exceeding what GHMSI needs not to become financially
8 unsound or inefficient as described in determination
9 number 1. Similarly, GHMSI's obligation pursuant to
10 determination number 1 is to engage in community
11 health reinvestment to the maximum feasible extent,
12 meaning that any excess surplus as described in
13 determination number 2, is to be used for community
14 health reinvestment rather than for other purposes.
15 To read the two determinations in tandem
16 requires us to look for a target amount surplus that
17 complies with the statutory requirements by being
18 neither too high nor too low. If GHMSI's surplus is
19 above that target amount, GHMSI has not satisfied
20 determination number 1 since it's not engaged the
21 community health reinvestment right up to the edge
22 of what it can do without presenting an
23 inappropriate risk of becoming financially unsound
24 or inefficient, and under determination number 2, it
25 has excess surplus.

1 However, if GHMSI's surplus is below that
2 target amount, it has gone beyond engaging in
3 community health reinvestment to the maximum
4 feasible extent since it is into the territory of
5 having an inappropriate risk of becoming financially
6 unsound or inefficient.
7 It's also important to note that
8 determination number 1 mentions both financial
9 soundness and efficiency and we considered both
10 aspects in our analysis. Our December report
11 highlighted the "financial soundness" phrase
12 consistent with the fact that the bulk of our report
13 contained the financial results calculated pursuant
14 to the projection amount. However, we also
15 concluded that GHMSI could adhere to the RBC surplus
16 target and benchmark range set out in our report
17 without becoming inefficient.
18 In that regard, we also were aware that
19 GHMSI now is subject by law to certain medical loss
20 ratio requirements that would cause it to return a
21 portion of its surplus to subscribers if it does not
22 operate within the legal limits of efficiency set
23 out in the law. So the two determinations set out
24 by the Court of Appeals order when read together
25 have prompted us to look for the point where surplus

1 above that number is excess and is evidence that the
2 requirement to give to the maximum feasible extent
3 has not been honored, and yet where surplus below
4 that number is not excess and, in fact, is evidence
5 that GHMSI has given more than what a maximum
6 feasible effort to give would lead to.
7 So that's the number our work was geared
8 toward finding. How do we go about finding it?
9 First, we looked at two different RBC thresholds,
10 200 percent and 375 percent RBC, and we evaluated
11 what the impact on GHMSI would be if it reached
12 those thresholds.
13 Those thresholds were not chosen
14 arbitrarily. The 200 percent threshold was chosen
15 because it's defined under insurance law as the
16 company action level, a level that signals to
17 regulators that an insurance company is at
18 significant financial risk, requiring mandatory
19 action by the company under heightened regulatory
20 oversight.
21 The 375 percent threshold was chosen
22 because it is Blue Cross/Blue Shield Association's
23 early warning level. It would be best if GHMSI did
24 not cross either threshold. That leaves open the
25 question of what's the appropriate percentage chance

1 GHMSI should be allowed to risk in crossing it.
2 For example, should GHMSI have enough
3 surplus that it has no more than a 2 percent chance
4 of crossing the 200 percent RBC threshold? No more
5 than a 1 percent chance? Would holding surplus in
6 an amount equivalent to having a 5 percent or a 10
7 percent chance of crossing that threshold been
8 acceptable?
9 There are no right or wrong answers.
10 It's a matter of judgment, and ultimately, it's a
11 matter of the Commissioner's judgment. However, the
12 DISB has asked for our thoughts and recommendations
13 regarding the issue and we provided those in our
14 report.
15 It's important to point out that we made
16 the choice of what thresholds to guard against and
17 the percentage chance allowed to cross them before
18 we ran any calculations. We did this on purpose.
19 We wanted input from Appleseed, UHAS, GHMSI and
20 Milliman on those issues before making our
21 decisions, and we knew we had to get their input
22 before numbers were run. Otherwise, we thought it
23 would be impossible for those entities to separate
24 their views as to the appropriate thresholds and
25 percentages from an awareness of the impact those

1 choices would have on the final answers. In other
2 words, we wanted to make the rules and then play the
3 game rather than playing the game and then trying to
4 set the rules afterwards.
5 At the outset, before the numbers were
6 run, everyone agreed that one of the selections
7 should be that GHMSI should have no more than a 2
8 percent chance of crossing the 200 percent RBC
9 threshold. GHMSI, Milliman, Appleseed and UHAS
10 agreed to the selection in meetings with us.
11 Appleseed and UHAS documented their agreement in
12 letters to the DISB, which have been made available
13 to the public on the DISB's website and will be
14 admitted into the record for this hearing.
15 Appleseed, UHAS, GHMSI, Milliman did not
16 agree with each other as to the 375 percent RBC
17 threshold. GHMSI and Milliman thought there should
18 be no more than a 5 percent chance of crossing that
19 threshold. Appleseed and UHAS did not believe the
20 375 percent threshold should be used at all.
21 However, if it were used, they've urged a 75 percent
22 confidence level relative to it; in other words,
23 that GHMSI protect against a 25 percent chance of
24 crossing that threshold.
25 After giving the matter a significant

1 amount of thought and taking into consideration the
2 views expressed by GHMSI, Appleseed, Milliman and
3 UHAS, we ended up selecting the following: First,
4 that GHMSI have no more than a 2 percent chance of
5 crossing the 200 percent RBC threshold, and two,
6 that GHMSI have no more than a 15 percent chance of
7 crossing the 375 percent RBC threshold. As a
8 technical matter, these were expressed in our report
9 as confidence levels that the threshold not be
10 crossed rather than as percentage chances --
11 percentage chances that it would be crossed.
12 In other words, we selected that, one,
13 there be a 98 percent confidence level that GHMSI
14 does not cross the 200 percent RBC threshold, and
15 two, that there be an 85 percent confidence level
16 that GHMSI not cross the 375 percent RBC level.
17 We selected a 98 percent confidence level
18 relative to the 200 percent RBC threshold because
19 crossing 200 percent RBC would be extremely
20 problematic. As I indicated previously, the 200
21 percent level itself is designated by insurance
22 regulators as the company action level in which
23 insurance companies are required to take action to
24 try to prevent financial insolvency. In fact,
25 regulators often step in even when an insurance

1 company is significantly above the 200 percent level
2 and especially when the insurance company is losing
3 money rapidly. The Blue Cross/Blue Shield
4 Association also could terminate GHMSI's Blue
5 Cross/Blue Shield trademarks if GHMSI fell below 200
6 percent RBC.
7 Second, it's noted the projection model
8 calculates the percentage chances of what could
9 happen before a three-year period of time. So we
10 are not talking here about a situation where a
11 company has been hovering in a stable fashion at the
12 200 percent RBC level consistently for years. Even
13 if GHMSI were in that position, it would still be a
14 serious concern because the company could slip so
15 easily from there to insolvency. But the scenario
16 that we are seeking to protect against is
17 significantly worse than that.
18 When Appleseed, UHAS, GHMSI and Milliman
19 all agreed to a 200 percent RBC threshold and a 98
20 percent confidence level, they and we were saying,
21 in essence, that GHMSI needed to have enough surplus
22 to protect against the drop from where it is now
23 with an RBC in the 900s down to an RBC of 200
24 percent in just three years. To put that in dollar
25 terms, the scenario we're seeking to protect against

1 where one -- would be one where GHMSI were to lose
2 approximately $700 million in surplus in just three
3 years.
4 You might think that it's impossible for
5 GHMSI to lose that much money that fast, but
6 remember, that we're talking about something that
7 has a 2 percent chance of happening, something that
8 would happen statistically twice every 100 years.
9 We tend to forget the calamities that we think could
10 never happen do happen, including at that level of
11 frequency. For example, just before the Great
12 Recession hit, no one thought that we would ever
13 again have a financial catastrophe even approaching
14 that of the Great Depression. But we've now had two
15 such financial catastrophes in less than 100 years,
16 roughly the same probability as we measured relative
17 to GHMSI.
18 If GHMSI were to lose $700 million in
19 surplus in a three-year period, we believe it would
20 cause extreme distress in the DC market, even if
21 GHMSI could be pulled out of the nosedive before it
22 becomes insolvent. Employers and individual
23 policyholders would worry about whether their health
24 care was collapsing. And given GHMSI's dominance in
25 the DC health insurance market, this would be far

1 more troubling and disruptive in DC than if the loss
2 were by a similarly sized health insurer with a more
3 modest share of the DC market.
4 We also think it would be difficult to
5 pull GHMSI out of such a steep nosedive. Unlike
6 publicly held, for-profit insurance companies, GHMSI
7 does not have the ability to go to the capital
8 markets to obtain funds if needed, nor does GHMSI
9 have a parent company that might have cash available
10 to contribute to GHMSI.
11 Further, although GHMSI, in theory, could
12 raise its premium rates to offset the losses, there
13 are limits because of rate regulation and because of
14 market restrictions on the size of premium increases
15 allowed and the speed with which GHMSI could
16 implement the increases. We think it's very
17 questionable whether GHMSI could do enough quickly
18 enough to offset such a huge nosedive over a
19 three-year period. For these reasons, we think it's
20 appropriate for GHMSI to hold enough surplus to make
21 it highly unlikely that it would fall to the 200
22 percent RBC threshold over a three-year period of
23 time.
24 Now, what's the right percentage? Again,
25 there are no right or wrong answers. It's a matter

1 of judgment. Ultimately, in our view and in the
2 view of Appleseed, UHAS, GHMSI and Milliman, at
3 least based on what they all said before we ran the
4 numbers, we decided that there should be only a 2
5 percent chance of that occurring. But it's a matter
6 of judgment. And the DISB could certainly decide to
7 select a different probability if it's willing, as a
8 matter of public policy, to take a different level
9 of risk that GHMSI would fall below the 200 percent
10 benchmark.
11 Falling below the 375 percent RBC
12 threshold is not as significant a matter as falling
13 below the 200 percent. At the 375 percent RBC level
14 GHMSI, would be trending toward trouble, but it
15 would not yet be in trouble. Further, as noted
16 above, unlike the 200 percent threshold, there was
17 no agreement between Appleseed, UHAS, GHMSI and
18 Milliman as to the 375 percent threshold. We ended
19 up selecting 85 percent as the appropriate
20 probability. In our judgment, we concluded that
21 having a 15 percent chance of crossing the 375
22 percent threshold is appropriate.
23 Similar to the discussion above regarding
24 the 200 percent threshold, however -- or with regard
25 to the 200 percent threshold, our concern here has

1 perhaps as much to do with the precipitousness of
2 the drop as it does with the 375 level in an
3 absolute sense. In other words, if GHMSI were to
4 fall from where it is now, RBC in the 900s, down to
5 375 percent in the three-year period, we believe
6 that would be evidence of a serious financial
7 problem with the company. As with the 200 percent
8 threshold, though, selecting the appropriate
9 probability relative to the 375 percent threshold is
10 a matter of judgment, and the DISB could certainly
11 make a different selection if it's willing -- as a
12 matter of public policy, if it's willing to take a
13 different level of the risk that GHMSI would fall
14 below the 375 threshold.
15 So to summarize, we recommended that the
16 DISB define the target I've referred to previously,
17 the number where GHMSI's surplus is balanced
18 relative to the two determinations, by assigning a
19 98 percent confidence level to staying above the 200
20 percent RBC threshold and by assigning an 85 percent
21 confidence level to staying above the 375 percent
22 RBC threshold. Those confidence levels equate in
23 our view -- equate to our view that GHMSI should
24 hold enough surplus so that it has no more than a 2
25 percent chance, a one in 50 probability, of falling

1 below the 200 percent RBC threshold and no more than
2 a 15 percent chance of falling below the 375 percent
3 RBC threshold, each over a three-year period of
4 time.
5 If GHMSI has more surplus than what is
6 needed to meet those probabilities, then in our view
7 it's not given to the maximum feasible extent and
8 has excess surplus. If GHMSI has less surplus than
9 what is needed to meet those probabilities, it has
10 given more than the maximum feasible extent.
11 As described in our report, applying the
12 model to those two tests resulted in the conclusion
13 that GHMSI should have surplus equivalent to 958
14 percent RBC. So that's what we describe in our
15 report as the surplus target. However, as also
16 described in our report, calculating such a specific
17 number implies a degree of precision that could
18 being misleading. Honing in on such a specific
19 number could cause someone to believe that if
20 GHMSI's surplus is higher or lower than that by even
21 one basis point, 959 percent versus 958 percent, or
22 957 percent versus 958 percent, then GHMSI would
23 need -- either need to put more into community
24 health reinvestment or would need to grow surplus
25 respectively, and that's not accurate. Because of

1 the complexity of the projection model and the
2 imprecision that is inherent in trying to make
3 projections about the future, it's inappropriate to
4 make those kinds of conclusions based on such
5 razor-thin margins.
6 To provide what we believe is better
7 guidance to the DISB, we decided to put a
8 plus-or-minus band around the surplus target. To
9 arrive at the appropriate band, we reviewed changes
10 to GHMSI's RBC historical levels during the period
11 1999 to 2012. Although GHMSI's RBC varied from year
12 to year by 100 or more basis points during the early
13 part of the period, most year-to-year changes since
14 2004 have been less than 100 basis points. The
15 average year-to-year change during that period was
16 82.5 basis points. So we selected a range
17 consisting of the target surplus level, 958 percent
18 RBC, plus or minus 82.5 basis points.
19 To summarize, our recommended surplus
20 target is 958 percent RBC and our recommended
21 benchmark range is 875 percent to 1,040 percent RBC.
22 We are not saying that any number between 875 to
23 1,040 is equally good. Rather, 958 percent RBC is
24 our best specific conclusion as to the appropriate
25 amount of surplus for GHMSI. That's the number we

1 recommended the DISB require GHMSI to target. If
2 GHMSI's surplus is above that number, we believe
3 GHMSI should start doing things, including
4 increasing community health reinvestment to move
5 down toward the 958 percent target.
6 Conversely, if GHMSI's surplus is below
7 958 percent, we believe GHMSI should begin taking
8 steps to move up toward the 958 percent target. So
9 we recommend that DISB select 958 percent RBC as the
10 target. However, we also recommend DISB be in
11 mostly a watchful mode, evaluating GHMSI's own
12 actions to move toward the target rather than
13 stepping in to require GHMSI to take action so long
14 as GHMSI's surplus does not fall below 875 percent
15 or rise above 1,040 percent RBC.
16 Those of you who followed the surplus
17 review of GHMSI for some time will no doubt note
18 that our recommendations here are higher than our
19 recommendations in connection with the review of
20 GHMSI's surplus we did in 2009. In 2009, we
21 recommended a surplus range of 600 percent, 850
22 percent RBC. This time, as I just indicated, we
23 recommended a target surplus of 958 percent and a
24 benchmark range of 875 to 1,040 percent RBC.
25 In other words, the high end of our range

1 at this time is approximately 190 RBC basis points
2 than it was in 2009. We've talked with the DISB
3 about the reasons for the difference in these
4 ranges. In turn, the DISB provided written
5 materials to Appleseed describing the reasons and
6 those materials are part of the record here. I
7 refer you there for more detailed description for
8 the reasons for the difference; however, I'll try to
9 highlight some of those significant aspects here.
10 As we discussed with the DISB and as
11 described to Appleseed, it's difficult to identify
12 and quantify the precise reasons behind the
13 differences, in part because we use somewhat of a
14 different approach from the 2009 review than we did
15 for the current review. In the 2009 review, we made
16 our adjustments after Milliman completed the
17 stochastic modeling portion of the process. We took
18 Milliman's stochastic modeling answer and adjusted
19 it. For the current review, however, we made
20 adjustments to the underlying assumptions and the
21 probability and severity distributions that
22 generated the stochastic model results.
23 In other words, rather than taking
24 Milliman's answer and adjusting it, this time we
25 adjusted the assumptions that generated the answer.

1 This difference in approach between the two reviews
2 makes it difficult to identify and quantify the
3 impact any individual factor had on the difference
4 in the ranges. A further complication is that the
5 answer, to the extent we can determine it, also is
6 significantly different, depending on how you try to
7 measure the difference between the results from 2009
8 and the results from the current review.
9 In other words, the factors -- the
10 factors that led to the differences in the tops of
11 the two ranges are different from the factors that
12 led to the differences in the bottoms of the two
13 ranges and are different again from the factors that
14 led to the differences in individual data points
15 that make up the ranges. So there's no easy way to
16 attribute a specific percentage point impact to each
17 reason for a difference between the 2009 result and
18 the current result.
19 Having said that, it seems clear that the
20 biggest reason for the difference is that because of
21 the timing of when our work was performed, our
22 results in 2009 did not include any potential impact
23 from the Affordable Care Act, the major health
24 reform legislation, whereas our results this time
25 included the effects of ACA.

1 Certainly, ACA provides opportunities to
2 an entity like GHMSI, but it also adds risk. And
3 neither the opportunities nor the risks were
4 factored into the analysis in 2009. In the current
5 review, however, the risks and opportunities
6 attributable to the ACA were carefully considered
7 throughout the entire process and impacted the
8 assumptions selected made as part of the stochastic
9 modeling process.
10 We believe other things contributed to
11 the difference, too. Differences in approach
12 between the two reviews, changes in what we believed
13 management could do if GHMSI started losing money,
14 changes in the probability or confidence levels
15 tested, et cetera. As we believe a number of things
16 contributed to the difference. And as I mentioned,
17 there's extensive information regarding this topic
18 in the DISB's answers to Appleseed's questions that
19 are part of the record of this hearing.
20 However, big picture, we believe the
21 biggest driver of the difference is the 2009 review
22 did not factor in the opportunities, risks or
23 uncertainties generated by health reform whereas the
24 current review did.
25 The final topic I'd like to cover is the

1 Commissioner's request that the scope of our review
2 include an analysis of GHMSI's community health
3 reinvestment expenditures during 2011 and 2012, of
4 its projected community health reinvestment
5 expenditures during 2013, and of its anticipated
6 community health reinvestment expenditures for 2014
7 and future years.
8 The Act defines community health
9 reinvestment expenditures to mean expenditures that
10 promote and safeguard the public health for the
11 benefit of current or future subscribers, including
12 premium rate reductions. GHMSI indicated that it
13 considers its community health reinvestment
14 expenditures to fall into five categories. We
15 believe that three of those categories meet the
16 statutory definition of community health
17 reinvestment, but that two of them do not.
18 I'll start with the three categories that
19 we concluded meet the statutory definition of
20 community health reinvestment. First, corporate
21 giving. This category covers such things as program
22 initiatives to support a specific population; for
23 example, the District of Columbia Department of
24 Health, maternal and child case management program
25 and corporate sponsorships; for example, the DC

1 Chamber of Commerce.
2 At the time of our review, GHMSI
3 indicated that its corporate giving equaled the
4 following amounts for the following years: 2011,
5 3.4 million; 2012, 3.9 million; estimated 2013
6 amount, 3.5 million. GHMSI indicated that it would
7 be very difficult to predict its corporate giving
8 for 2014 and future years.
9 I will say that we struggled some as to
10 whether this category met the statutory definition
11 of community health reinvestment. We aren't
12 completely sure it directly promotes and safeguards
13 the public health and benefits current or future
14 subscribers as required. However, we recognize that
15 these expenditures do support the DC business
16 community, many of which are current or future
17 subscribers, and support organizations that provide
18 needed health care resources to the DC community.
19 Accordingly, we treated GHMSI's corporate
20 memberships and community sponsorships as community
21 health reinvestment expenditures.
22 The second category is open enrollment
23 subsidies. Prior to January 1, 2014, the District
24 of Columbia had a program in place that allowed
25 individuals to enroll their commercial products

1 regardless of a person's health condition or status.
2 Under this program, GHMSI was required to subsidize
3 the costs of the individual's coverage by charging a
4 lower premium than it would otherwise charge based
5 on the individual's health status. At the time of
6 our review, GHMSI indicated that its open enrollment
7 subsidies equaled the following amounts for the
8 following years: 2011, 4.5 million; 2005, 7.5
9 million; estimated 2013 amount, 9.6 million.
10 Although we concluded those historic
11 amounts constitute community health reinvestment
12 expenditures within the meaning of the statute, this
13 category essentially is going away, since as a
14 matter of health care reform, the open enrollment
15 program no longer accepted new enrollees as of
16 January 1, 2014. Accordingly, GHMSI will only
17 provide open enrollment subsidies in 2014, while any
18 remaining employees in the program convert to other
19 coverage available due to health care reform.
20 The third category is GHMSI's funding of
21 the DC Healthcare Alliance program. This program
22 provides a full range of health care services to
23 individuals who have no health insurance coverage,
24 including Medicare and Medicaid, and have a limited
25 income. Since 2009, GHMSI's been required to

1 provide funding of 5 million each year from the DC
2 Healthcare Alliance program. Our understanding is
3 that the funding requirements are included in a
4 public-private partnership agreement that will end
5 in 2014.
6 As I indicated previously, GHMSI provided
7 information regarding two other categories that it
8 believes constitute community health reinvestment,
9 but that we concluded are not community health
10 reinvestment within the meaning of the statute. The
11 first of those two categories is premium taxes.
12 Based on discussions with the DISB, we did not think
13 that premium taxes meet the definition of these
14 types of expenditures. We didn't think that GHMSI's
15 premium tax payments necessarily are an expense that
16 promotes or safeguards the public health or that
17 benefits current or future subscribers. As a
18 result, we didn't include premium taxes in our
19 report as part of the GHMSI's community health
20 reinvestment expenditures.
21 The other category GHMSI provided was
22 premium health reductions -- premium rate
23 reductions. We recognize that the statutory
24 definition of community health reinvestment
25 expenditures references premium rate reductions and,

1 therefore, the premium rate reductions could be
2 community health reinvestment expenditures.
3 However, after talking with DISB staff regarding
4 this category, we understand that premium rate
5 reductions are not automatically community health
6 reinvestment expenditures, rather, it depends on
7 things such as the reason the rate reductions were
8 made. Here, we were unable to quantify GHMSI's past
9 premium rate reductions as reductions that were
10 intended for community health reinvestment purposes
11 instead of for other reasons. Accordingly, we did
12 not include the premium rate reduction information
13 that GHMSI provided to us in our report as part of
14 GHMSI's community health reinvestment expenditures.
15 To summarize, we found that GHMSI's
16 community health reinvestment expenditures for the
17 time periods for which the DISB asked to review were
18 in total for 2011, 12.9 million; for 2012, 16.4
19 million; for 2013, an estimated amount of 22.1
20 million; for 2014, an estimated amount was not
21 available -- able to be provided because of
22 uncertainty regarding community giving.
23 I want to close by saying that we're very
24 proud of our work here and we stand behind it.
25 However, we also encourage you to listen carefully

1 to those who disagree with us. As I have indicated
2 on several occasions during my testimony today,
3 there are no right or wrong answers on the key items
4 that drive the result. Our sole motivation in
5 reaching our conclusions has been to try to
6 faithfully carry out the intent of the statutes. We
7 recognize, though, that the questions are complex
8 and difficult and we cannot claim a monopoly as to
9 the answers.
10 We're glad you will hear some opposing
11 views so that you will have in front of you a full
12 range of views which collectively should allow you
13 to make the best decision possible based on what the
14 law requires and what's best for the people of the
15 District of Columbia. We look forward to being of
16 whatever further help you think appropriate.
17 COMMISSIONER McPHERSON: Thank you,
18 Mr. Rector.
19 Okay. Thank you for your patience.
20 Thank you, Panel. Thank you, Mr. Rector. Thank
21 you, Mr. Toole. We have some questions here. Both
22 Mr. Barlow and myself have decided to share
23 questions. Since he's smarter than I, he will get
24 to ask all the technical questions, and I will get
25 to help those in the audience who haven't been

1 following this issue as closely as some of us with
2 some of the basic fundamental questions.
3 One of the base questions that I would
4 like to explore is your recommended range is
5 expressed in terms of RBC, and so I think it would
6 be helpful to understand what is RBC and how does it
7 relate to a surplus determination. And an
8 additional question I have is why are surplus
9 determinations again expressed in RBCs versus
10 absolute dollar figures? So if you could help me
11 understand that, I will be -- I'll appreciate it.
12 MR. RECTOR: Certainly. If you try to
13 look -- I'm trying to think of a hypothetical.
14 Let's say you have two different insurance
15 companies, one of which has $10 million of surplus;
16 another has $100 million of surplus. It would be
17 easy to think that the company that has $100 million
18 of surplus is stronger financially than the company
19 that has $10 million of surplus because it actually
20 has ten times as much surplus.
21 But it is clear to insurance regulators
22 that you cannot automatically make that decision
23 because it -- the surplus is there, but it depends
24 upon the risks that are in the company and that the
25 risk of that surplus supports; the kind of business

1 that's in the company, the asset base that's in the
2 company, the geographic market where the company
3 writes, the levels of reinsurance, the types of
4 reinsurance, the quality of the reinsurers. All
5 sorts of items could, in fact, make the $10 million
6 surplus company a much stronger company financially
7 than the $100 million surplus company.
8 So a number of years ago the National
9 Association of Insurance Commissioners and insurance
10 regulators developed a risk-based capital model that
11 all companies are now required to calculate annually
12 that makes a comparison of the amount of surplus in
13 the company to the risks and other characteristics
14 of the company. So -- and that's expressed in that
15 RBC percentage.
16 So it could be that the company with $10
17 million of surplus might have an RBC level of 1,000
18 and it could be that the company with $100 million
19 of surplus might have an RBC level of 600 and you
20 would be able to look at it in a rough the
21 companies' financial position in a relative sense as
22 opposed to in an absolute sense.
23 I think that may have been another
24 question there, but at least that's the part I'm
25 remembering.

1 COMMISSIONER McPHERSON: Okay. So that
2 just led to the next question that I have. So there
3 is surplus and there are reserves. And so could you
4 distinguish the difference between surpluses and
5 reserves? And maybe you could help me understand
6 why reserves aren't the appropriate means for
7 addressing the number of risk factors an insurer may
8 have?
9 MR. RECTOR: Yes. As a technical matter,
10 a reserve is a liability on a company's balance
11 sheet. And what it does -- if you -- when you
12 purchase an insurance policy from a company, you
13 give that company premium money and that company has
14 a requirement -- a legal requirement to pay your
15 health care bills or life insurance or auto bills,
16 depending on the type of company, once you -- you
17 know, once there's a trigger for that payment.
18 The company sets a portion of that money
19 aside in an account, more or less, I mean, but
20 sets -- designates a certain portion of that money
21 aside for the purpose of paying those claims.
22 There's an actuarial -- actuarially determined
23 estimate as to how much money needs to be set aside
24 to pay those claims. And those are the reserves,
25 and that money should be used only to pay claims.

1 But in addition to that, companies need
2 to have a cushion. You can have some -- almost like
3 a rainy day fund. They need to have something
4 beyond that to cover things if the claims end up
5 being higher than what was initially projected or if
6 the company loses money because of, you know,
7 financial collapse in the economy or through bad
8 investments or if a reinsurance company that it
9 ceded business to is unable to pay claims. It's an
10 amount of money that's there to cover contingencies
11 that aren't specifically booked as liabilities
12 within the company. And it's the surplus, it's that
13 cushion which is what is -- we believe and should be
14 measured to determine whether there's too much of a
15 cushion or not enough of a cushion, and that's
16 really what we believe that the statute is trying to
17 get to.
18 COMMISSIONER McPHERSON: So if the
19 company has financial experiences where it has to
20 make a determination as to excess in reserves versus
21 surplus, in order of utilizing those resources
22 available, is there a certain order in which the
23 issuer would use the funds that are available?
24 MR. RECTOR: Yes. If the money is needed
25 to pay a claim pursuant to a policy, it would come

1 out of reserves first.
2 COMMISSIONER McPHERSON: Okay.
3 MR. RECTOR: If -- to the extent that
4 there are claims that exceed the amount of money
5 that was set aside in reserves, it would then come
6 out of surplus. But surplus supports not only to
7 the extent that there's a deficiency in the
8 reserves, in case the claims are higher than the
9 amount of money set to pay claims, but if the
10 company also has a financial loss, if its stock
11 portfolio were to drop so that it would lose money
12 through its investments or if it was supposed to
13 receive money from a reinsurance company and it
14 didn't receive money from that, it's -- the surplus,
15 that cushion, is designed to cover any and all
16 business risks in the company that exceed what it
17 has specifically set money aside to cover.
18 COMMISSIONER McPHERSON: Okay. So, for
19 example, if the pension provisions or the pension
20 set-asides were to underperform or were not adequate
21 to meet the claims, again, which of these two
22 buckets would the company have access? Would it be
23 the reserves or would it be surplus that the company
24 would have to use to support its pension payments?
25 MR. RECTOR: Well, reserves could --

1 cannot be used for -- the money in reserves
2 aren't -- is designated solely for claim payments.
3 So anything outside of paying policyholder claims
4 would not come out of reserves. So pension would
5 not, loss in the stock portfolio would not,
6 reinsurance would not, all other risks would not
7 come out of reserves. So a pension deficiency that
8 has to be covered by the company would have to be
9 paid out of surplus. Stock losses would have to be
10 paid out of surplus; reinsurance losses paid out of
11 surplus. Those would be other things that would
12 come out of surplus.
13 COMMISSIONER McPHERSON: Okay. Thank
14 you. Let me see what else I have on my cheat sheet
15 here.
16 I'm going to ask you a question about the
17 Milliman model. So you indicated in your testimony
18 that there was a collective decision to use the
19 Milliman model rather than develop your own model.
20 And so if you could kind of help me understand what
21 was the thinking behind that. And if we were to ask
22 you to create your own model for this exercise,
23 could that be done? And would you be able to create
24 a model that's even better than the Milliman model.
25 MR. RECTOR: Well, first of all, I want

1 to clarify in terms of a collective decision to use
2 the Milliman model as the base. It was a collective
3 decision between FTI, Rector & Associates and in
4 discussions with the DISB. It was not a collective
5 decision that included input -- I'm not suggesting
6 at all that Appleseed, UHAS or GHMSI or Milliman
7 were were involved, you know, in that decision. It
8 was our collective decision.
9 But as to the -- as to the reasons why we
10 did it -- and I think Jim really talked about this
11 in his testimony -- the projection model -- it
12 really is oversimplifying it to call it just a
13 calculator, but -- because it is very complex, it
14 needs to be tailored to the specific risks in a
15 different company. It really is a very complex
16 thing.
17 But I think from a conceptual point of
18 view, you can think of it in some ways like a
19 calculator. If you have -- whether you use the
20 Milliman model, the Milliman methodology, the
21 Milliman calculator as it were, or whether you were
22 to use a different one, so long as they're done
23 right and made right, they should lead to
24 approximately the same answers.
25 The really important thing are the

1 assumptions. And what we decided to do is rather
2 than changing both the model and the assumptions,
3 let's keep the model constant so that we can all
4 really focus on the assumptions, because that's
5 really what drives the results.
6 But again, having said that, as Jim also
7 indicated in the testimony, even though we used the
8 Milliman model as the base, we did, in fact, develop
9 our own projection model that we used to -- as kind
10 of a second check to make sure that the Milliman
11 model was, in fact, working the way we thought it
12 would work. And we made also some fairly
13 significant adjustments to some of Milliman's
14 modeling methodology. So we didn't just accept
15 their model as it was. We made changes to it.
16 I think your question also was could we
17 build our own model or build a better one? And we
18 did build our own which we used for validation
19 purposes. We could -- we could always, you know,
20 beef it up and, you know, do other things. And
21 everyone's got pride of ownership as to, you know,
22 what they build, but I think in terms of generating
23 an answer -- the really best response is that any
24 really well-constructed model, if it has the proper
25 assumptions in it, should lead to approximately the

1 same result.
2 And the key really here, and I think what
3 our recommendation to you is that the real focus
4 ought to be on the assumptions and listening to the
5 testimony to try to determine whether the
6 assumptions that we chose, whether you believe that
7 they're reasonable and fit within the public policy
8 of the statute as you understand it.
9 COMMISSIONER McPHERSON: Thank you.
10 Okay. So now I will pass the microphone over to
11 Phillip Barlow, who is our associate commissioner
12 for insurance, and he will take the next round of
13 questions.
14 MR. BARLOW: Thank you, Commissioner.
15 As I believe I'm supposed to do, my name
16 is Phillip Barlow. I'm the associate commissioner
17 for insurance, for the Department of Insurance,
18 Securities and Banking. I can't read, but I'll put
19 on my glasses.
20 You just mentioned that you made some
21 adjustments to the Milliman model. You didn't just
22 accept it as it was. Could you describe some of the
23 adjustments that you made to the Milliman model?
24 Give us a flavor of that.
25 MR. TOOLE: Sure. Yeah. We didn't just

1 accept the model as presented. We did a thorough
2 review and we made substantive changes to all the
3 aspects of the model, including the data, the
4 methodology and the assumptions that comprise the
5 model. We incorporated additional data such as
6 ongoing ACA developments and national information on
7 health expenditures. We revised the methodology to
8 incorporate premium growth and trend misassumptions
9 into the stochastic process itself as opposed to
10 outside the model, and we reviewed all of the
11 assumptions and made -- we modified many of those
12 underlying assumptions and we described those at
13 length in our report.
14 MR. BARLOW: So Milliman -- I mean, you
15 weren't actually running the model. Milliman was
16 running the model. So you requested adjustments to
17 the model that Milliman ran and then provided you
18 with results; is that --
19 MR. TOOLE: That is how it operated. We
20 would determine a set of assumption changes that we
21 wished to see the results to based on communication
22 with the DISB and ourselves. We would write those
23 up and submit them to you and it would be sent to
24 Milliman for them to run and we would review the
25 results.

1 MR. RECTOR: I'm sorry, the one thing I
2 would probably add to that is before that was done,
3 as Jim mentioned, there were a couple of fairly
4 significant changes to the modeling methodology
5 itself. The whole idea of the trendness piece and
6 the premium was brought in, and then also the
7 Affordable Care Act was dealt with differently.
8 So we first had them to make adjustments
9 to that, to kind of the base model, and then, as Jim
10 described, then gave them very specific assumptions,
11 saying change this assumption from X to Y, this one
12 from Y to Z, and then had that done. And then we
13 validated all that through the work that was done
14 relative to the model that we constructed
15 separately.
16 MR. BARLOW: Okay. Did the model as you
17 adjusted it cover all the risks that you think it
18 should have covered?
19 MR. TOOLE: Yes, it did.
20 MR. BARLOW: And did it include the
21 impact of any risks that you think should not have
22 been covered?
23 MR. TOOLE: No. We carefully reviewed
24 all the assumptions, made sure that -- you know, a
25 special effort to ensure that no risks were double

1 counted in different places in the model or
2 inappropriately included in the projection, and we
3 did take out certain aspects, certain assumptions
4 that we felt were unnecessary or double counted.
5 MR. BARLOW: Okay. The -- you mentioned
6 that one of the adjustments that you made to the
7 model was how it handled health care reform. Could
8 you describe that, those changes?
9 MR. TOOLE: Sure. Health care reform, or
10 the Affordable Care Act, ACA, posed a moving target
11 throughout the process because it was evolving as we
12 were doing our review. But because of the magnitude
13 of the impact of the ACA on model results, this was
14 the one consideration that we felt was important to
15 incorporate new developments in the model to refine
16 those assumptions as -- and the primary adjustments
17 to the projection assumptions resulting from the ACA
18 included first the impact on premium growth, and
19 second, the volatility -- it applied more volatility
20 to the rating adequacy assumptions.
21 The impact of other ACA requirements
22 including the MLR restrictions, which we've heard
23 earlier, including there was guaranteed issue
24 requirements and benefit requirements, all these
25 assumptions and changes were considered.

1 We also kept abreast of the ongoing
2 development of risk mitigation programs, or the
3 three Rs, which include the reinsurance, risk
4 adjustment and risk corridors. When we began our
5 analysis in 2013, the final rules for these programs
6 hadn't even been published. And even today, the
7 potential impact of these programs is uncertain.
8 And the federal processes for reconciliation and
9 review are still in the course of being implemented
10 and the funding levels are far from certain.
11 MR. RECTOR: I think I'd like to add just
12 in terms of a big picture, we treated the ACA stuff
13 different conceptually than Milliman did, I think,
14 in part because of the timing of our review. When
15 Milliman did their work that led to their report,
16 some aspects of ACA had been implemented and those
17 were actually incorporated into the model that they
18 did themselves, the work that they did themselves.
19 But parts of it hadn't and they just said, well, we
20 don't know what those are, so we're just going to
21 estimate 100 to 150 basis points in addition to tack
22 on at the end just to cover those other things.
23 So what Milliman did is split part of it
24 including the model and part of it as a tack-on
25 afterwards, and we -- what we did was really

1 different in that we took all of it and tried to
2 include it in the model through making changes to
3 the assumptions. So I think that's a -- in a big
4 picture way, that's really the big difference
5 between how we handled ACA and how Milliman handled
6 ACA.
7 MR. BARLOW: You kind of described the
8 uncertainty around the ACA. So with uncertainty, I
9 guess, comes risk. And for risk, one needs surplus,
10 I suppose. So as the -- as the ACA becomes more
11 known and operates for a while, do you believe -- I
12 mean, are there risks that are currently in your
13 model that would be minimized or eliminated as --
14 that could then potentially result in a lower
15 surplus need in the future than right now?
16 MR. TOOLE: That's an interesting
17 question. And at this point it's unclear. It could
18 go either direction. There are a number of programs
19 that are coming online, but as we are all aware,
20 there are changes that can be made to the law.
21 MR. RECTOR: I think it's unclear as
22 to -- you know, because -- because we don't know for
23 sure how things will play out, you don't know
24 whether the end result will be better or worse than
25 what was predicted. But I think it is clearly fair

1 to say, and I think we had testimony, too, that when
2 further reviews are done, the more that's known
3 about ACA and more of its impact, that it's best to
4 incorporate that information into the model.
5 And at the time we did our work -- our
6 report was published in December 2013, but, you
7 know, much of the work was obviously done well
8 before that. More is known about the ACA today than
9 it was then and more will be known about the ACA and
10 its impact a year from now than is known now. So
11 certainly, any further work that's done should
12 incorporate the most up-to-date information that you
13 have.
14 MR. BARLOW: Okay. Your report says that
15 you incorporated certain assumptions to address
16 extreme adverse events. Does this mean that the
17 model was set up to protect the company no matter
18 what happens?
19 MR. TOOLE: I definitely wouldn't say --
20 wouldn't characterize it that we're recommending
21 surplus levels protecting against any and all
22 possible catastrophic events. All of the risk
23 categories that were used, including catastrophe,
24 have probability distributions for frequency or how
25 often something occurs and for severity for how much

1 it costs when it occurs. We don't place
2 probabilistic probabilities on specific events such
3 as a pandemic or a terrorist attack. Instead, we
4 just demonstrate the potential impact of events of a
5 certain probability of magnitude on surplus levels
6 no matter what caused it.
7 MR. RECTOR: I was the person who put
8 that language in our report. I mean, I wrote that
9 section myself and over the objections of some. And
10 I wish I hadn't. I mean, because I think it's led
11 to some confusion. I mean, we -- what I was trying
12 to say is that through the stochastic modeling
13 process, when you look at the 98th worst -- you
14 know, having only a 2 percent chance of something
15 happening, once every -- you know, twice every 100
16 years, it obviously means that some bad things are
17 going to happen and some bad things are going to
18 happen in combination to be able to get to that
19 level.
20 Bad things had to happen for the Great
21 Depression to happen, bad things had to happen for
22 the Great Recession to happen, and multiple bad
23 things had to happen. But what we didn't look at --
24 we weren't saying, well, let's see what can happen
25 with this potential event or that potential event or

1 what happened if we had five of these specific
2 potential events. We didn't look at potential
3 events like that at all.
4 What we looked at were things like, well,
5 what's the chance that, you know, instead of claims
6 happening as we think that they'll happen, what if
7 they went up 10 percent worse than what we thought?
8 What's the percentage chance of that happening? Or
9 what's the percentage chance that the company's
10 stock portfolio might fall by 20 percent? What's
11 the chance of that happening? So it had more to do
12 by looking at the percentage chance of certain
13 drivers of GHMSI's financial condition happening
14 than looking at specific adverse events. And, you
15 know, I knew what I meant at the time I wrote it,
16 but obviously, when you look at the prehearing
17 reports, I'd go back and rewrite that section if I
18 could.
19 MR. BARLOW: You've read all of the
20 prehearing reports?
21 MR. TOOLE: Correct.
22 MR. RECTOR: At least read through them.
23 MR. TOOLE: Yes.
24 MR. BARLOW: Okay. Based on reading the
25 prehearing reports, are there any adjustments that

1 you have determined at this point that you would
2 make to the work that you did?
3 MR. TOOLE: I think that the short answer
4 is it's no, unless we were asked to consider
5 information after the 12/31/11 point in time at
6 which we presented our results.
7 MR. RECTOR: Yeah. I think that's a fair
8 statement. Yeah.
9 MR. BARLOW: Okay. Which of the factors
10 of the model had the biggest impact on the results?
11 MR. TOOLE: Yeah, good question. But as
12 a health insurer, by far, the biggest risk factor
13 that GHMSI faces is the adequacy of the premium
14 rates. Rates are developed a year or more in
15 advance of the rating period using historical data
16 as well as forward-looking data. And in that time,
17 the assumptions used to determine them may prove to
18 be inaccurate. And this risk has been exacerbated
19 by the rollout of ACA.
20 But in addition to rating adequacy, other
21 significant factors which drive the model results
22 included the assumed number of years of trendness,
23 premium growth assumption, which was also driven by
24 the ACA rollout, and projected asset adequacy
25 values. Now, those are the main assumptions.

1 But in addition to assumptions that drive
2 results, but are not exactly risk factors in the
3 model, include the confidence level that we choose;
4 i.e., is it 95 percent or 98 percent, the percentile
5 test as it were. And also the choice of RBC
6 threshold. Are we looking at 200 percent or 375
7 percent or some other threshold? Those are the main
8 drivers.
9 MR. BARLOW: Okay. To that last point,
10 it seems as though the 200 percent threshold is more
11 significant than the 375 percent threshold. Does
12 that -- at least in, you know, in the information
13 that you've -- that we've discussed today?
14 MR. RECTOR: For this particular review,
15 that is the calculation that was the highest of the
16 two, and so therefore, it was the one that, you
17 know, drove the target surplus number. But it
18 doesn't have to be that way. In the 2009 review,
19 actually, the calculation relative to the 375
20 percent threshold was the one that drove the higher
21 number. So it -- in connection with the next
22 review, I'm not sure which of the two would. But
23 certainly for this particular review, the
24 calculation relative to 98 percent confidence level,
25 that's the 200 percent RBC threshold, is the one

1 that drove the target surplus.
2 MR. BARLOW: Okay. And then the -- and
3 we -- you've discussed, I think, many times in your
4 testimony today the 98 percent confidence level.
5 What -- you may have mentioned this in your
6 testimony, but I'm going to ask anyway because I
7 don't remember, so -- the -- could you tell me what
8 kind of standard that you used in determining where
9 you set the assumptions? I don't want to know what
10 all the assumptions are, but how did you go about --
11 because you said that the assumptions are the most
12 important thing. How do you go about determining
13 the assumptions that you used in the model?
14 MR. RECTOR: Well, we had -- when we had
15 the meeting with the companies at the beginning of
16 the project, there -- what we tried to do with the
17 assumptions -- I'm not sure this is the question
18 you're asking -- but what we tried to do with the
19 assumptions was on the assumptions themselves, we
20 tried not to be overly conservative or overly
21 aggressive with the assumptions.
22 If we thought premium growth was going to
23 go up by a certain percent, and that's our honest
24 belief as to what we truly thought was the best view
25 as to what would happen with premium growth. We

1 thought it was a 50 percent probability of that, the
2 assumption says there's a 50 percent probability
3 that it's going to go up that much. If we truly
4 thought there was a 25 percent chance it could go
5 higher than that, that's what we put; 25 percent
6 chance lower, then that's what we put.
7 We wanted the assumptions as we drafted
8 them to be what I call right down the middle of the
9 fairway. We're not trying to game it to make it
10 conservative or aggressive. Because when you start
11 doing that with individual assumptions, that degree
12 of conservatism would build on itself or that degree
13 of aggressiveness would build on itself. The
14 assumptions themselves, we tried to have it be
15 exactly what we thought was actually going to happen
16 with the degrees of probabilities.
17 Where you get appropriate levels of
18 conservatism or not has to do with the stochastic
19 modeling process. If you're saying, okay, premium,
20 we think it's going to go right down here, but it's
21 got a 25 percent chance of doing -- of being higher,
22 25 percent chance of being lower, then the
23 stochastic model calculates all those combinations
24 and permutations.
25 And then you say -- to decide how

1 conservative or how aggressive you want to be is by
2 selecting the confidence level. Do I want only a 2
3 percent chance of this bad thing happening or a 10
4 percent chance or a 50 percent chance? What am I
5 willing to have? And we felt that was the place
6 where you should make decisions about conservatism
7 or not conservatism rather than through the
8 assumptions.
9 I don't know if that was responsive to
10 your question.
11 MR. BARLOW: Yes, that was -- that was
12 what I was trying to understand.
13 MR. RECTOR: Okay. Great.
14 MR. BARLOW: I have one last question.
15 And that is, in your testimony, I believe you said
16 that the MLR is a measure of efficiency. Did I --
17 is that what -- did I get that right?
18 MR. RECTOR: Yes.
19 MR. BARLOW: Okay. Is that -- do you
20 believe that the MLR -- maybe you can expound on
21 that a little bit, but do you believe that that is a
22 measure of efficiency or the measure of efficiency?
23 MR. RECTOR: I would say a measure of
24 efficiency would be how I would describe it. It is
25 a statutory measure of efficiency.

1 MR. BARLOW: Okay.
2 COMMISSIONER McPHERSON: Okay. Back to
3 me again. So in your presentation, you mentioned
4 that you reviewed historic RBC from 1999 through
5 2012. So I think one of the criticisms in the
6 Appleseed report was that time period or that range
7 was just too long. So can you help me understand
8 why that period was chosen versus maybe a shorter
9 period?
10 MR. RECTOR: Well, first of all, what we
11 looked at that range -- what we looked at that for
12 was developing the plus-or-minus range around the
13 surplus target. As I indicated in the testimony,
14 once you run the calculations, it came to a very
15 specific number, 958 percent. But that specific
16 number, it just doesn't make sense in the real
17 world. Having any very specific number, in our
18 judgment, doesn't make sense in the real world
19 because companies' RBCs will bounce around it with
20 some -- some ways. It's just the way it naturally
21 happens.
22 And you can't, through the imprecision or
23 projection model, come down to that level of
24 refinement. So we felt we needed a plus-or-minus
25 band around it. So what we wanted to do was to say,

1 okay, well, how much does GHMSI's RBC tend to bounce
2 around just in the normal -- in the range of things?
3 Although we started looking from the 1999 period up
4 to the later period, as we indicated in the
5 testimony, we basically excluded the '99 up through
6 2004 period. The plus-or-minus band we determined
7 was from -- was the average from 2004 and later. So
8 it's like we started looking at the bigger data set,
9 but what we actually used to develop the
10 plus-or-minus band range was 2004 and later as
11 opposed to that earlier information.
12 COMMISSIONER McPHERSON: Okay. And in
13 doing your analysis to prepare your report -- you
14 may have mentioned this, but I just want to, you
15 know, for it to be confirmed -- did you consider the
16 Court of Appeals' requirement for the determination
17 to be made in tandem the surplus attributable to the
18 District not being unreasonably large and
19 inconsistent, and also the community health
20 reinvestment to the maximum extent feasible with
21 financial soundness and efficiency?
22 MR. RECTOR: Yes. I did cover that in
23 the testimony and I'll try to -- because it's a very
24 complex issue, I'll try to refer to the transcript,
25 you know, back to that. But we absolutely did.

1 And in a big picture way, what it really
2 had us do was to look for, again, that number -- the
3 target number where if the company has surplus above
4 that number, in our judgment, it is not given to the
5 maximum feasible extent. If it's below that number,
6 then it has the risk -- an inappropriate risk of
7 being financially unsound. And we also, again, then
8 measured that against making sure that getting to
9 that number would not have the company run an
10 inappropriate risk of being inefficient, in our --
11 in our judgment.
12 So we spent a lot of time -- I mean, I
13 have to say that -- well, we just spent a great deal
14 of time trying to think through how best and how
15 most appropriately to consider those two
16 determinations in tandem, and I believe we've done
17 that.
18 COMMISSIONER McPHERSON: Okay. So I
19 think I heard earlier where there was discussion
20 that in this latest go-round of analysis there was
21 not a comparison to other insurers. Given
22 subsequent development, what's your view as to
23 whether or not that would have been a beneficial
24 exercise, or is the conclusion at the start which --
25 is that still the prevailing conclusion? Is that

1 still a reasonable conclusion?
2 MR. RECTOR: Well, as I mentioned, we did
3 it in 2009. It wasn't the primary part of our
4 analysis. The primary part of our analysis in 2009
5 still was using the projection model and going
6 through all the assumptions and doing all that. But
7 we did do, you know, what you might call a peer
8 group analysis as almost kind of like a reality
9 check or some sort of a check. It was part of our
10 2009 work, part of our 2009 report.
11 And at the beginning of this work, I --
12 you know, I think we found it somewhat helpful, but
13 not really frankly -- not frankly, that much
14 helpful. So what I wanted to do was to just get
15 others' views. I didn't want to just do work if
16 people didn't find it was helpful. But at the same
17 time, I didn't want to not do it if someone did find
18 it helpful.
19 So we met with GHMSI, Milliman, Appleseed
20 and UHAS and asked everyone did you find this
21 helpful and to a person, they all said nope, it
22 wasn't helpful to us. And I asked the DISB and they
23 indicated it wasn't helpful to them. So I figured
24 if it's not helpful, why spend the time doing it.
25 Again, I think it's always -- it's hard

1 to ever say that more information is worse than less
2 information. So, you know, it can always provide
3 some help, but I don't really know how one would use
4 it because there always are -- there are
5 differences, whether you're talking about
6 for-profits versus not-for-profits. But even in the
7 not-for-profit world, GHMSI is a small -- you know,
8 much smaller concentrated market than other
9 companies. You know, it may have reinsurance
10 difference. I mean, there are always ways that one
11 could talk about apples and oranges differences, but
12 in our judgment, we didn't see a great deal of value
13 for it and everyone we met with said the same thing.
14 So our -- so the DISB said don't do it. That's why
15 we didn't do it.
16 COMMISSIONER McPHERSON: Thank you.
17 Okay. So I think I'm getting to the end of my
18 questions for this panel. Let me see on my list
19 here. I made some notes while you were providing
20 your testimony. So -- I just want to note that, you
21 know, you've presented your report and we've heard
22 from both GHMSI and from Appleseed, and I can't say
23 that they're all supportive of your recommendation.
24 In fact, they're not. And so I most definitely will
25 be interested in hearing from GHMSI and from

1 Appleseed as to their views of your analysis.
2 I may have further questions that I will
3 pose in writing after the hearing to yourselves and
4 also to GHMSI and to Appleseed as it relates to the
5 nature of your analysis. And again, I will make all
6 those reports and those questions public.
7 I will say that for me, one of the issues
8 that I've been thinking about is the relevance of
9 the confidence level. I've read the various reports
10 and the various analysis. And so one of the
11 questions that I have for myself, and I will go on
12 the record to say, you know, should it be 100
13 percent confidence level when you do these analyses?
14 Should it be 75 percent? Should it be 50 percent?
15 Should it be 98 percent?
16 So to the extent that there are experts
17 here who believe that they have an answer that will
18 be very informative and helpful to me in making my
19 decision, again, I invite you to provide information
20 on that as you build the record to come to a
21 decision on this very complex issue.
22 So with that, I will dismiss the Rector
23 and FTI panel and I think it's about time for us to
24 take a break. So we'll break for 15 minutes and we
25 will return -- if my watch is correct -- we will

1 return at 11:00 a.m. Okay. So thank you. See you
2 back at 11:00.
3 MR. RECTOR: Thank you.
4 COMMISSIONER McPHERSON: We're in recess,
5 I guess, until 11:00.
6 (Recess taken.)
7 COMMISSIONER McPHERSON: Okay. It's now
8 11:00 a.m. the same day that we started. We're now
9 back on the record. Could I have the next panel
10 take its seat, please.
11 According to the agenda, this is the
12 panel from GHMSI. If you all could raise your right
13 hands so I could swear you in.
14 Whereupon,
15 CHET BURRELL, MARK CHANEY,
16 PHYLLIS DORAN and DOMINIC PERELLA,
17 having been duly sworn by Acting Commissioner
18 McPherson, gave testimony as follows:
19 COMMISSIONER McPHERSON: Thank you. And
20 if you have written testimony or written copies of
21 your presentation, if you could make them available
22 to us here on the panel and also to our transcriber,
23 that would be very helpful. And just, again, to
24 remind everyone that the presentations that are
25 given today will be made available on our website.

1 So with those housekeeping rules out of
2 the way, if the panel could get started. Again,
3 please identify yourself and your affiliation once
4 you get started with your presentation. Thank you.
5 MR. BURRELL: Thank you, Commissioner. I
6 am Chet Burrell. I am the CEO of GHMSI. I have
7 been CEO for the last six and a half years and have
8 in various capacities a 30-plus year experience in
9 the healthcare field, including as CEO of another
10 Blue plan in the New York area.
11 With me is our chief financial officer,
12 Mark Chaney, and to his right, partner at Hogan
13 Lovells, Dominic Perella, and to my left, Phyllis
14 Doran from Milliman, who is a consulting actuary
15 with Milliman.
16 We thought we would start with me giving
17 some general perspective and the company's view of
18 these proceedings and the issues that are contained
19 within them, and then turn to the others on the
20 panel for answers to questions or further
21 embellishment of anything that you would like.
22 I guess I would start with the
23 observation that health care, cost of health care
24 has been among the most fundamental societal issues.
25 Just to put that in perspective, the average premium

1 now in the District of Columbia is $500 per person
2 per month. And so we handle in that context the
3 care of people who in many, many cases actually
4 fully need health care services. They are extremely
5 expensive for them and well beyond their means of
6 paying, so we are their insurer, taking risk for
7 them in a way that they could not for themselves.
8 I thought I would take, in giving you our
9 perspective, a number of points that were not
10 discussed by the previous panel. But let me start
11 by observing that the report that Mr. Rector and
12 Mr. Toole described and the testimony that they gave
13 we find in the main to be creditable and to be
14 professional.
15 And while it is always possible to
16 disagree with a certain assumption or a certain
17 aspect of a model, we think they came to essentially
18 a sound conclusion. So we will be happy to go into
19 whatever detail you would like about that model and
20 about those assumptions, but I thought I would focus
21 my comments on some other things that were not
22 touched upon.
23 I think it is a legitimate question to
24 ask to whom does the surplus belong? And I think
25 our view of that is clear. I'd like to start with

1 just quoting the GHMSI chart. The reason I do this
2 is because we know that there has been the assertion
3 that the surplus belongs to the public.
4 Let me just read from the -- from the
5 GHMSI charter. "Said corporation shall not be
6 conducted for profit, but it shall be conducted for
7 the benefit of the aforesaid certificate holders,
8 subscribers. District law, as well as Maryland law
9 recognizes this and indeed requires that the money
10 be used, in the case of Maryland, for the benefit of
11 subscribers."
12 I'd like to read to you, just to
13 highlight this point, the testimony that was given
14 at the 2009 hearing. Just take a brief excerpt of
15 it from then Commissioner Tyler, who was with the
16 Maryland Insurance Administration. This is what he
17 said at that hearing. "If there is any excess
18 surplus, that excess was the result of premiums paid
19 by or on behalf of policyholders and plainly not the
20 result of anything that the public did. As a matter
21 of fact, therefore, the excess belongs to
22 policyholders because they generated it. Similarly,
23 under the plain words of the District law, the
24 company has the unconditional right to spend down
25 any excess that might exist for the benefit of

1 current subscribers of the corporation. And by
2 example, providing them with prospective rate
3 relief. The public has no colorable right to share
4 in any excess absent a determination by GHMSI in its
5 distribution plan that the public should do so."
6 That was Commission Tyler.
7 Recently, Commissioner Goldsmith
8 submitted a statement in the context of this
9 hearing. I would just like to take a minute to
10 quote one portion of that. It reads as follows:
11 "It is the Maryland Insurance Administration's
12 position that distribution of any excess surplus to
13 GHMSI policyholders, including, for example, in the
14 form of a premium subsidy or premium rate relief is
15 the only 'fair and equitable manner of
16 distribution.' Any excess surplus the commissioner
17 may find to exist would represent premiums paid by
18 or on behalf of GHMSI policyholders. Diversion of
19 any such funds for any 'community health
20 reinvestment' purposes would fail to recognize that
21 fundamental fact and would be neither fair nor
22 equitable."
23 So I want to place this point in the
24 record clearly that obviously, you, DISB, have an
25 interest in this, but so do others, other regulators

1 who have taken this point of view. If indeed excess
2 is found, one of the most fundamental questions is
3 to whom does it go? We would suggest to you
4 strongly and hold the position that that is the
5 subscribers' money and if excess were to be found,
6 it goes to them, either through rate reduction or
7 rate relief.
8 We think that what Rector has
9 described -- Mr. Rector described and his firm did
10 in describing what it means to be financially sound
11 and efficient, in other words, to have a point of
12 RBC that you should strive for, and to have a range
13 around that point because of the inherent
14 fluctuation that occurs month to month, year to
15 year, that is a sound way of thinking. Further,
16 that if you were to go above that or out of that
17 range on the high side, that might be excess and
18 that you would bring it down. And if you were
19 below, it would not.
20 They calculated, as he said, a range of
21 875 to 1,040 RBC with 958 as a mean. In 2011, I
22 would just point out GHMSI was at 998, right close
23 to the middle of the range, slightly above that
24 target. Presently, based on 2013 data that we now
25 know, GHMSI is below that target. It is at 932.

1 And we expect that it will go further down during
2 the course of 2014, not the least reason for which
3 are the requirements of the Affordable Care Act.
4 Maybe put one other thing in perspective
5 in this connection. Every statute of every charter
6 has in the minds of the founders, I think, a hope,
7 an expectation, of what would be achieved. There
8 were certainly hopes and expectations when GHMSI was
9 chartered. And among those hopes were that there
10 would be a community-based, nonprofit organization
11 which would provide coverage to people who needed
12 coverage, particularly the most vulnerable, which
13 would include individuals and small groups. That
14 was 70 years ago.
15 If you move forward to today, just to put
16 the numbers in perspective, CareFirst has 76 percent
17 of all individuals under 65 in the District covered
18 of all of those commercially covered, and 72 percent
19 of all small groups as well as 80 percent of the US
20 Congress. That is not because the market was forced
21 to go to GHMSI so much as chose GHMSI presently and
22 over the course of many years.
23 It is these people, the individuals and
24 the small groups on whose behalf we take risks and
25 who pay premiums. We do serve many, many larger

1 employer groups. Those groups tend to be
2 self-insured. But for small groups and individuals,
3 we charge premiums and on their behalf we take risks
4 that they couldn't otherwise bear.
5 It is that part of the market,
6 individuals and small groups, that have paid into
7 and built the surplus that GHMSI currently has. If
8 it were to be found that GHMSI has accumulated too
9 much surplus, then by rights it should go back to
10 them and would be argued that that is the proper
11 disposition of that excess.
12 One way that could be done is to cut
13 rates, but I caution you that if rates were cut,
14 there will be a rebound in those rates to catch up
15 to what the actual adequacy would need to be in the
16 future and that there are strong limits in the ACA
17 preventing that from happening. And I'll discuss
18 that a little further.
19 One of the points that was made by
20 Mr. Rector and Mr. Toole was the fact that surplus
21 is a highly technical, very complex issue. We
22 agree. I would liken it to the engineering
23 complexity of designing a bridge over which you
24 intend to cross. It's one thing to say I will
25 design it that it can carry one car in fair weather.

1 But what's that bridge like in foul weather? In
2 freezing weather? In rain? In snow? At full
3 traffic load? Is the bridge able to bear that load?
4 Just as another analogy. Is it
5 acceptable that the risk of getting across the
6 bridge is anything less than 100 percent? Would you
7 cross a bridge like that? And that is the
8 perspective we like to bring to this.
9 I'm not sure that it is possible to get
10 to 100 percent certainty. Perhaps not desirable
11 given the cost of trying to be that sure. But
12 Rector's recommendations of 958 as a focal point
13 with a range around between 875 and 1,040 seem to us
14 to be reasonable. It gave the assurance, as you
15 discussed, within 98 percent confidence level or 85
16 percent for 375 percent of RBC as a threshold.
17 To argue that it should be materially
18 lower than that, we think, puts the company and its
19 subscribers at substantial risk in an environment
20 where it will be very, very difficult to recover.
21 There will be no government saving of it if, in
22 fact, costs and trends turned out to be different
23 than what was expected.
24 I think it is also fair to ask how much
25 has our surplus over the years been studied? Is

1 this the first time? And I think the answer to that
2 is instructive. Since 2005, our surplus has been
3 studied nine times. Multiple times by us and by
4 firms chosen by other regulators, particularly
5 Maryland, twice by Rector. In none of those studies
6 was there a conclusion that our surplus was
7 excessive. All have concluded that it was not
8 excessive.
9 So there's a consistency we have found in
10 the conclusions that were reached in those studies
11 done at different points in time, done by different
12 experts, some of which we called in. No one in
13 particular. The point was made earlier that we are
14 a one-product, one-region company. The source of
15 our income -- our revenue comes from only one place
16 and one type of customer.
17 It was also raised as to how challenging
18 ACA makes the current and future environment. I'd
19 like to comment on that. The Affordable Care Act
20 does a number of very substantial things. Among
21 them guaranteed issue. The idea that anybody could
22 get coverage regardless of what their health status
23 is, that is an idea that we have totally supported
24 from the beginning.
25 In the District of Columbia, we have

1 operated an open enrollment program and in the State
2 of Maryland, we have operated a high-risk pool in
3 the State of Maryland where people who in the past
4 were turned down for coverage could get coverage
5 through the state program in Maryland. It's the
6 third largest in the country.
7 Both the open enrollment program in the
8 District and the Maryland program are going away
9 because the Affordable Care Act affords them access
10 to coverage without regard to medical underwriting
11 or preexisting conditions or any other condition.
12 This is what we know: That the people who have come
13 in through open enrollment in the past in the State
14 of Maryland are four times as sick as the people in
15 the general population. And here in the District,
16 only several thousand people ran up $7 million
17 dollars in losses. These are people that have been
18 sick and are sick.
19 So you have one of the most fundamental
20 forces at play that is caused by the Affordable Care
21 Act, which is that people now have access to
22 coverage -- and we're glad for this -- that they
23 couldn't get before. But that will bring into the
24 risk pool people who are, we think, somewhat older,
25 somewhat sicker and perhaps somewhat poorer. And

1 the evidence that is mounting up based on the
2 demographics that we are observing as it occurs is
3 that that is true.
4 The challenge is can the rates that are
5 charged, the premium rates, accurately reflect as it
6 occurs what the nature and extent of that risk and
7 cost actually is. For us, missing it by a percent
8 or two is tens of millions of dollars. What exactly
9 will be the composition of the risk pool as we get
10 into the latter part of this year, into the
11 beginning of next and the following year, none of us
12 can say. We can make assumptions, we can make
13 models, but we cannot be certain that we can pay the
14 premium entirely correctly.
15 We think there is strong, and by design,
16 regulatory and perhaps appropriate pressure to hold
17 premiums down, of course. But that -- that volcanic
18 force of having people come in that have higher
19 intrinsic experience and need against the desire to
20 hold rates down could result in rates not fitting
21 the circumstance correctly, and that the risk of
22 that, I think, is the highest in my experience.
23 There are mechanisms discussed by the
24 previous panel to deal with that. Let me just
25 briefly comment on them. One is risk corridors, the

1 idea that if you were to lose more than you
2 expected, there would be funding to make up for
3 that, at least in part, for a limited period of time
4 during '14, '15 and '16. Just in the last several
5 months, that has been on the table, off the table,
6 in terms of regulatory oversight from CMS and
7 different opinions as to whether the protection that
8 was intended would be there or be there in the form
9 in which it was originally understood creates
10 incredible uncertainty.
11 Another feature, and you commented on it
12 earlier, is risk adjusters. The idea behind a risk
13 adjuster is to try to accurately capture an
14 understanding of the risk inherent in an individual
15 and in a group of individuals and what the future
16 might look like for them in cost. Our caution on
17 this is that there is no model that we have seen --
18 and we're extensive users of risk adjusters -- that
19 can adequately and fully predict even a majority of
20 what likely would happen for an individual or a
21 population of individuals, and therefore, it's
22 likely to be wrong. This creates uncertainty.
23 On top of these uncertainties, benefit
24 plan designs have changed. The coverage that you
25 have under the Affordable Care Act is different, and

1 it changes somewhat every year based on federal
2 requirements. So, for example, just in moving from
3 '14 to '15, out-of-pocket maximums, the amount
4 people would have to pay out of pocket for their own
5 coverage, will go up materially. That creates
6 uncertainty and confusion as to who will buy and how
7 they will use and how you predict that. We have
8 never faced those kinds of uncertainties before.
9 So I only make these points to underscore
10 the level of uncertainty that ACA introduces. It
11 does a couple of other things, just to underscore
12 the point. For small groups, it charges premium
13 based on every individual in the group and a
14 different premium for every age. It causes billing
15 to be different for the group as well as the
16 coverage to be different. This creates uncertain
17 behavior on the part of the group. What will they
18 do in reacting to that? Our task is to try to
19 calculate premium rates going forward that would
20 anticipate these things and get them within a very
21 tight margin of accuracy. Very, very difficult
22 challenge.
23 Let me build on that by a related
24 observation. It would be fair to consider, we
25 think, and look at what our actual margins have been

1 in our business. Has GHMSI made large margins in
2 the past? Is it likely to in the future? And I
3 would only make the point that I think you well know
4 that we operate on tiny margins.
5 I can speak to the period that I have
6 been CEO. During that period, our average operating
7 gain based on billions of dollars in revenue has
8 been .6 percent -- six-tenths of 1 percent -- over
9 the last five years. There was only one of those
10 five years in which we made more than 1 percent.
11 Since 2012 -- which we understand is
12 beyond what you're considering here in 2011 surplus,
13 but you opened the possibility of commentary beyond
14 2011 -- I would point out that GHMSI had operating
15 losses in the tens of millions of dollars in the
16 period subsequent to 2011, and that that appears to
17 be continuing in 2014.
18 One of the things that we did in looking
19 at 2000 ACA premium rates was to keep those rates as
20 low as we possibly could consistent with our own
21 financial solvency. We had received actuarial
22 advice that would suggest that the premium rates
23 should be a great deal higher than they currently
24 are. We deliberately held them down until we had
25 more facts. We did not want to get too far in front

1 of the actual facts in terms of what the claims, the
2 demographic information told us.
3 We now know and we are currently booking
4 losses as a consequence of that decision. I would
5 put in perspective that our historical operating
6 gains, prior to the full effect of ACA, have been
7 well below our own peer group's in terms of Blue
8 plans, who are nonprofit, Blue Cross and Blue Shield
9 plans, who tend to average about, over the same
10 period, about the last five to seven years about 3
11 percent in operating gain.
12 (Interruption.)
13 MR. BURRELL: Just to put perspective on
14 our performance, which has been at six-tenths of 1
15 percent over the last five years in terms of
16 operating gain, we have looked at what other similar
17 nonprofit Blue Cross/Blue Shield plans have had in
18 that same period and this averaged about 3 percent.
19 We have never averaged 3 percent. Nor do we expect
20 to produce an operating gain in 2014. We are
21 concerned about whether that would occur in '15 or
22 '16.
23 So having said that, we think it is
24 appropriate to look at, well, if you lose, is there
25 a reasonable chance of recovery? How would that

1 work? And one of the profound effects of the
2 Affordable Care Act is to -- it was referred to
3 earlier as MLR limits, medical loss ratio limits.
4 Normally what a business would do if it lost in some
5 products and had gains in others, it would try to
6 even that out over time. It would try to cover
7 losses in some by gains in others.
8 But under the Affordable Care Act, if our
9 medical loss ratio drops below 80 percent, in other
10 words, the portion of premium that's there for
11 claims, or 85 percent for individuals, we rebate
12 that difference back to the subscriber; in other
13 words, the company does not retain it, and
14 therefore, it does not contribute to surplus. This
15 is a profound change from the past. There is no
16 concept that you could have large operating profits
17 that you could retain if you violated the MLR
18 requirements. They must be returned in the form of
19 rebates to subscribers.
20 It is worth considering, also, a number
21 of other aspects that might not be so obvious. It
22 has been interesting to us that when you look at the
23 first open enrollment period that has now concluded,
24 that people in the District -- this is true also in
25 the other jurisdictions in which we operate --

1 overwhelmingly chose BlueChoice HMO plans. By that
2 I mean about 75 percent of them chose to be covered
3 under our BlueChoice HMO.
4 We think the reason for that is that the
5 product price is somewhat lower. Nearly 40 percent
6 of GHMSI's surplus comes from its co-ownership with
7 the Maryland company, 50/50 from BlueChoice. So
8 what happens with BlueChoice is a matter of great
9 interest and concern, I think, to the District, but
10 also to Maryland because of the 50/50 nature of the
11 Blue Cross -- of the BlueChoice ownership
12 arrangement.
13 We have had, with all of this said,
14 experience in one year, 2010, where it turned out
15 that medical trends were substantially lower than we
16 thought they would be, so that the premiums have
17 been priced at a certain assumption on how fast
18 medical costs were to rise. It turned out that they
19 rose lower. Nobody foresaw that, nobody predicted
20 that, but it happened. In that year, that is the
21 one year where our operating gain was greater than 1
22 percent.
23 Our own policy on our own surplus has
24 been adopted by our board. It is very, very
25 consistent with what Rector described, which is that

1 we had a range of surplus, we pick a midpoint in the
2 range, and if we went too high, we would cut rates.
3 Indeed, we did exactly that. We cut rates in the
4 District or moderated rates in the District in
5 direct response to the fact that we had had a
6 better-than-expected year. And that was reflected
7 in our filings and noted at the time to the DISB.
8 It also had a bearing on what the subsequent
9 operating results were, which, as I've said, have
10 turned negative as a consequence of that and other
11 factors.
12 So I think in the main, our perspective
13 is that the report you have received is essentially
14 a creditable piece of work, that it represents a
15 sound set of conclusions. We have filed, in our
16 prehearing material and briefs, issues we have with
17 various assumptions and pieces of the model. We'd
18 be happy to discuss them today. But in the main, we
19 think it reached essentially a sound conclusion.
20 And based on that, we think we are in a position,
21 since we are presently below it and only slightly
22 above that center point, but well within the range
23 of 2011, that there is nothing that could be said
24 regarding us having an excessive or unreasonably
25 large surplus.

1 When you look at our actions, we think of
2 it in these terms. If our rates have too great a
3 margin such that we were to drift high in the range
4 or even above the range, we would unilaterally act
5 to bring them down or to moderate rates specific
6 with return. And that is what we did.
7 In addition, we are among the most
8 generous givers in the District in a wide variety of
9 programs. Without going through point-counterpoint
10 on the testimony that was given earlier, we give in
11 the millions of dollars to the District in a variety
12 of programs, most of it to vulnerable populations
13 who, were it not for the giving, would not have
14 access to healthcare services that we think they
15 need.
16 One final point to keep in mind, and that
17 is that the test under the law is to look at the
18 portion of the surplus or potentially any excess
19 that is attributable to the District. I just want
20 to put in perspective some basic facts. There are
21 728,000 members of ours who are GHMSI members.
22 284,000 of them live in Maryland, 235,000 of them
23 live in Virginia, and only 210,000 of them live in
24 the District. Two-thirds of the revenue out of 3.3
25 billion in revenue that GHMSI brings in, 2.4 billion

1 of it are in these outer jurisdictions.
2 As I noted earlier, particularly in the
3 case of Maryland, multiple studies of our surplus
4 have been commissioned by the commissioner in
5 Maryland. We are presently under a consent order
6 from that commissioner that commands us to bring our
7 point of surplus up by about 200 points beyond where
8 Rector's point is at 958. That command is a shall,
9 the company shall take such actions as necessary to
10 get up to that point.
11 There is a provision in District law that
12 requires a coordination between the District and
13 Maryland. From the company's standpoint, we would
14 encourage that coordination to occur so that we are
15 not in a position of being under conflicting orders
16 from two different regulatory agencies on the same
17 company.
18 So bottom line here is if there were any
19 excess, which we don't believe there is, and we
20 believe there's ample evidence of us meeting the
21 tandem test that was established by the appellate
22 division, by the Court of Appeals, that we are
23 meeting the terms of the law as the law is presently
24 drafted. And that if an excess were ever to occur,
25 that it is the subscribers' money and that it would

1 go back to them, and that a plan would have to be
2 put together to show how that would happen, not to
3 have it be given away to the public as if the
4 public's need in general was superior to the need of
5 the subscribers who already struggle to pay very
6 high premiums reflecting a high cost.
7 So, Commissioner, that concludes my
8 remarks and we stand ready to answer any questions
9 you might have.
10 COMMISSIONER McPHERSON: Thank you. Will
11 there be anyone else on the panel --
12 MR. BURRELL: I think what we would
13 prefer to do is answer any questions you have and
14 not have any further statement today inasmuch that
15 we have submitted on the record and that we would
16 add to as a consequence of today, but no further
17 statement prepared.
18 COMMISSIONER McPHERSON: All right. If
19 you'd just give me a few seconds so I can consult my
20 pre-prepared questions and the ones that I have made
21 note of.
22 You talked some about your market share
23 and the distribution of your market in the region.
24 If you could just -- don't mind restating again your
25 market share by enrollees in the District and

1 Maryland and Virginia.
2 MR. BURRELL: Let me get that reference.
3 I want to quote it again correctly. I'm sorry.
4 COMMISSIONER McPHERSON: It's okay.
5 MR. BURRELL: Well, the share -- the
6 percent -- I gave you the numbers. The percent is
7 what I think you're after. Is that correct?
8 COMMISSIONER McPHERSON: Well, if you
9 don't have the percentage, I guess we could do our
10 own calculation if you have the numbers, if you
11 could just --
12 MR. BURRELL: It's actually between 70
13 and 80 percent, depending on whether you're talking
14 about. What I had said earlier was this: For
15 individuals, we think it's about 76 percent of all
16 individuals in the District who are under age 65 who
17 have coverage. Not the whole population. And about
18 72 percent for small groups, and about 80 percent of
19 the US Congress that enrolled through the exchange
20 this past January.
21 COMMISSIONER McPHERSON: So you mentioned
22 728,000 enrollees?
23 MR. BURRELL: Yes.
24 COMMISSIONER McPHERSON: And I just want
25 to make sure that I have my numbers correctly. So

1 are those total enrollees or are these individual
2 and the smaller groups market?
3 MR. BURRELL: Total members.
4 COMMISSIONER McPHERSON: Total, the
5 universe of members --
6 MR. BURRELL: For GHMSI.
7 COMMISSIONER McPHERSON: -- for GHMSI.
8 And again, if you don't mind repeating, and that
9 membership is divided. We have Maryland, DC,
10 Virginia. Do you have those numbers?
11 MR. BURRELL: Yes, I do.
12 COMMISSIONER McPHERSON: Please restate.
13 MR. BURRELL: 728,000 members in total.
14 284,000 who live in Maryland, 235,000 who live in
15 Virginia, and 210,000 who live in DC.
16 COMMISSIONER McPHERSON: Now, you also
17 mentioned your revenue of some X billion dollars and
18 I didn't quite get that correctly. You mentioned
19 2.4 billion?
20 MR. BURRELL: 2.4 billion.
21 COMMISSIONER McPHERSON: Is that your
22 total or is that the portion that's for Virginia and
23 Maryland?
24 MR. BURRELL: Virginia and Maryland. So
25 3.3 billion in total across all jurisdictions. 2.4

1 in Maryland and Virginia.
2 COMMISSIONER McPHERSON: Now, do you have
3 any data -- so you gave me information on the
4 enrollees. Do you have a breakout as to the situs
5 of the policies that you issued per jurisdiction?
6 MR. BURRELL: We do. There's always some
7 degree of inaccuracy in that.
8 MR. CHANEY: First of all, my name is
9 Mark --
10 COMMISSIONER McPHERSON: I'm sorry, Mark.
11 MR. CHANEY: My name is Mark Chaney. I'm
12 executive vice president and CFO of CareFirst and
13 its affiliates. And I've been in the CareFirst
14 family of companies for over 29 years. I can give,
15 for the record, the copies of the Schedule Ts, which
16 are included in our annual filing, which breaks down
17 the revenue by each of our jurisdictions. I have
18 that for all three of our companies. I'd be happy
19 to provide it.
20 I think one relevant piece of linking
21 this all back to the actuarial models, because GHMSI
22 and CareFirst of Maryland own equally CareFirst
23 BlueChoice, and it has become a very significant
24 piece of the three companies' overall business, that
25 it's my understanding when the actuaries did their

1 models, they always talked about not only GHMSI's
2 revenue stream, which drives very much the
3 calculation of RBC, but also half of BlueChoice's
4 revenue for GHMSI and its financial modeling.
5 So Chet's figure of 3.4 billion is
6 exactly what GHMSI is. When you add in half of
7 BlueChoice, you're in excess of $4 billion. And
8 again, we can provide that broken down by
9 jurisdiction for the record after our comments.
10 COMMISSIONER McPHERSON: Okay. Just a
11 few seconds. Phil, do you want to jump ahead while
12 I check my sheet here?
13 All right. I think, again, I just
14 wanted, for the benefit of everyone here who don't
15 regularly review insurance filings, Schedule Ts,
16 et cetera, I don't do that regularly in my day job,
17 so I rely on experts in my office, but I think it's
18 important for the layman -- as I look into the
19 audience, I'm not quite sure if there's a
20 noninsurance professional here, so -- anyway, for
21 the benefit of the record, I just wanted to kind of
22 establish some baselines as to the nature and size
23 of GHMSI, the share of your -- the market share of
24 your revenue, your enrollees, your policy. So we
25 kind of have that as the basis, you know, for me to

1 frame some additional questions. So that was the
2 nature of my inquiry.
3 In addition -- so I'm going to get back
4 on script here so my lawyers are not totally mad
5 with me for maybe inadvertently putting my foot in
6 my mouth, but I guess it's my prerogative, right?
7 So I am curious to hear from you, Mr. Burrell, as
8 to, in your view, what do you think are the
9 distinctions or the advantages or the disadvantages
10 between being a not-for-profit versus a for-profit?
11 And if you could just help me understand the nuances
12 so I could better appreciate as I take all of this
13 information into consideration.
14 MR. BURRELL: I think the main advantage
15 of being a nonprofit -- perhaps there are two.
16 First, we're mission driven, not bottom-line driven.
17 We seek to serve the broadest portion of the
18 population in the community we serve as we possibly
19 can. Largely seek only to break even with a small
20 margin that would keep us financially sound.
21 We have no shareholders to pay. We
22 retain earnings for the benefit of the members. Any
23 surplus that we accumulate over a long period of
24 time, typically, is to their benefit and any
25 earnings on it goes to their benefit, not to

1 shareholders or to any other third party.
2 So I guess the -- you can sum it by
3 saying we operate -- it enables us to operate with
4 incredibly small mergers, very close to cost, with
5 only a fraction of a percent above that on average
6 over a multi-year period. It enables us to focus on
7 the quality of the care they receive, the
8 accessibility of their care. We have the broadest
9 networks, provider networks typically, and it
10 enables us to take a long view of what would be in
11 the subscribers' interest.
12 And beyond that, it affords us the
13 ability to invest in the community, which we do
14 extensively, either through moderation of
15 premiums -- because we're not seeking to make a
16 profit beyond a tiny margin -- or by direct giving
17 to the community, typically for programs that
18 benefit vulnerable populations or particular types
19 of populations. One was mentioned earlier on
20 maternal and child health, for example, that we have
21 done a lot with to foster healthier babies and
22 mothers. I would say those are the advantages.
23 MR. CHANEY: And I think as well as the
24 advantages and disadvantages, there's many
25 misunderstandings about not-for-profit companies

1 such as GHMSI. Some people believe we don't pay
2 taxes. That is not the case. We pay premium taxes
3 and income taxes substantially equivalent to all our
4 for-profit national competitors.
5 Most of the profitability is now in the
6 HMO because so much have moved there over time.
7 That pays the same federal income tax rate
8 effectively as all of our national for-profit
9 vendors. Thirty-five percent of every dollar we
10 earn goes to the federal government. And our two
11 parent companies, they get some special tax
12 treatment that makes their taxes about a 20 percent
13 level instead of the 35. But we pay across all of
14 our jurisdictions 2 percent premium taxes generally
15 just like our for-profit competitors.
16 And one of the advantages -- or all the
17 advantages that Chet mentioned are very true and we
18 are focused on maximizing the achievement of our
19 mission instead of maximizing shareholder value.
20 And one of the things we have to be very focused on
21 is the efficiency, or that small piece of our
22 premium dollar that goes towards managing our
23 customers' business.
24 There's been some question about whether
25 the MLR measures that efficiency well or whether

1 there's other measurements. Every not-for-profit
2 Blue has the same concern. Can they justify to
3 their regulator, to their boards and to their
4 communities that they are doing everything that they
5 possibly can do to be as efficient as the for-profit
6 carriers that we are competing against. They are
7 ten times our size on average; however, we do
8 compete very, very much on the same level.
9 And I couldn't agree more with
10 Mr. Rector's statement when you start pulling
11 different peer plans, you can get all sorts of
12 different percentages. That depends upon the types
13 of books of business that each of those Blues has.
14 For ten years, the Blues have sought to better
15 understand administrative efficiency. They were one
16 of the first six plans to hire an independent
17 company to look into it. And now we have over half
18 the Blues participating and they do it on a
19 month-for-month basis by line of business, and we
20 are in the middle of the pack as far as efficiency
21 despite -- despite having invested substantially
22 more dollars in preparing for ACA and the
23 capabilities necessary, which is why we've been able
24 to help out our local exchanges to the degree that
25 we have.

1 So it all comes back financially to one
2 key bottom line assumption. You're going to
3 maximize by making your prices more affordable, your
4 mission to maximize shareholder value.
5 COMMISSIONER McPHERSON: Okay. Thank
6 you. So one of the, I think, prevailing themes that
7 I have read in your submissions from GHMSI is as it
8 relates to your nonprofit status and your inability
9 to access the capital market. So one of the
10 questions I have is: Should you need access to cool
11 and to the additional capital, what are the
12 resources that you would have available? What are
13 your options? How would you address that concern?
14 MR. BURRELL: I think Mark maybe
15 embellished on this, but I think we have no
16 traditional way of accessing capital in the way that
17 a for-profit company would, which is to issue stock
18 and raise money through a stock issuance. We don't
19 have debt and we don't -- we -- so we have one
20 source, which is the income we derive from our
21 policyholders. And that source, as I've said,
22 produces, over a period of years, a tiny margin.
23 I would point out this company in the
24 '90s was on the edge of bankruptcy. So we talk
25 about the degrees of uncertainty and confidence that

1 some catastrophic event would occur, but this
2 company actually experienced it and was on the verge
3 of bankruptcy.
4 In the 20-some-odd years since, we have
5 slowly, because we have this -- only this one
6 source, built that surplus back up to where it
7 presently is, and that the forces that are at play
8 today with ACA threaten that surplus and make the
9 future more difficult and more uncertain. And while
10 we support the basic objectives of ACA, we think the
11 impacts of ACA are creating an environment that is
12 probably the most uncertain the company has ever
13 been through. We have no other source essentially
14 other than through our policyholders' premiums.
15 MR. CHANEY: And people oftentimes say,
16 "Well, a company of your size and your longevity,
17 why can't you get some sort of bank financing?"
18 It's not so much as a cash flow issue that we would
19 ever have, it's a statutory surplus issue. Because
20 a statutory surplus is looked at by the regulators
21 in a certain way. If we went to a bank and borrowed
22 money, the only way it could be repaid if it were
23 going to be counted towards achieving the surplus
24 level that we may be short of is if it stood behind
25 the Commissioner's approval in each of our

1 jurisdictions. A bank, when it wants to be repaid,
2 doesn't want to have three different commissioners
3 potentially having to approve the repayment of their
4 loan.
5 So it is very much different, a cash need
6 versus a surplus need. And what has typically
7 happened by the nature of the Blues plans, there's
8 cash there, but they run into issue with their
9 risk-based capital and their surplus that are
10 difficult to meet by any other means than what Chet
11 just said, with underwriting performance and through
12 the very small investment income that we get on our
13 investment portfolio.
14 Mr. Rector mentioned a couple of times
15 we're always at risk for our stock portfolio going
16 awry of our particular market. We only have less
17 than 10 percent of our corporate investment
18 portfolios in that place. We are prescribed by
19 statute and rule that most of it has to be in fixed
20 income, bond securities, mainly US treasuries.
21 COMMISSIONER McPHERSON: So I've heard a
22 lot also about your tiny margin and I guess over
23 time, that tiny margin has accumulated into a
24 surplus which, I guess, is why we're probably here
25 today. So one of the questions that has popped into

1 my head is from a philosophical perspective, do you
2 think it's reasonable to establish a surplus beyond
3 which you as a nonprofit should not exceed?
4 MR. BURRELL: Yes. I've said that. We
5 believe that that is appropriate.
6 COMMISSIONER McPHERSON: It's appropriate
7 to have an upper limit or not have--
8 MR. BURRELL: It's to have a limit, a
9 range and a target. We believe it's appropriate to
10 do what Rector has recommended, that that concept or
11 if your question is philosophically, we believe it
12 is important and appropriate that there be a target
13 point and a range around that point for the very
14 reasons that Mr. Rector identified.
15 And we ourselves internal to the company
16 have had just such a policy since 2008. And so when
17 we found, particularly in one year, 2010, when our
18 gain was more than 1 percent, that one year in which
19 it happened, we found that our surplus went up above
20 the target point. And we ourselves filed rates with
21 the DISB in subsequent periods to bring them down.
22 And we so noted it at the time, and we did it for
23 that very reason. So we are strong supporters in
24 that concept.
25 And then I think as I said at the outset,

1 the work that Rector has done as a firm we find
2 creditable. We have noted areas where we don't
3 agree with every assumption or every detail of the
4 model, but we would want to convey to you that we
5 think that the basic overall conclusion that they
6 came to is sound and that the range around the
7 target that they established is also sound.
8 But also point out that this same
9 exercise for this same purpose has been done in the
10 State of Maryland. We've been through an exactly
11 parallel process. The consequence of which --
12 through independent consultants to them. And the
13 consequence of that was a range that's 200 points
14 higher for GHMSI and a midpoint that's higher. And
15 we're now in the uncomfortable position of having
16 two regulators tell us two different things about
17 where that point would be. But the concept that
18 there should be a point and that there's volatility
19 around that point and there should be a range is a
20 concept that we completely support. And if it gets
21 too high, gets inefficient and should be returned in
22 the form of community health reinvestment. And if
23 it is, that the principal way that that could occur,
24 perhaps not the only, but the principal is through
25 rate moderation or rate reduction.

1 Everything that we have filed, everything
2 that we have done, not just our words, but our
3 action, supports that. We are presently at a point,
4 and you've invited comment about periods subsequent
5 to 2011, but in '13, 2013, our surplus is now at 932
6 for GHMSI, as I said earlier. We believe it will
7 head down and is in the process of heading down in
8 '14.
9 If that turns out to be true, then we
10 will be substantially below the bottom of the range
11 that Rector has recommended to you by the time we
12 get finished with this year, and that has been
13 largely driven by the uncertainties that I outlined
14 related to the Affordable Care Act and the nature of
15 the people that are coming in for coverage that tend
16 to be more adverse risks. For society's sake, we
17 think that's a good goal, but for the company's
18 sake, it creates an environment that has more risk
19 and uncertainty embedded in it than I think we have
20 ever faced.
21 So we are looking at a loss in 2014, we
22 believe, because of the newness of the Affordable
23 Care Act and the Affordable Care Act itself
24 envisioned a three-year period, '14, '15 and '16, of
25 uncertainty and that is certainly coming about. So

1 we do not see in that period a strengthening of our
2 surplus. In fact, we believe that we will be below
3 the minimum in the range that has been identified by
4 Rector in its recommendation to you during that
5 period.
6 The only way to get it back up is to
7 create a margin in the rates to get it back up.
8 We've got no other way. And you have to be careful
9 with the margin because if you have too great a
10 margin, even a few percentage points, you might wind
11 up paying rebates back to subscribers, you can't
12 hold on to it inside the company. And that's new,
13 too, that is a requirement of the Affordable Care
14 Act. And that is the environment within which we
15 operate.
16 So to use my analogy, there is enormous
17 crosswinds on the bridge. And the surplus we hold
18 is well below what has been identified through a
19 very professional review. It is not excessive in
20 that sense.
21 COMMISSIONER McPHERSON: All right. So
22 you mentioned previous reports and that your surplus
23 has been studied and Maryland has issued its own
24 opinion. And we certainly have looked at this issue
25 before, but one of the questions that has arisen is

1 it appears that each time there is a review, that
2 your ranges are on an upward trajectory. So I am
3 curious as to your perspective on that. Because
4 it's well and good to say we believe in a range and
5 that you should operate to -- you know, within the
6 midpoint of that range. But if every analysis
7 results in an increase in range, then it begs the
8 question whether or not the range is self-serving.
9 So I'm curious as to your views as to your reports
10 to date as to that.
11 MR. BURRELL: I think it is absolutely
12 true that our range based on Milliman and Lewin work
13 advice to us, it went up from previous levels as ACA
14 impacts were being felt. That's principally the
15 reason it went up. It is not true that it has
16 continued to rise. And we have recently completed a
17 study of our present 2014 surplus position. That
18 range is not increasing. And so the range in terms
19 of the recommendations we have been given from
20 independent actuarial sources, principally Milliman,
21 do not keep raising the range.
22 What the range is intended to do is to
23 recognize the realistic combination of risks and
24 exposures we have. The principal reason it went up
25 from previous levels years ago was for ACA reasons.

1 It's exposed the company to the very risks that
2 we've described and the uncertainties and then more
3 or less stabilized at that. And the most recent
4 review that we have, which we have not yet filed,
5 but we will, shows a stability in that range and not
6 a continuing rise. It doesn't show a decrease, but
7 it certainly doesn't show an increase.
8 So we're not looking to increase ranges
9 simply by doing ever more recent reviews. We're
10 looking to get changes that actually reflect the
11 combination of risks that we take and the exposures
12 that we have. And I would say that in the nine
13 studies that have been done on our surplus, there
14 has been not complete unanimity of opinion, but a
15 strong overlap in their conclusions. Mostly, they
16 overlap with each other. It is not a stairstep up.
17 It is an overlapping thing and it's reacting to
18 changing circumstances as those become known and
19 changing exposures to different combinations of
20 risk.
21 I do believe we enter a period in '14
22 that we have entered, and '15 and '16 to continue
23 with the Affordable Care Act, that is the most
24 destabilized, uncertain period the company has ever
25 gone through because of what the law does. It opens

1 it up to anyone at any time in an open enrollment
2 period. It forces rebates where rebates never were
3 there before causing inability to recover when you
4 lose.
5 COMMISSIONER McPHERSON: Not to be
6 disrespectful, but isn't that true for all insurers
7 in the marketplace, so --
8 MR. BURRELL: It is true. And all
9 insurers will face this in varying degrees. Some
10 commercial insurers have chosen to get out of the
11 market because of this. And -- or to price high
12 because of this. And so in our case, we would never
13 do that, couldn't do that and wouldn't do that. We
14 are here to stay to serve this community. Our only
15 goal is to have rate adequacy and to understand the
16 nature of the risk that we take, and therefore, to
17 provide premiums at the most affordable level that
18 is possible consistent with our own financial
19 soundness. Because for individuals and small
20 groups, it is that protection that they buy, and
21 that is what they expect of us. It's the core of
22 our mission. And so that is our only goal. We're
23 here to stay and we only want adequacy and solvency
24 and soundness. Nothing more.
25 COMMISSIONER McPHERSON: Okay. Thank

1 you. So now again, I'll have Associate Commissioner
2 Barlow take over the questioning.
3 MR. BARLOW: In your recent report from
4 Milliman, I believe they recommended a range from
5 1050 to 1300 plus 100 to 150 basis points for the
6 impact of the ACA, yet when you set your -- when the
7 board set the range, I believe you set it at 1,000
8 to 1300. So could you explain -- I mean, if I have
9 that right, and if -- why you set it lower than what
10 was recommended by Milliman?
11 MR. BURRELL: I'll give you the essence
12 of the answer and Mark, perhaps, can add to it from
13 the standpoint of any technical aspect. The board,
14 first of all, is composed of, as you know, people in
15 the community who support the mission of the
16 company. They believe in what we are doing, to
17 provide affordable access to health care for the
18 community.
19 The board took the Milliman
20 recommendation under advisement. It considered it.
21 It did not feel that it was bound to take it
22 literally. That was not the idea. The idea was
23 it's -- we sought a consultative advice and we got
24 advice and then we had to pass it through the
25 judgment of the board and the management, which we

1 did. And when that recommendation went forward and
2 was considered and debated by the board, they
3 decided to take it down modestly for the benefit of
4 the community and for that specific reason, and to
5 keep things as moderate as possible. And there was
6 some risk in doing that. They were doing that eyes
7 wide open and that was their considered judgment.
8 And it was essentially for that reason, and it
9 didn't turn on one particular twist or another or
10 methodological feature. It turned on the judgment
11 of what they felt was the right range, was
12 consistent with our mission.
13 MR. CHANEY: And as you may recall from
14 the Milliman report, it said that potentially would
15 raise their rate by 100 to 150 points, but they
16 separated that distinctly from the base range that
17 considered everything that was known at that point.
18 As was just mentioned, we are getting ready to file
19 our report due to you by July 1st in which Milliman
20 went back and looked at all the impacts of ACA and
21 in their opinion, that 100 to 150 additional points
22 is not needed at this point. So they're
23 recommending essentially the same rate, which will
24 be very close to what we adopted. But because it
25 had that qualifier as was just said, the board did

1 not wish to go ahead and put that as a higher
2 target.
3 MR. BURRELL: With reason.
4 MR. BARLOW: Okay. Do you look at any
5 other financial reports that look at your financial
6 condition other than the statutory reports that you
7 give to us? Do you have some internal --
8 MR. BURRELL: I'll just comment generally
9 and Mark can add to this. We have a variety of
10 reports we look at. We also look at extensive data
11 that we have on other Blue plans because they are a
12 reference point. We also, as Mark mentioned
13 earlier, have commissioned studies of administrative
14 expense through an independent third party. There
15 are a variety of -- we also do GAAP statements. And
16 so we have a variety of ways of looking at the
17 business, which in fact we do do.
18 I would point out, and I would only do it
19 as a point of reference, that we do look at our
20 surplus against other nonprofit Blues. And our
21 surplus -- just as a point of reference, it is an
22 apples-to-oranges comparison to some extent, but we
23 are in the lower half of plans that hold surplus.
24 We are neither the highest nor the lowest and we are
25 not -- and we are slightly below the median.

1 And so I think it would be a point of
2 interest if we were really high or really low, but
3 we are not. And then there indeed are differences
4 among the plans that would account -- we do look at
5 that as a point of comparison, as well as
6 administrative expense, as well as operating results
7 on a whole -- and service statistics. So we always
8 look at ourselves as -- in the fullest possible
9 context that we can.
10 MR. CHANEY: And just to echo Chet's
11 comments, we do monthly GAAP statements. We
12 review -- they're available to our board monthly.
13 We go over statutory results quarterly. We look at
14 it by -- company-by-market segment every month.
15 Statutory accounting is very
16 conservative, as you know, and differs from GAAP
17 accounting. And the best example that I can give
18 you, in addition to the one that's always been
19 there, is that there's about a $500 million
20 difference in GAAP net worth and statutory reserves
21 because of noncommitted assets primarily.
22 But in the first quarter, as you would be
23 aware of, our statutory results were lower than they
24 have ever been because even the NAIC made a decision
25 that all carriers had to recognize the full annual

1 cost of the new health insurance tax that's being
2 charged to every carrier in the country that equates
3 to $8 billion this year, will go up to $14 billion
4 over the next three years. Our portion of that, as
5 just confirmed by the IRS, is $104 million. We have
6 estimated it would be 100. So our first quarter
7 statutory results show the flowing through of a full
8 year's worth of that health insurance tax. Our GAAP
9 quarterly numbers do not because that's amortized
10 for the whole year. So there are distinct
11 differences and our board sees both GAAP and
12 statutory. Looking at the company, I was a little
13 concerned, GAAP; looking at it from a regulator's
14 perspective, statutory.
15 MR. MARLOW: And do you do GAAP
16 statements because you're required to do them for
17 some purpose or do you just do them for your own
18 information?
19 MR. BURRELL: Both. We're not required,
20 but I would make the comment that relates to some of
21 the questioning earlier of the previous panel. The
22 larger employer group, the more sophisticated they
23 are -- and we are the biggest carrier among those
24 groups -- the more concerned they are about your
25 financial strength. And we get asked direct

1 questions. No large employer purchases health
2 coverage without the advice of an army of
3 consultants who swarm over our capabilities, our
4 solvency, our financial wherewithal.
5 And it would be a serious issue if our
6 surplus were to decline towards -- below 375. And
7 it's not just a question of going right down and
8 touching, you know, a 200 percent RBC, it is well
9 before you reach that point. If we were in a
10 position where we did not have, in the eyes of some
11 these large employers, adequate financial strength
12 and there are many alternatives in the market, and
13 if we were to begin to lose the enrollment among
14 those large employers, it would seriously weaken
15 this company and it would seriously undermine its
16 ability to serve the people who are most vulnerable,
17 the individuals and small groups, where we are the
18 dominant carrier and always have been.
19 And I just want to make that crystal
20 clear that these things are interrelated from a
21 business point of view. I just came back from a
22 Blue Cross/Blue Shield Association meeting last
23 week. There are 37 Blue Cross CEOs around the
24 country. I'm one of them. They cover a hundred
25 million Americans. And one of the principal topics

1 of discussion was what degree of risk is embodied in
2 the things that are coming as a result of ACA. And
3 the conclusion was what I have said to you today,
4 which is the largest set of risks and unknowns we
5 have ever faced. And one of the things that they
6 are concerned about, with good reason, and we are as
7 well, is rapid diminishment of surplus where in a
8 year you get an 80 to 100 percent drop in RBC.
9 Based on what we now know about '14,
10 which is not the subject of this hearing, we know
11 now '12 and we know '13 and we know how '14 is
12 emerging, we expect that our RBC in '14 will drop as
13 much as 80 to 100 points. And if that were the
14 case, after it took 20 years to build the RBC up, it
15 does not take long to take it down. Nor will it be
16 easy to turn it. And the MLR limits, it says you
17 can't make more than a certain amount, very small,
18 will delay the day when you can recover, if you
19 actually do start to go into a dive.
20 And I would underscore how threatening
21 that actually is to a nonprofit that wants to hold
22 its arms open to anybody that wants coverage and be
23 seen as safe harbor for them, which we take very
24 seriously as our mission. And, in fact, they see us
25 that way based on our market share. We didn't twist

1 their arm to become covered by us; they chose us. I
2 might add, the company lied, I don't know what it is
3 off the top of my head, but we take in something on
4 the order of 34 billion a year in claims billings.
5 We don't pay that out because of our contractual
6 discounts and so on, but that's the value we add to
7 the subscribers. But can you imagine if you miss
8 that by 1 percent because you made certain
9 assumptions that were wrong in crosswinds that
10 nobody on earth could predict with complete
11 accuracy? That is the situation we find ourselves
12 in.
13 Thank God we don't have shareholders to
14 pay and thank God we don't have to produce a big
15 profit margin. We're trying to thread a stable
16 course through uncertain times and we are trying to
17 keep as a main focus of our activity accessibility
18 to health care. We did not narrow networks. We did
19 not curtail benefits in some way. We have tried to
20 keep good coverage for the people that we serve and
21 for the -- in general, for this community. That's
22 always been sort of a guiding principle.
23 MR. CHANEY: If I could just clarify my
24 comment. Not only do we make monthly GAAP
25 statements available to the board, we get separate

1 audited GAAP statements from our independent
2 auditor. And one thing that we'll supply to the
3 written record, Commissioner, you are right, every
4 carrier is subject to risk adjusters and MLR
5 rebates. We are very unique because our total
6 revenue has to be cut into so many smaller buckets
7 because we have three companies serving three
8 jurisdictions, and not all of Virginia. If you
9 compare us to other companies, we are taking on far
10 more risk by having an MLR as the upper end in an
11 asymmetric calculation that you can lose as much as
12 you can possibly lose, but you are very much limited
13 by each of these 18 separate calculations that are
14 made for GHMSI and BlueChoice, and even further
15 calculations for the Maryland company. That, plus
16 the risk adjusters, which I will not go into the
17 details. It was said by Chet never been tested in
18 the commercial population. The correlation between
19 costs and claims which are driving this and the fact
20 that we had a two-year delay between the first time
21 Mr. Barlow sees a rate filing from me that I
22 actually know my risk adjuster makes this one of the
23 riskiest parts of the Affordable Care Act, because
24 unlike reinsurance and risk corridors, this does not
25 go away, rebates and risk adjusters.

1 MR. BARLOW: You know, you've talked a
2 lot and I think generally, there's been a lot of
3 talk about the new MLR ranges that were established
4 by the ACA and how limiting they are. Can you -- I
5 mean, did you change your loss ratio targets as a
6 result of the ACA or -- I mean, are you doing
7 anything --
8 MR. BURRELL: I'll answer in general and
9 then Mark can be specific. Our current -- the loss
10 ratio overall for business as a whole is in the 83
11 to 84 percent range, well above the 80 percent
12 minimum. Over time, we're headed towards an 85 to
13 86 percent level we think, but that, in turn,
14 depends on underwriting results and a whole string
15 of other things.
16 We don't want to be constantly scurrying
17 along the edge. We're not looking to get near an 80
18 percent loss ratio or 78 and have to pay rebates.
19 And so our medical loss ratio generally,
20 if you want to put it in the context of other Blues,
21 compares quite favorably to what most others do. We
22 haven't changed it. We are working to keep medical
23 loss ratio as high as it possibly can be consistent
24 with remaining sound. That is the goal of the
25 company.

1 MR. CHANEY: We paid rebates in 2011. It
2 was quite a disruption to not only the company, but
3 more importantly, to our customers and implementing
4 something that was brand new. And the rules came
5 out very, very late. We will not pay for GHMSI or
6 CareFirst BlueChoice; we did not pay rebates in
7 2012; we will not pay them in 2013. Part of that is
8 a federal calculation. It's a rolling three-year
9 average. But it will be very, very difficult, no
10 matter what we've said, as a target loss ratio to
11 keep that from happening in the future because of
12 these risk adjusters. And that is going to be the
13 wild card in this. And it's just -- it is a huge
14 uncertainty, and with huge uncertainty comes risk,
15 but this is even more than that. It's an asymmetric
16 risk. We don't have any upside. Most of our rebate
17 sales are less than 1 percent and under and we know
18 that we're going to have some issues with having to
19 pay rebates no matter how good of a job we do
20 actuarially in projecting our costs.
21 MR. BURRELL: This is interesting, just
22 as a point of interest, but in 2010, when we
23 actually made a little bit more than we thought we
24 would because medical terms were lower, had that
25 been -- had MLR constraints been in place at that

1 time, we would have paid rebates. And we wouldn't
2 have been able to retain any of those at bottom
3 line.
4 MR. BARLOW: Okay. On -- just a little
5 bit more on financial things. Your reserves on
6 your -- are probably the most significant item on
7 the liability side of your balance sheet, I believe.
8 So I just want to get an understanding and -- you
9 know, there's judgment involved in setting reserves,
10 too. So could you tell us a little bit about how
11 you -- you know, your process, your philosophy of
12 setting your reserves?
13 MR. CHANEY: Yes. We have an actuarial
14 person on our staff who has all the highest level
15 certifications for actuaries. Specifically, she is
16 a valuation actuary, not our chief actuary. It's a
17 separate individual. She sets what she believes is
18 her best 50/50 estimate and as is done by, I
19 believe, probably every other carrier and it's part
20 of actuarial -- not standards, but general direction
21 provided to actuaries, because we want to be
22 conservative in our treatment of an unknown such as
23 reserves, which on our balance sheet is over $200
24 million, put an additional 10 percent, it's called
25 provision for adverse deviation, and we try to

1 maintain that every year.
2 So it's not impacting our annual earnings
3 because we reset it every year. On the balance
4 sheet, does it give you an extra $20 million
5 potentially should those claims go higher than what
6 your best estimates are? Yes. But as was made
7 clear by Mr. Rector, those moneys are only there to
8 pay claims. They can't really be used for anything
9 else.
10 And that is reviewed, the whole actuarial
11 memorandum is provided to our audit committee and it
12 is reviewed by the valuation actuary with the
13 auditor.
14 MR. BARLOW: Okay. In your prehearing
15 report, you -- it's tab 7 of your prehearing report,
16 whichever one that is -- you indicate that your
17 experts recommended confidence levels between 95 to
18 98 percent for the 200 percent RBC threshold. Could
19 you explain why, if your experts said 95 to 98, why
20 you think 98 is the proper number?
21 MR. BURRELL: That is not directed to me.
22 MR. CHANEY: Well, I can give, from my
23 preface as the CFO, and I will ask Ms. Doran to
24 speak to the basis for that are. Again, this goes
25 back to the basic fiduciary responsibility that

1 officers of the company have to the board and that
2 the board has to the community that we want to be as
3 conservative as we possibly can. So we took the
4 upper end of the confidence level range. And as was
5 said earlier by Mr. Rector and others, that's a
6 judgment. And that was the judgment of management
7 and that was the judgment of our board.
8 MS. DORAN: My name is Phyllis Doran.
9 I'm a consulting actuary with Milliman. I am a
10 fellow of the Society of Actuaries and I'm a member
11 of the American Academy of Actuaries. I have worked
12 as a consulting actuary with Milliman providing
13 consulting services to health insurance plans for
14 over 30 years.
15 In our 2011 surplus study and development
16 of surplus target range for GHMSI, we did recommend
17 a surplus target range based on a 98 percent
18 confidence level for a 200 percent of RBC-ACL
19 threshold. So I can't speak to the 95 percent.
20 That was not our recommendation. But our
21 recommendation was 98 percent, which we believe is
22 appropriate. We believe it's actuarially sound. It
23 is -- as Mr. Rector discussed earlier today, it is
24 consistent with a 1 in 50 probability, or twice out
25 of 200 years probability, of falling below the 200

1 percent threshold. And we do not feel that anything
2 greater than that is reasonable.
3 One of the things we mentioned in our
4 report is that the Standard & Poor's rating service
5 published a risk-based capital adequacy model
6 methodology, and they state that for their purposes,
7 they would be looking for a 99.9 percent confidence
8 level for a AAA rating; a 99.7 percent confidence
9 level for a AA rating; and a 99.4 percent confidence
10 level for an A rating. We think that 98 percent is
11 the lowest that we would want to go with respect to
12 the standard for the 200 percent RBC-ACL level.
13 MR. BARLOW: Do you know, in those
14 confidence levels that you've cited for Standard &
15 Poor's, what time period they're looking at? Is
16 it --
17 MS. DORAN: They're looking at a one-year
18 period.
19 MR. BARLOW: What would the consequences
20 be if GHMSI fell below 200 percent RBC?
21 MR. BURRELL: Catastrophic. Before that
22 were to happen, we would lose a lot of large
23 customers. It would have a profound effect on all
24 the ratios that are so critical to the viability of
25 the business. We would be put on a watch list by

1 the association and have teams in looking at our
2 viability and our plans to recover, of course, which
3 would be very difficult because of the MLR
4 constraints, and we would generally suffer
5 substantial market damage as well as financial
6 damage.
7 If we were to get that low, in all
8 likelihood as a consequence of loss of enrollment,
9 look at layoffs and other consequences to staff to
10 try to control administrative expense on a relative
11 basis, and there are ripple effects to all of these
12 things in the operation of the business. It would
13 be catastrophic.
14 And the reason I think our answer would
15 be 98 confidence on 200 is that's the last thing you
16 ever want to get yourself into.
17 MR. BARLOW: Okay. And just to complete
18 this, what's -- what are the consequences falling
19 below 375?
20 MR. BURRELL: Again, there would be a
21 market reaction to that, and -- particularly on the
22 large group side. When -- and understand that
23 groups come up for renewal every year. This doesn't
24 go away for us. We're constantly being looked at
25 for financial strength and wherewithal in terms of

1 being able to serve medium and large groups. It
2 would trigger review by the association, and to the
3 extent that action needed to be taken, they would be
4 very much into our business and looking for
5 creditable plans to bring it back up.
6 If the only way you can bring it back up,
7 you can't issue stock, you can't go into debt, you
8 have no access to capital elsewhere, the only way to
9 bring it back up is to increase margins, and we
10 don't think we could increase margins given the MLR
11 constraints, very much anyway. It would take a
12 long, long time to restore it.
13 And so what happens in the meantime is
14 all the consequences in the market would have to
15 play out. We don't know.
16 We are, for example, the single biggest
17 support to the federal employee program. We have
18 620,000 people who are federal employees that we
19 support in this region and we support the operations
20 center that runs it US wide for 5 million. If we
21 were to get weak in the eyes of the association that
22 we are part of who holds that contract, there is
23 nothing that prevents them from pulling out and
24 putting it with a stronger member. If that ever
25 happened, it would have a cascading consequence into

1 the rest of the business that would be catastrophic.
2 MR. BARLOW: Do you have -- are there any
3 specific RBC thresholds in any of your contracts
4 that you have with the FEHBP or with any of the
5 employers --
6 MR. BURRELL: Typically, they make
7 judgment through their advisors as to whether we are
8 sound and it's left with that. We have a variety of
9 other performance standards to complete, not
10 typically on RBC.
11 MR. BARLOW: Okay. Could you explain in
12 a little bit more detail, you mentioned that you
13 maybe instituted or participate in an expense study
14 with the Blue Cross/Blue Shield association. Can
15 you provide us some additional information about the
16 nature of that study and --
17 MR. CHANEY: Yes. As I mentioned
18 previously, when one looks at administrative expense
19 ratios as a percentage of premium, you can see a
20 wide variation in those. What everyone who is in
21 the industry believes is even a better indicator or
22 combined with the ratio is a per-member-per-month
23 G&A factor, general and administrative costs that
24 you are spending on each of the members you are
25 servicing. Because then, you know, if it's still

1 linked to a revenue flow, it can vary widely.
2 Some of these Blue plans have Medicare
3 Advantage programs where the premium is four times
4 the commercial premium. The FBP program has a very
5 low percentage of overhead because a lot of the
6 functions are done by the association. And that's
7 known by the other Blues' CFOs. We've struggled for
8 decades over trying to share information back and
9 forth and talk on an apples-to-apples basis.
10 A company started by setting up -- it's
11 called the Sherlock Company. Its results are very
12 confidential, but it has expanded to look at other
13 carriers, and other parts of the insurance market.
14 But what it does for those plans who volunteer to be
15 part of it, which is about half of the -- slightly
16 more than half of the 38 licensees, is it requires
17 each of us to submit data on very specific
18 instructions, so we're all defining terms the same.
19 And it comes back to us by function, some 30-some
20 different functional areas within the administrative
21 costs, what is our commitment per month? By
22 different lines of business, fully insured,
23 self-insured, Medicare Advantage, which we don't
24 have.
25 And it allows us to compare not only in

1 totality how we might be fairing, but it also lets
2 us look at, gee, how much are we spending in medical
3 management? And it's become very helpful in
4 reaching out to other Blues when that information is
5 shared as to who is who, which is done on a one-off
6 basis, to work with another Blue to maybe learn from
7 them. And we've had some come to us.
8 I would just add to that in that over
9 time what has become clear, though, is you're
10 talking about Blue plans around the country for
11 almost -- not almost every -- every Blue, more than
12 half of their administrative costs are the people
13 they employ in their local communities and the
14 leased rental space where their employees -- their
15 office space where they reside.
16 And I think it's fair to say here in the
17 District, we are above average in not only what we
18 have to pay people our people, we have qualified
19 people, but what we have to pay to have rental
20 space. We don't own buildings. So by being at the
21 average and knowing we're being compared against
22 Montana, Illinois, Indiana, as well as New York, we
23 feel very confident that we are operating at or
24 below the average not-for-profit Blue.
25 And the other comment I would make is it

1 all depends upon how much a Blue has invested
2 recently to prepare for the Affordable Care Act and
3 to make sure its capabilities are equal to the
4 for-profit care groups. And since Chet became our
5 CEO, we have invested significantly to do just that,
6 and I think we're viewed at one of the leaders in
7 both of those.
8 MR. BURRELL: One other point that I
9 think bears on this, many Blues operate in a single
10 state. We operate in three different jurisdictions.
11 Three different -- three different implementations
12 of exchanges, just to cite one example, which
13 compounds costs. It's not just one rate.
14 MR. BARLOW: Do you have any other -- I
15 mean, have you done any other comparisons to local
16 companies or any other kind of expense?
17 MR. CHANEY: We can look at publicly
18 tradeds and actually, our percentages look quite
19 good against them, but publicly traded, United, that
20 type -- Cigna, Humana, they have so many different
21 lines of business that we share that with their
22 board because they want to see it, but I think we
23 would have a much tougher time representing that's a
24 true apples-to-apples comparison because we are a
25 sole line of business, health insurance. They own

1 PBMs, they own all sorts of different companies.
2 But we look at the average percentages
3 and then we use this study to make sure that we are
4 performing at the level that we are pretty certain
5 we are already performing, and that is very
6 efficient.
7 MR. BARLOW: In your -- as we talked
8 about earlier, in a recent report by Milliman, they
9 said 100 to 150 basis point for the Affordable Care
10 Act. It sounds like now that -- there may not be
11 100, 150 additional basis points needed for the
12 Affordable Care Act. Can you talk a little bit
13 about the impact of the Affordable Care Act on your
14 need for surplus and whether it's, you know, a
15 long-term need or a short-term need. I mean,
16 what's --
17 MR. BURRELL: I'll give a general and
18 again, we'll do the same with Mark on a further
19 response. But as I said earlier, what the
20 Affordable Care Act does is change all the benefit
21 plan designs, all the manner of rating, introduces
22 guarantee issue, it changes the way billing occurs.
23 It changes almost every aspect of the business. And
24 the Act itself assumed considerable turmoil during
25 2014, '15 and '16. We certainly agree with that.

1 It creates a degree of uncertainty that we've never
2 experienced before. I think -- and I think Mark
3 thinks -- it will go well beyond that.
4 Just one example of this that I
5 personally lived and we did is on risk corridors.
6 Risk corridor concept is simple to understand, not
7 so simple to do. But the simple concept as a
8 cushion was to say that if you lost more than 3
9 percent, 50 percent of that loss up to 8 percent
10 would be picked up, in fact, guaranteed by the
11 federal government. And beyond that, 80 percent
12 would be picked up.
13 Well, if you knew you had that cushion,
14 it might influence the way you price. It, in fact,
15 influenced us. We counted on that cushion. And
16 then we were told in March, no, it's not there.
17 There will be no federal money. Well, then what do
18 you do? You don't have it. We already priced it.
19 Is that going to come back? Well, now it came back
20 because of the politics of the problem. And so I'm
21 only using that as an example.
22 As we go along, we're expecting
23 unintended effects from the rules that are clearly
24 existing, some changes in the rules that are being
25 made as they're being made. It creates an

1 environment in which it's very difficult to predict
2 with accuracy what exposures you actually have.
3 Will that settle down over a three-year
4 period? Probably. Probably longer. Is it possible
5 for us to be 1 percent wrong? Of course. Is it
6 possible to be 5? Yes. If it were, it's not likely
7 to be on the high side. It's much more likely to be
8 on the low side. And then how do you get it back?
9 You don't because of the MLR constraints, and that's
10 the environment we're in. So that's the way we see
11 the impacts and then some.
12 What effects does it have on people's
13 behavior? The Affordable Care Act specifies
14 benefits now. What's a Bronze Plan? What's a
15 Silver Plan? What's a Gold Plan? Those are
16 brand-new product designs that have no history in
17 the marketplace. What is the way that people react
18 to them? Who buys them? Then how do they access
19 care? What does that cost? How do you know? How
20 sick are they when they come in? We know that
21 they're 20 percent older. We know that they're
22 substantially less financially able. We also know
23 that as income goes down, need goes up.
24 All these things are playing out at once.
25 And we're threading through that and saying we

1 can -- nobody on earth could see through that
2 completely clearly. So we're trying to take as
3 measured a course as we possibly can and hold only
4 that surplus which we think is sound.
5 MR. CHANEY: And I would just -- you
6 know, some people think that the Affordable Care Act
7 is going to be a windfall for insurance carriers.
8 Here's what it does. It makes a guarantee issue,
9 which is going to increase premium, especially in
10 the individual market. Changes all the underwriting
11 rules. Some people think that DC small group was a
12 guaranteed issue. It is. It's not community
13 graded.
14 Every unhealthy small group, whether they
15 came to us or another carrier, was medically
16 screened and their rates can be raised multiples of
17 what the healthy groups were getting. Not the right
18 thing to do. That's -- those were the rules that --
19 and markets differ. In Maryland, it was community
20 rated and a guaranteed issue. So premiums are going
21 to go up in the individual market.
22 Premiums are going to go up in the small
23 group market. It will affect all the market
24 segments. The larger fully insureds -- these larger
25 employer groups, those have above 50 employees will

1 fall under the same rules that those employers that
2 have below 50 employees in 2016. What that will do
3 is it will drive more and more of those middle-sized
4 employer groups -- we consider them to be small
5 groups; and some people consider them to be
6 middle-sized. We have 99 employees, we'll go to
7 self-funding. The healthier ones will go to
8 self-funded arrangements.
9 Oh, and by the way, when all the fees and
10 taxes were added in ACA in 2014, all of our rates
11 had to go up 3 to 5 percent. If you decide to be
12 self-funded, they don't pay those fees in taxes.
13 And when you get to the larger groups that are
14 self-funded, what's going to happen there is they're
15 using this as an opportunity to go to something
16 called "private exchanges." Basically, that is to
17 go -- national employers are going to national
18 carriers and they're giving their people -- their
19 employees a fixed amount of money and saying, "We're
20 going to do this like we do our benefit" -- "our
21 pension plan. It's now defined contribution. You
22 can buy from any one of these ten carriers." And
23 what that does is it makes it easier for them to
24 manage their long-term healthcare costs.
25 Because the one thing that was not

1 addressed in ACA except by one new rule was 80-plus
2 percent of our premium is made up of payments to
3 healthcare providers. Nothing in that law changed
4 anything with healthcare providers' fees and
5 payments except they implemented something called
6 the "accountable care organizations," which is a
7 means by which hospitals and providers can come
8 together and get a different type of arrangement
9 with Medicare.
10 And what's happening right now is the
11 large medical systems are buying out the providers
12 in our community. And if you think we have to pay
13 those large medical systems the same amount that we
14 pay a physician in the community, it's not even
15 close. And so the one thing that was in the law
16 that would control healthcare costs, the 80 percent
17 of the costs related to the healthcare provider
18 payments actually changes the leverage point between
19 us and the providers. We're losing leverage daily.
20 MR. BURRELL: We're seeing a congealing
21 of the large systems bringing in community
22 hospitals, bringing in their medical staffs. The
23 average increase that that typically relates to in
24 terms of inpatient admission costs or outpatient or
25 fees is 50 to 100 percent higher. That is happening

1 as we speak around the region and around the
2 country.
3 And it was one of the things that the
4 Affordable Care Act actually sponsored, integrated
5 healthcare delivery systems that are called
6 accountable care organizations. And that creates,
7 we think, a set of oligopolies that are inherently
8 higher costs and have more leverage against carriers
9 to demand concessions on fees and so on. That is
10 happening all over the country. So on top of
11 everything else that's uncertain in the Affordable
12 Care Act, that force is currently at play as well.
13 MR. BARLOW: Okay. Was there any
14 information that you've provided to DISB or to
15 Rector as part of the surplus review that you didn't
16 provide to Appleseed, and why?
17 MR. BURRELL: I don't know I can answer
18 that question.
19 MR. CHANEY: No. I know, and I'll let
20 Ms. Doran speak to what she can on behalf of
21 Milliman, but any information that was requested of
22 us that went beyond anything that had been given to
23 Milliman, I can't recall what that would have been.
24 So I think we've flowed everything that was coming
25 out of this study by Rector under your all's

1 guidance to Milliman, as best as I can recall.
2 MS. DORAN: We provided to Rector a very
3 detailed documentation of our surplus analysis and
4 also all of the details of our surplus model. We
5 developed that information for our client,
6 CareFirst, GHMSI, and when we were asked to provide
7 it to the DISB through Rector, we did that, also.
8 The information that I believe has been
9 passed on to Appleseed from Rector is not all of the
10 detailed spreadsheets from our model, but rather,
11 the -- a summary of all assumptions sufficient to
12 reproduce the results of the model. And in the
13 recent report issued by Mark Shaw, he indicated that
14 he was able to, for the most part, replicate our
15 model using a somewhat different approach, but we
16 provided all of the assumptions and general
17 description of the methodology such that it was
18 possible to reproduce our model.
19 MR. BARLOW: Okay. But could you just
20 address why there was information that was given to
21 Rector and not to Appleseed?
22 MS. DORAN: Well, some of it was the
23 detailed workings of our model which is, to some
24 extent, somewhat proprietary, but more importantly,
25 as -- as Mr. Rector mentioned this morning, it's the

1 assumptions that drive the results. And we felt
2 that by providing the assumptions, that was the
3 information that was critical.
4 MR. BARLOW: Okay.
5 COMMISSIONER McPHERSON: Okay. So least
6 anyone should think that we're not going to focus on
7 the tandem analysis, I'm going to try to take us to
8 the "community reinvestment to the maximum extent
9 feasible" line of questioning.
10 And so my first question to GHMSI is:
11 How do you determine what sort of community
12 investments to engage in? Who makes that decision
13 and how do you go about establishing your threshold,
14 your levels, et cetera?
15 MR. BURRELL: We do that in a very
16 systematic way. We organize our giving into a
17 variety of different categories, starting with what
18 we would identify as access to care for vulnerable
19 populations, and secondarily, going to people who
20 would benefit from particular programs that might be
21 sponsored in the community. We always give to
22 nonprofits in the community. And so there could be
23 a program that -- a typical example would be a
24 maternity program or some diabetes control program
25 or something of that nature.

1 We give for programs that we would call
2 catalytic; in other words, where the giving might
3 sponsor a new idea that would benefit the community,
4 an example of which would be how to extend
5 monitoring into community hospitals from an ICU that
6 was capable of doing it to benefit people in the
7 community that might not otherwise happen were it
8 not for the giving.
9 We establish a budget for giving in a
10 given year, and any giving of any material nature
11 that we undertake is reviewed by a committee of our
12 board project by project whose sole purpose is
13 mission-related giving.
14 And so the numbers that we have filed
15 with our report show what we have given to; over the
16 course of years, tens of millions of dollars to
17 various community-based organizations. That giving
18 is viewed in the light of, I think, pretty
19 accurately the way Mr. Rector described it, which is
20 we give in the context of a target for our surplus.
21 If we are above that target, one of the principal
22 things we do is we cut or moderate rates. We've
23 done that. We've done that in the District, as I
24 reported earlier.
25 If we're below that target or below the

1 range, it gets at issues of soundness, financial
2 soundness and efficiency. We have tended to give,
3 nevertheless. Our total giving in the community has
4 not abated. In fact, it's risen during the years in
5 which I have been CEO.
6 But we do give in an organized manner.
7 Typically, a set of -- we get requests for giving
8 from nonprofit agencies, all over the District and
9 all over the region, and we evaluate those on their
10 merits for how they might apply for rheumatic
11 enhancements, catalytic improvements or access to
12 care for vulnerable populations.
13 Let me give you an example of the latter.
14 We have given to safety net clinics who deal largely
15 with undocumenteds and we have supported them in
16 their efforts to become a stronger patient-centered
17 community clinic. And we have done that throughout
18 the region, some of which is in the District.
19 So our giving is targeted, evaluated and
20 always goes through, if anything, a material size
21 through a committee of our board whose sole purpose
22 is to oversee that. It's what we call our
23 "CareFirst commitment." So there's that type of
24 giving and then there is rate moderation or rate cut
25 of the type that I described if our surplus level

1 gets too high.
2 MR. PERELLA: I would expand on that
3 briefly. My name's Dominic Perella from Hogan
4 Lovells. I wanted to mention, following up on
5 Chet's comments, that Appleseed says in their
6 report -- their prehearing report repeatedly that
7 under Rector's analysis, in terms of the target that
8 Rector has in place, GHMSI will not be spending a
9 single dollar of community reinvestment according to
10 page 2 of their executive summary. They say that
11 elsewhere over and over again. That's simply not
12 accurate.
13 As Chet was just discussing, GHMSI has
14 always given millions of dollars a year to the
15 community, both in terms of direct grants,
16 supportive organizations and in terms of rate
17 moderation and rate cuts. That's happened each and
18 every year, you know, from the beginning of this
19 process to now and will continue happening in the
20 future. So, you know, what Appleseed is calling
21 community reinvestment is a distorted idea of what
22 that really means. They seem to limit it to forced
23 drawdowns of the surplus when, in fact, it's much
24 broader and GHMSI engages in this pretty
25 extensively.

1 COMMISSIONER McPHERSON: To the extent
2 that you could quantify your community reinvestment
3 as a ratio, so we have seen numbers and again, in my
4 view absolute numbers sometimes are not very useful
5 because they're just absolute numbers. And, you
6 know, I don't know the size of the pot that's
7 available. So are there targeted ratios that you
8 use when you're trying to define your -- since you
9 were given a schedule for any periods of time?
10 MR. BURRELL: There aren't fixed targeted
11 ratios of the type of giving that I just described.
12 COMMISSIONER McPHERSON: You say there
13 are?
14 MR. BURRELL: There are not.
15 COMMISSIONER McPHERSON: There are not.
16 Okay.
17 MR. BURRELL: We do set a budget each
18 year. That budget has typically been in the 50 to
19 $60 million range each year companywide. This is
20 for all of CareFirst. A piece of it -- I'll give
21 you the actual numbers we have given. $340 million
22 over the last seven years, 60 million of it in GHMSI
23 in the last three years alone. Forty-seven million
24 of that 60 million was in DC.
25 The amount of our giving approximates our

1 bottom line. We give essentially as much as our
2 bottom line, our operating gain. And that's in the
3 form of giving. But I would point out that we also
4 moderate or cut rates to our subscribers if our
5 surplus gets too high above a target point. And
6 that did happen and we did do that in 2010 going
7 into '11. We actually cut or moderated rates and
8 that returned tens of millions of dollars to our
9 subscribers. We are presently at 932 percent RBC.
10 We are below the target that Rector has recommended
11 and we are dropping. We are still giving. And
12 there's nothing that we have curtailed in our giving
13 as a result of where our RBC is right now.
14 COMMISSIONER McPHERSON: So I guess in my
15 simple mind, maybe you could divide your community
16 reinvestment broadly into two categories, tangible,
17 which are the grants that you provide to various
18 recipients and the intangibles, which is your rate
19 reductions or where you don't propose rates as high
20 as they could have been. Be that as it may, what's
21 your view as to your level of total community
22 giving? Do you believe that you are up to the
23 maximum level feasible for financial soundness or is
24 there any room at all?
25 MR. BURRELL: We believe we are, because

1 we are below the target levels that have been
2 identified in terms of RBC. If you were to take
3 literally what Mr. Rector said earlier, which is you
4 seek to attain that midpoint, it bounces around
5 within a range, anything above that is inefficient
6 or excessive, you would either reduce rates or give,
7 but below that you're not in an inefficient position
8 or excessive position.
9 We are actually below that point right
10 now. We, nevertheless, give substantially. We give
11 the equivalent of our whole bottom line on average.
12 Our whole operating gain. And embedded in our
13 financial plan is a targeted number typically, as I
14 said. Typically, 50 to 60 million for the company
15 as a whole. A portion of which --
16 COMMISSIONER McPHERSON: Can you expound
17 just so I understand better? You said you give to
18 the extent of your total bottom line?
19 MR. BURRELL: If our bottom line averages
20 in the 50 to 60 million range, that's equivalent to
21 the level of actual community giving we give each
22 year. This is company-wide. We can break it down
23 for GHMSI alone. And we will. If you'd like that
24 information.
25 COMMISSIONER McPHERSON: Yes, please. I

1 think that would be helpful.
2 MR. BURRELL: And then we moderate rates
3 on top of that if we were too high in the surplus
4 range. If you took Rector's range that they have
5 recommended where the point in the middle is 958, we
6 are below that number right now and we are
7 declining. We are still giving.
8 We think that the rates that we have
9 established for 2014 for the Affordable Care Act on
10 the exchanges may be too light. That's a subsidy in
11 effect to what -- meeting community health
12 reinvestment, the subscribers of this community. It
13 is not yet adequate to cover their costs. Now,
14 facts will come out as to whether that is true or to
15 what degree that is true as we get more experience.
16 But we can break down by category what we
17 give to and we can express it as a ratio, I just
18 don't have it right here. But I can certainly do
19 that. Absolute dollars and ratio and how much we
20 give in the form of rate relief and show that.
21 COMMISSIONER McPHERSON: Okay. In
22 Mr. Rector's presentation this morning, and I think
23 in some of your written submissions, and I believe
24 in submissions by Appleseed, there are some
25 categories which I do believe at first blush causes

1 a second look as to whether or not they're
2 appropriately categorized in your community giving.
3 And so Mr. Rector went into details and I believe on
4 my list here, there are two that comes readily
5 quickly to mind, yours corporate memberships and
6 your sponsorship of community events. And so again,
7 I'm just curious as to the basis why you believe
8 that that fits squarely within --
9 MR. BURRELL: It's part of our overall
10 giving to be a sound member of the community. But
11 that portion that's corporate memberships, that form
12 of giving is a tiny portion of the total, and we'll
13 break that out for you. In the scheme of things,
14 it's essentially immaterial. But we do that to be
15 part of the community and involved in the life of
16 the community, the business life of the community.
17 And so in a broader context, we think
18 that is consistent with the whole role the company
19 plays in the community, but it's a tiny piece. The
20 vast majority of the giving goes for programmatic
21 initiatives, catalytic developments, and access to
22 care for vulnerable populations.
23 COMMISSIONER McPHERSON: And I'm sure
24 Appleseed will provide some additional thoughts on
25 their view as to how you're viewed in the community

1 health reinvestment component of the tandem study.
2 If you just bear with me for a second so I make sure
3 I don't miss important questions that I have listed
4 here.
5 Could you talk some about the notion of
6 premium taxes being considered community
7 reinvestment? Can you help me that you understand?
8 MR. BURRELL: I would put that in one
9 context, and maybe Mark can expand on this. The
10 District does something that, for example, Maryland
11 does not acknowledgement. The District taxes us and
12 then the giving is on top of the tax. Maryland has
13 an in-lieu-of program. You can give in lieu of
14 paying the tax. The District doesn't do that. The
15 District taxes and then giving has to be on top. So
16 you pay the tax, which is considerable for us, and
17 then you give on top.
18 We're a nonprofit, but we pay tax as if
19 we were for-profit in effect. It is in that context
20 that I think that was put forward. If you took that
21 out, it is very possible to identify by program, by
22 grant recipient, what we give and who we give to and
23 it's in the tens of millions of dollars.
24 COMMISSIONER McPHERSON: So if I may be
25 the devil's advocate here. So you are a for-profit

1 and you pay taxes and you have a community
2 reinvestment requirement. Would that be a
3 reasonable assumption to say that my taxes or my
4 franchise taxes or whatever taxes I pay should be
5 categorized or included in the community
6 reinvestment component of your, I guess, P&L?
7 MR. BURRELL: We're identifying it as a
8 way in which we support the District community.
9 COMMISSIONER McPHERSON: But is the
10 nature of the law, again, at your indirect support?
11 Because one could argue that that's an indirect
12 support. And so is the essence of the law more
13 concerned with your ability to provide, again, what
14 I would describe in my early analysis as tangible
15 support to the community, that which the community
16 actually receives in the form of a payment?
17 MR. BURRELL: Yes. I think if you go to
18 the essence of what is intended, it would be giving
19 to programs in the community and it would be rate
20 moderation or rate cut for subscribers, as the two
21 principal categories. I totally believe that. We
22 do both.
23 MR. PERELLA: If I could expand on that
24 for a moment. I think it makes sense, Commissioner,
25 to consider what GHMSI's giving to the community

1 directly in terms of tangible support as you say.
2 But I think it's also important to reorient as far
3 as what the statute requires. And the statutory
4 definition of community health reinvestment includes
5 premium rate reductions. So rate moderation, rate
6 cuts are important, and I think a key part of
7 community health reinvestment.
8 If I could just finish the thought, you
9 know, I think the key question that the statute then
10 asked, if you look at it that way, is could GHMSI
11 lower its rates or moderate its rates any more than
12 it already has without falling below the surplus
13 level that is appropriate, that's necessary for
14 financial soundness and efficiency. That's the key
15 question.
16 And community reinvestment directly
17 through giving is important, but at the end of the
18 day, you consider that together with the rate
19 levels, and I think the rate levels are producing
20 the appropriate surplus as Rector has suggested.
21 COMMISSIONER McPHERSON: And keep in mind
22 that I'm trying to, you know, obtain information so
23 I can do an in-tandem analysis. And so this line of
24 questioning really goes towards the reasonableness
25 of the premium tax as a part of the community

1 reinvestment obligation. So that's what I'm trying
2 to ensure, that at least I have an appreciation for
3 what you're thinking when you include that as part
4 of your community reinvestment obligation.
5 MR. BURRELL: I understand. I do think
6 this point that was just raised is important to
7 underscore, that people pay premiums, as difficult
8 as it is for them to pay them, with the expectation
9 that the premium will be applied to the cost of
10 their care. If we give to somebody else and don't
11 use the premium income that way, will that, in the
12 end, increase the premium cost to the subscriber is
13 a very legitimate question to ask.
14 We're concerned that the giving, not
15 increase the premium cost to the subscribers. If
16 the cost of the giving drives our surplus down below
17 a sound level -- and these things are interconnected
18 -- then premiums would have to be increased to bring
19 it back to a sound level. We're trying to balance
20 that, and that is, I think, the tandem test. And
21 you can't give so much that you cause your premium
22 payers to have to pay a higher burden that they
23 cannot afford. And so we see the tandem working
24 that way.
25 We give substantial amounts and we're

1 able to keep ourselves generally within a range that
2 would be considered sound. At the present time, we
3 are below that range in terms of the range that
4 Rector recommended. And the only way to get back
5 into the range, as I've said repeatedly, is to
6 increase premiums with a margin to get restored.
7 There's no other way to get back at a time range.
8 COMMISSIONER McPHERSON: I do have a few
9 more questions, again, on the community impact. You
10 have an existing public-private partnership, I
11 believe. When does that expire?
12 MR. BURRELL: Fourteen.
13 COMMISSIONER McPHERSON: End of this
14 year?
15 MR. BURRELL: (Nodding head up and down.)
16 COMMISSIONER McPHERSON: Are there any
17 plans to have that renewed?
18 MR. BURRELL: Well, ACA is the renewal,
19 in effect. ACA, what that does is provide money to
20 the District supporting a variety of, in effect,
21 open enrollment programs. ACA is open enrollment.
22 And our subsidy of rates and our calculation of
23 rates is the principal way.
24 MR. BARLOW: And I think he was -- the
25 Commissioner was talking about the public-private

1 partnership that you signed.
2 MR. BURRELL: The 5 million.
3 MR. BARLOW: The $5 million, right?
4 COMMISSIONER McPHERSON: Which is not --
5 they're different than the open enrollment, I think.
6 MR. BURRELL: We're expecting discussions
7 with the District on that this year. Nothing has
8 yet emerged from the District itself.
9 COMMISSIONER McPHERSON: All right.
10 Before I wrap up with the panel here, you mentioned
11 the analogy of the bridge, and so I want to inquire.
12 In Appleseed's prehearing presentation, they made
13 mention to the fact as to the reasonableness -- and
14 I'll refer to accumulated surplus such that any and
15 all catastrophic events, no matter how remote and
16 unforeseeable, are covered.
17 So in your view, how do you respond to
18 that statement from Appleseed, which I believe was a
19 criticism of the 98 percent confidence level which
20 was used to run the numbers that were presented by
21 Rector? And, you know, I appreciate the bridge,
22 that no one wants to have a bridge built where
23 you're midway, you know, the stands will give way,
24 but is that a reasonable analogy in the light of
25 running a health insurer? I don't know, so I'm just

1 curious.
2 MR. BURRELL: Again, I would go back to
3 the observation that if we were to drop to a 200
4 percent RBC level, that is a catastrophic event from
5 which it is very difficult to recover on which
6 depends the coverage of tens of thousands of people
7 and their access to health care. It is something to
8 be avoided. So you would want a very high degree of
9 certainty that it wouldn't occur. Maybe you never
10 can get to 100 percent, but what the models have
11 indicated and what the judgments have been from the
12 actuaries that have advised you and us is that there
13 should be a confidence level of at least 98 percent
14 that that wouldn't occur given the catastrophic
15 nature of what would happen when it does occur. It
16 is not easy to recover from.
17 MR. PERELLA: I'd like to -- Chet, if
18 you're done, I'd just like to add a couple of
19 thoughts.
20 The first one is, Commissioner, I think
21 Ms. Doran mentioned earlier that 98 percent is the
22 number that Milliman had proposed and had found to
23 be reasonable, but I wanted to expand on that and
24 mention that that's also the confidence level that
25 the Maryland actuary, McGladrey, found to be

1 reasonable. It's the confidence level that the
2 State of Maryland itself endorsed via an endorsement
3 with the McGladrey report; it's the confidence level
4 that Rector endorsed; and it's the confidence level
5 that Appleseed itself and Appleseed's actuary,
6 Mr. Shaw, endorsed both in writing and in meetings
7 with Rector and others prior to the beginning of
8 this proceeding and in connection with this
9 proceeding.
10 And so I think there's a widespread
11 agreement that 98 percent confidence of not falling
12 to this catastrophic 200 percent level is
13 appropriate.
14 And as far as Appleseed's
15 recommendations, I wanted to note that if you look
16 at page 43 of Appleseed's report, if you take the 90
17 percent confidence level that they're proposing and
18 combine it with Mr. Shaw's assumptions, you arrive
19 at, by their own admission, a target RBC-ACL range
20 of 205 percent. That's 5 percent above the
21 catastrophic level that even the DC Council said
22 should be avoided. It's at page 5 of the committee
23 report.
24 And I just wanted to add one coda to that
25 kind of startling fact, which is that 205 percent

1 actually excludes an entire adjustment that was
2 proposed by Mr. Shaw. It excluded the adjustment
3 for administrative expenses. If you include that
4 adjustment as well and you take Appleseed's
5 confidence level, they're proposing a target RBC-ACL
6 for this company that we don't have a specific
7 number, but it appears to be in the range of 100
8 percent RBC-ACL, a level that would essentially
9 amount to having the company in receivership.
10 COMMISSIONER McPHERSON: Elsewhere in the
11 Appleseed report, they seem to suggest that the
12 industry standard by actuarial peers, and I don't
13 know if you know who those are, but there is a
14 strong suggestion, at least in the narrative on page
15 17 of the Appleseed report, that 90 to 95 percent
16 probably is or should be the confidence level that
17 should be used in these various calculations.
18 And GHMSI, I want to hear from you as to,
19 again, you've defended 98 percent, but I just want
20 to know what's your view on 90 v 95 or a confidence
21 level within that range as it relates to,
22 quote-unquote, "good industry practice."
23 MR. BURRELL: I'll just answer and
24 then ask those two to embellish. But I would say
25 the quick answer to that is that is irresponsibly

1 low. We know of no one that is that low. We know
2 of no Blue plan that has ever been given advice that
3 is that low. It is not consistent with industry
4 practice. It's not consistent with any of the
5 advice that Dominic just mentioned from any party.
6 And so we think it's an aberration. It's at odds
7 with what is the standard industry view.
8 MR. PERELLA: And I would actually ask
9 Ms. Doran to weigh in on this, because my
10 understanding of that one citation Appleseed offers
11 is that it's not any kind of an industry standard,
12 but was simply an outlier mentioned at meetings that
13 this organization had that goes to individual risk
14 factors and not to the confidence level as a whole.
15 MS. DORAN: I believe the specific
16 comment referred to some 90 percent and 95 percent
17 tests that had been done in connection with the
18 development of the original RBC formula that was
19 developed, I believe, in the late '90s. That
20 statement, which came from a report submitted by the
21 American Academy of Actuaries to the NAIC, and it
22 was not a statement that said that that was the
23 standard that is appropriate for determination of
24 surplus standards or for confidence levels
25 associated with determining the levels of surplus.

1 It was a statement about some testing of
2 factors that had been done. And I don't know what
3 detail exists about that. We have not been able to
4 find any. We've not been able to find any basis for
5 that other than what's in that report, and so we
6 have nothing to suggest that it has anything to do
7 with actually setting the standard of that -- I'll
8 refer to some factors.
9 I would add that I've never seen any
10 actuary recommend a range of lower than 90 percent.
11 The consultants in our firm that consult in all
12 areas of insurance, including casualty insurance,
13 life insurance and health insurance, typically have
14 standards of 99 percent confidence levels.
15 COMMISSIONER McPHERSON: Okay. And while
16 I have you, just procedurally, I did receive a
17 written report from Milliman for today's hearing.
18 And so, is it your intent that this be made a part
19 of the record?
20 MS. DORAN: Yes.
21 COMMISSIONER McPHERSON: The report?
22 Okay.
23 MS. DORAN: And I would add that we will
24 have a follow-up report, also, as is mentioned in
25 that.

1 COMMISSIONER McPHERSON: All righty. And
2 I think I have one last question and then I think
3 Mr. Barlow has a question and then it will be his
4 fault why you all will be late for lunch.
5 So how do you recommend we deal with the
6 coordination with Maryland given that they had
7 issued their report and they have a certain range
8 and we're still a little behind getting our analysis
9 of 2011 done and before you know it, it will be 2014
10 and -- you know. So, I mean, how efficiently and
11 how do you think, I guess, legally, from your
12 perspective, we should accomplish this mission or
13 this goal of the statute?
14 MR. BURRELL: I think as you complete
15 your review, I know that the commissioner in
16 Maryland would be eager to talk to you and I think
17 the best way is direct communication between you and
18 her and her team about things that you're observing
19 and about the way you evaluate the situation, and
20 she can do the same. And I think direct
21 communication is the best way.
22 MR. BARLOW: In your testimony, you
23 talked about a situation that occurred a couple of
24 years ago -- I don't remember exactly when it
25 occurred, but I remember it occurring -- that there

1 was a -- that the -- not to get too technical, but
2 the trend assumption, I believe, came in less than
3 anticipated and -- for many products and the
4 District of Columbia GHMSI actually filed rate
5 decreases -- not moderated increases, but filed
6 actual reduction in rates as a result of the trend
7 being lower.
8 Now, do you -- you seem to be saying that
9 all or part of that premium reduction should be
10 counted as a community health reinvestment? Could
11 you explain that?
12 MR. BURRELL: Yes, I'll start and Mark
13 can finish. When you set rates, you're setting
14 rates in advance typically and you're making
15 judgments about what you think the rise in medical
16 costs will be in the use of medical services. But
17 those are projections. You do the best you can.
18 In that particular year, as I said, no
19 one entirely foresaw it, but the actual trend in
20 medical expense dropped precipitously. We think it
21 had something to do with the fact that the economy
22 was going into recession, deep recession, and that
23 people were deferring care. But nobody can actually
24 pin down the cause and effect. But because what
25 that did is cause our premiums to have a bigger

1 margin in them than we otherwise thought they would.
2 And because that expressed itself as a rise in our
3 surplus, which happened, we felt that what we should
4 do is bring the rates down. And so that that rise
5 would be abated and reversed. And actually, it was.
6 And the filings were specifically for that purpose.
7 And so it did take that rise down. And
8 then what you want to do after that is stabilize the
9 rates at where they are adequate or sufficient to
10 cover, which is what we've tried to do since. But
11 it came down. What we think as we face an
12 environment going forward where the rates may not be
13 adequate because the risks are not known under ACA,
14 and there we were conservative. We went on rate
15 increases less than we thought might otherwise be
16 justified given the circumstances.
17 MR. CHANEY: And exactly what Chet said
18 and what -- the specific number that was triggered.
19 At the end of 2010, GHMSI's RBC got to be 1,098.
20 Our range at that time went up to 1,000. So we did
21 exactly what was testified to back in 2009, exactly
22 where our policy is set, exactly what we've been
23 saying since 2008. We used surplus dollars to bring
24 our premiums down.
25 Now, the filed exhibits, Mr. Barlow, have

1 all sorts of trends assumptions and contribution to
2 reserves and so forth. We tried to make those
3 filings as clear as possible product by product,
4 GHMSI and CareFirst BlueChoice. Where we're taking
5 between 5 and 10 percent for that product of its
6 total premium and taking it out of our surplus and
7 reducing the premium to our subscribers. It wasn't
8 done to buy market share; it wasn't done anything
9 other than to comply with our policy.
10 And we testified back in 2009, once you
11 do that, if trends started going back up, it's going
12 to be tough to recover. That's exactly what
13 happened. And GHMSI has lost over -- it's averaged
14 about 25 to $30 million underwriting loss since then
15 and mainly offsetted by BlueChoice. I think the
16 stark fact that since 2011, which was the first year
17 of MLR rebate, if you combine GHMSI's performance
18 under the statutory filings we've presented to the
19 DISB and half of BlueChoice's performance, total
20 revenue for those three years, 2011, '12 and '13, is
21 $12 billion. And how much we made on that was not
22 anything. We lost $30 million, which is a fraction
23 of 1 percentage point, but even when you add in
24 investment income, we made about 1 percent added to
25 our reserves.

1 And what has happened to our risk-based
2 capital is it has gone 1,098 to 932 percent. We've
3 lost 15 percent of our risk-based capital end of
4 those three years. That since the first step,
5 rebates of ACA, not yet even risk adjusters and
6 guaranteed issue and everything else. That is -- as
7 much as a catastrophic risk needs to be protected
8 against in one's risk-based capital, a continuing
9 inability to recover your cost in your rates is
10 every bit as concerning as filing rates --
11 COMMISSIONER McPHERSON: I guess I
12 misspoke earlier when I said Phil would have the
13 last question and probably will do so for the rest
14 of the hearing. So did I hear you correctly that
15 you indicate on your rate filings when surplus would
16 be used to supplement other -- what would have been
17 a request for an increase in rates?
18 MR. CHANEY: Yes. I didn't review all
19 the rate filings, but I looked through my actuaries
20 and I believe they identified -- we started --
21 earlier on it was in sort of an implied contribution
22 to reserves. I believe it has been identified in
23 the majority --
24 COMMISSIONER McPHERSON: I'll
25 double-check with the staff when I get back to the

1 office to make sure that that is indeed true.
2 Well, I want to thank the panel from
3 GHMSI, Mr. Burrell, and your team. As all here
4 present could really appreciate, it's very
5 important, again, for us at DISB, for me in
6 particular, to have this dialogue and have this
7 exchange.
8 As I mentioned earlier, we will
9 undoubtedly have additional questions that we will
10 submit to you in writing, and I'm sure -- and we
11 will make them publicly available and I'm sure there
12 will be some rebuttals, but, you know, I want to
13 thank you for coming down today. I wanted to thank
14 you for sharing your presentations with us for
15 helping me to better understand the issues.
16 As I mentioned, it's very complex. You
17 are the object of the hearing, and so to the best of
18 my ability, I will review and discuss and study and
19 contemplate in coming to my decision, but I just
20 wanted you to be reassured that it is a duty that I
21 take very seriously and I will undertake to the best
22 of my ability.
23 So with that speech, it's about 1:15 p.m.
24 in the afternoon and we will adjourn for 60 minutes.
25 We will be back at 2:15 and the Appleseed and

1 company will be the next panel. Thank you.
2 (Lunch recess taken.)
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1 AFTERNOON SESSION
2 COMMISSIONER McPHERSON: Okay. Welcome
3 back. It is now 2:15 p.m. on the same day that we
4 started. We are now back on the record for this
5 hearing into the surplus review of GHMSI and
6 currently, we have a panel from Rector &
7 Associates -- I'm sorry, I apologize. Appleseed.
8 That was this morning. We'll now hear a
9 presentation from Appleseed.
10 So if you gentlemen would just go ahead
11 and introduce yourselves. Oh, before you do that, I
12 guess I have to -- well, you know, I do this for a
13 living, so why should I make mistakes? Before you
14 go ahead, I'd just like to swear you in. If you
15 would raise your right hands.
16 Whereupon,
17 WALTER SMITH and MARK SHAW,
18 having been duly sworn by Acting Commissioner
19 McPherson, gave testimony as follows:
20 COMMISSIONER McPHERSON: Thank you. And
21 if you have copies of written document, if you could
22 ensure that those are made available. I'm not sure
23 if you have extra for the audience, but I know that
24 we here have received copies of your testimony.
25 Okay. So, yes, you may proceed.

1 MR. SMITH: Thank you very much. Good
2 afternoon. Thank you, Mr. Commissioner. My name's
3 Walter Smith. I'm the executive director of DC
4 Appleseed. With me is Mr. Mark Shaw, who, as you
5 know, has been working with us an actuarial expert
6 for several years on this project, actually since
7 2009.
8 I'd like to begin, Mr. Commissioner, by
9 first thanking you and your staff for allowing DC
10 Appleseed to participate in this proceeding the way
11 that you have. And also to thank you and to thank
12 Neil Rector and his colleagues for working with us
13 over quite a several-week period to try to gather
14 data that we thought were important for you to have
15 in the record to decide the matter. And we
16 appreciate all of that because it was a
17 time-consuming undertaking and we realize that.
18 I'd also, before I begin, like to, if
19 you'll let me, I want to acknowledge the folks who
20 have worked with DC Appleseed for quite some time.
21 This is a long-running project of ours as you know
22 and as the DC Court of Appeals laid out at some
23 length. And we're a fairly small organization, and
24 our ability to participate in this really relies on
25 pro bono support.

1 So I want to thank the folks from
2 Covington & Burling who are here, Marialuisa
3 Gallozzi and her team, Richard Herzog from Harkins
4 Cunningham who's been with us from the beginning,
5 and Debra Chollet from Mathematica. Without their
6 assistance, we could not have begun to try to
7 participate to do what we've tried to do here.
8 And I just want to say for the record
9 what it is we are trying to do. We are trying as
10 best we can to monitor the performance of this very
11 important company from the viewpoint of the public
12 interest. That's what we've tried to do from the
13 beginning. And our objective is ultimately that the
14 company remains financially sound, but at the same
15 time do the things that the statute requires them to
16 do in addition to that, and that is, have an
17 efficient surplus and to the maximum feasible extent
18 commit dollars to community reinvestment. That's
19 what we're trying to do.
20 What I'd like to do today, if you'll let
21 me, is rather than repeat the voluminous stuff that
22 you already have from us, is to try to present to
23 you our big picture view of what you're trying to
24 accomplish here. You're trying to determine what is
25 the maximum permissible surplus. And I want to

1 pinpoint for you how we differ from the other
2 actuarial studies what have been presented and
3 differ in a very fundamentally way. And -- but I'm
4 going to do that in a way that allows me to try to
5 be the lawyer here. I'm going to give you what I
6 believe is the legal standard that governs what
7 you're doing and what I'm going to say to you is
8 that the legal standard guides the use of actuarial
9 studies.
10 The actuarial studies, I believe, that
11 you rely on have to be in compliance with the legal
12 standards. Which means that different actuarial
13 experts might approach this case differently if all
14 they were asked to do was determine, for example,
15 the optimal surplus for the company. But in our
16 view, much more is required here than determining
17 the optimal surplus. It is to do what the statute
18 requires, to determine a surplus that maximizes
19 community reinvestment without undermining the other
20 elements of the statute that you're aware of. So
21 I'm going to talk about the law and then Mr. Shaw is
22 going to talk about actuarial stuff.
23 So there's been a lot of discussion in
24 the papers and today about the fact that there have
25 been nine actuarial studies done already, all of

1 which have found GHMSI's surplus permissible, and
2 that is true. And we have the greatest respect for
3 all of the actuarial experts that have done those
4 studies, from Neil Rector and his colleagues, the
5 folks from Milliman, McGladrey, Invotex, Lewin, but
6 our position is this: None of those studies met the
7 legal requirements of the statute as interpreted by
8 the Court of Appeals. So the fact that others have
9 upheld the surplus based on those actuarial studies,
10 in our view, is of no moment for the issue that is
11 now in front of you.
12 We came into this process understanding,
13 and it remains our understanding, that,
14 Mr. Commissioner, you intend to use the Milliman
15 model to assist you, the Milliman model as used by
16 Rector to assist you in determining the maximum
17 permissible surplus for the company. In our view of
18 Rector's analysis standing alone as given to you is
19 insufficient as a matter of law to meet the legal
20 requirements of the statute that you must apply.
21 And as you know from our June 10 filing,
22 that's our view with regard to the two key elements
23 that are used in the Milliman model. One is the
24 selection of the confidence level; the other is the
25 selection of the assumptions that go into the

1 stochastic model. And as we learned in response to
2 a question that Phil Barlow put this morning, we
3 know what the four biggest drivers are of the
4 recommended surplus that's in front of you. The
5 confidence level and three of the key factors used
6 in the model, the equity portfolio factor and the
7 rating inadequacy factor --
8 And what's the third one, Mark?
9 MR. SHAW: Premium growth.
10 MR. SMITH: The premium growth. And in
11 our view, the approach to selecting the confidence
12 level and in selecting the three -- those three key
13 assumptions -- governs the rest of them, but those
14 are the three that matter most for dollar. Neither
15 of those selections were done in accordance with the
16 statute as we understand it's been interpreted by
17 the DC Court of Appeals.
18 That, in a nutshell, is our view about
19 the case and that, in a nutshell, is where we think
20 the other actuarial studies, including Rector, have
21 gone wrong. And that, in a nutshell, is why we
22 think the numbers that we have offered to you and
23 the analysis that Mark Shaw has done for you need to
24 be carefully considered, because we think the
25 approach we have taken to confidence level and of

1 those three key assumptions meets the requirements
2 of the statute.
3 Now, let me tell you what I'm talking
4 about when I say that. Let me start with the
5 confidence level. In our view, under the
6 requirements of the DC Court of Appeals decision --
7 and I want to get these words right, so let me read
8 them -- you, Mr. Commissioner, are required to
9 calibrate the confidence level and to show how
10 surplus and community reinvestment are to be
11 calculated and balanced.
12 And in calibrating the confidence level,
13 according to the Court of Appeals, you have to take
14 into account the community reinvestment requirement.
15 And that is what Rector has not done, as we laid out
16 in our papers. And, of course, by definition, that
17 was not done by Milliman or any of the others
18 because none of them took the requirements of the
19 Act into account. And, of course, the consultants
20 in Maryland necessarily didn't take the Act into
21 account because they were acting under a different
22 statute that had only the unreasonably large
23 requirement. Did not have the efficiency
24 requirement; did not have the community reinvestment
25 requirement.

1 Now, we in our submission on June 10, in
2 light of the Court of Appeals decision and in light
3 of Judge Ruiz's observation that a one- or two-point
4 movement in the confidence level can make a big
5 difference in the amount of permissible surplus. In
6 fact, she said a small variance can implicate
7 millions of dollars.
8 And if you're going to calibrate your
9 confidence level in light of the community
10 reinvestment requirement, you need to know the
11 impact, we believe, of various different confidence
12 levels that you might select. So we bothered to do
13 a couple of exhibits on that and because you have
14 PowerPoint capability, we thought we'd put these two
15 charts up. These -- you don't have to look behind
16 you. They're in the document we filed on June 10,
17 pages 16 and 17.
18 And what we think these charts show, a
19 couple -- two or three things. One is they validate
20 Judge Ruiz's observation that there can be quite a
21 tradeoff between moving the confidence level a point
22 or two or three and the amount of money that then
23 becomes available for community reinvestment. So
24 that if instead of picking 98, you pick, for
25 example, 95, which is a number that was discussed

1 earlier today. If you look at the chart there at my
2 left, if you pick 95 percent instead of 98, you go
3 from having zero dollars available for community
4 reinvestment to having $148 million available for
5 community reinvestment.
6 Just move the confidence level by three
7 points down to a level that we believe is a level
8 that still maintains financial soundness of the
9 company and is a level that has been referred to by,
10 among others, some of GHMSI's own actuarial experts,
11 Mr. Barlow raised that earlier, that some of their
12 own experts had, in fact, advocated for a 95 percent
13 level. And as Rector pointed out in their paper,
14 although there was some discussion of this earlier,
15 that there have been some who suggested the use of a
16 90 to 95 percent confidence level for use in the RBC
17 health formula.
18 My point here, though, is that if you
19 calibrate the confidence level -- I keep using that
20 word because that's the word in the Court of Appeals
21 decision -- and you calibrate it in terms of
22 community reinvestment, which is what the court said
23 you had to do, you learn -- it's pretty startling
24 how much more money can become available for
25 community reinvestment if you move it down only a

1 few points. Now, obviously, if your view is that at
2 95 percent you have undermined financial soundness,
3 then, of course, you're not going to move it down.
4 We understand that.
5 But in our view -- and this is what we've
6 argued in our paper. In our view, you can move it
7 down to 95 percent and still feel very confident
8 that you're protecting the financial soundness of
9 the company and at the same time, you are serving
10 what the Court of Appeals said and what the counsel
11 said was the primary purpose of the statute. It was
12 to maximize community reinvestment.
13 So the remaining point I need to make --
14 have we got both charts up there? Ah, thank you
15 very much.
16 The remaining point that I need to make
17 about the calibrating of the confidence level in
18 accordance with the court's decision is if you look
19 at this chart, you see that the tradeoff between
20 dollars for community reinvestment and increase in
21 confidence level gets bigger for every point you
22 move up. The loss of dollars to community
23 reinvestment gets bigger, around 90. You see how it
24 trends up at a certain point. That to us suggests
25 that you ought to, at a minimum, consider the 90

1 percent confidence level, because in our view you
2 still have financial soundness at that level and
3 that is a level at which I believe you can best
4 maximize community reinvestment before you start to
5 lose lots of dollars as you move the confidence
6 level up.
7 Now, we don't tell you that this is the
8 only way you can do the calibration. This is our
9 recommendation about how you do it, how you take
10 community reinvestment into account when you select
11 the confidence level. Our point, though, is you're
12 required to take it into account when you choose the
13 confidence level and that neither Rector nor
14 Milliman did that.
15 Rather, as you heard today from
16 Mr. Burrell and from Neil Rector, what they did was
17 first determine the confidence level, determine the
18 target surplus level, and then see whether dollars
19 were available for community reinvestment once they
20 did that. In our view, that approach is not in
21 accordance with the court's decision. The court
22 said you have to do them, to use your word,
23 Mr. Commissioner, "in tandem." You have to look at
24 these two issues together. You have to choose the
25 confidence level in terms of financial soundness and

1 the impact on community reinvestment simultaneously.
2 And none of the other actuarial experts has done
3 that. And the payoff to community reinvestment once
4 you do that, from our viewpoint, is quite large.
5 Now, obviously, the lower you go, the
6 bigger the payoff. And we do not urge you to go
7 below a level that you think would undermine -- I
8 keep using that phrase because it's in the court's
9 decision. We don't want you to go to a level that
10 would undermine financial soundness, but we do want
11 you to lower the confidence level such that you
12 still think it's sufficiently high enough to protect
13 financial soundness and simultaneously maximize
14 community reinvestment. So that's the first big
15 area where, as a matter of law, we disagree with
16 what the other actuarial experts have done and what
17 GHMSI has done to date in calibrating permissible
18 surplus.
19 The second area has to do with the
20 efficiency legal requirement. And as you know, the
21 court was quite concerned that efficiency had not
22 been taken into account in the last proceeding along
23 with financial soundness. In fact, what the court
24 said in reversing the last commissioner's decision
25 was that there had been an -- she had had an

1 overriding concern about soundness without
2 considering the equal focus on efficiency. And we
3 in our filing have suggested to you how we think
4 efficiency should be taken into account.
5 And to date, in our view, none of the
6 actuarial studies has expressly tried to apply the
7 efficiency requirement of the statute, including
8 Rector. I heard Neil Rector say this morning that
9 they did consider efficiency, but if you look at the
10 report from December 2013 and if you look at exactly
11 what they did in deriving their assumptions for the
12 model, there really is no separate consideration of
13 efficiency apart from the statute's requirement to
14 consider financial soundness.
15 We think the right definition of
16 "efficiency" is the one the Pennsylvania case
17 adopted. And we say that, first of all, because we
18 think it's persuasive analysis and we think it's the
19 most important precedent that we have for
20 determining an efficient surplus for a Blue. But we
21 also think you ought to look to it because the
22 council referred to it before it adopted the statute
23 and because Commissioner Morrell, who is the first
24 to have written on this issue, referred to the
25 Pennsylvania decision in his own decision.

1 And under the Pennsylvania decision, an
2 efficient surplus for a Blue should be designed to
3 protect against all reasonably probable outcomes.
4 And it could include some that are different from
5 the historical record. But under the Pennsylvania
6 decision, a Blue surplus is not designed to protect
7 against the most remote catastrophic occurrences
8 that one can imagine.
9 And I know that Neil Rector said this
10 morning he regretted the use of his language when he
11 spoke of extreme, adverse, simultaneous events, but
12 I believe that is what the assumptions he put in the
13 model was designed to protect against, extreme,
14 adverse, simultaneous events. And we believe when
15 the council required efficiency to limit this
16 company's surplus, it used the word "efficiency" in
17 the way that the Pennsylvania commissioner used the
18 word "efficiency."
19 And if we're right about that, that
20 should guide your approach to the assumptions that
21 you put into the Milliman model. And that did not
22 guide the approach of Milliman or Rector or any of
23 the other actuarial studies that had computed
24 permissible surplus for GHMSI.
25 Mr. Shaw, on the other hand, did use that

1 approach in his work. And under that approach, you
2 look to the historical record of the company to help
3 you predict what the future is going to hold. You
4 don't tie yourself exclusively to that, but that is
5 the guide that you're supposed to use. And when you
6 depart from that guide and begin to try to use
7 surplus for implausible, not reasonably probable
8 outcomes, in our view, you depart from the
9 efficiency requirement that is in the statute. And
10 it makes a big, big difference as you -- as you
11 know, if you've had a chance to look at our filing,
12 which approach you use.
13 Just to cite one example, the premium
14 growth assumption. Even though Neil Rector said --
15 rightly so, we think -- in his paper that it is
16 important to take into account GHMSI's historical
17 premium growth experience in determining what
18 premium growth assumption to put into the model, we
19 think, in fact, that's not what Neil Rector did.
20 The average growth rate in the last five
21 years of the company is 2.8 percent. The highest
22 was 6.8 percent. Yet the assumption that's put into
23 the model is 12.5 percent, which is wholly -- in our
24 view -- wholly out of keeping with the principle
25 that Neil Rector said he was going to apply. Which

1 means that you are predicting outcomes that are
2 remote and depart from the historical experience of
3 the company. And when you do that, as Mr. Shaw
4 shows in his work, you drive the surplus up
5 dramatically.
6 Let's just take the premium growth
7 assumption. If you were to correct just for the
8 premium growth assumption alone, keep the 98 percent
9 confidence level, make no other changes in the other
10 assumptions that Mr. Shaw was critical of, it
11 reduces Rector's 958 RBC down to 752. And if you
12 use a 95 percent confidence level instead of 98 and
13 adjust the premium growth assumption, if reduces RBC
14 to 625.
15 What I'm trying to illustrate here is the
16 assumptions you pick move the surplus by hundreds of
17 millions of dollars. And we believe, as a matter of
18 law, that the right approach to picking these
19 assumptions is the approach that was described in
20 the Pennsylvania commissioner's decision.
21 And I want to also say that we were a
22 little surprised to read GHMSI's June 10 filing. It
23 looks as if -- to us -- they may actually believe
24 that the approach I'm suggesting to you here is the
25 right one. On page 15 of their filing, they defined

1 financial soundness as "the amount needed to protect
2 against reasonably foreseeable undue risk." We
3 think that's a good working principle to guide the
4 assumptions in the stochastic model. It also is
5 very close to being the same definition that the
6 Pennsylvania commissioner used. She said at page 35
7 of her decision that the surplus should be, quote,
8 "Such that any reasonably probable drain will not
9 reduce it below a safe operating level."
10 So our bottom line point here is that
11 efficiency limits your use of surplus. And if
12 you're going to give meaning, as I know you will try
13 to do, if you're going to give meaning -- separate
14 meaning to the efficiency requirement, which the
15 court said you must, it conditions how you go about
16 developing your assumptions for the model.
17 Now, Mr. Shaw is going to discuss with
18 you in just a minute how that guiding principle
19 affected his development of assumptions for the
20 other key elements in the model, the rating
21 inadequacy and the equity portfolio. And I keep
22 naming those three because those are the ones that
23 matter most. Although Mr. Shaw looked at the other
24 factors in the model and corrected for them, those
25 are the ones that matter most in determining a

1 permissible surplus under the statute.
2 And in our view, if you define
3 "efficiency" the way we are suggesting, it means
4 that you need to come at the whole question of
5 appropriate assumptions in a different way. Okay.
6 Before I close and let Mr. Shaw talk, let
7 me just say a couple of other things. We are here
8 suggesting you pick a confidence level lower than
9 98. We've recommended 90, but as a fallback, we've
10 recommended no higher than 95. It's been mentioned
11 more than once today that we already agreed to 98.
12 That's not fair or correct.
13 What happened was early in the process,
14 we were invited by the former commissioner to engage
15 in conversations about the possibility of reaching
16 an agreement about what would be the most sensible,
17 workable model, not just for this proceeding, but
18 for all future proceedings everyone could subscribe
19 to and avoid future hearings and litigation and all
20 the rest.
21 And during the course of those
22 conversations, we said -- and this was confirmed in
23 the letter that Mark Shaw wrote -- if the other
24 assumptions in the model were reasonable, if we were
25 going to reach an agreement about how to proceed, in

1 that context we could support a 98 percent
2 confidence level. Well, as everyone knows, it
3 didn't work out that way.
4 We were kind of hoping and anticipating
5 that before Neil Rector's report was issued, there
6 would be another meeting to see if we had reactions
7 and suggestions, possibly could there be a
8 compromise approach. It didn't happen that way.
9 Instead, we're going to go through another
10 proceeding, potentially another Court of Appeals
11 proceeding -- I hope not, but potentially. But in
12 that context, of course, from our viewpoint, we were
13 in something of a settlement discussion when we said
14 perhaps 98 was workable. We, in fact, don't believe
15 that 98 is in full compliance with the statute.
16 And in any case, even if you thought we
17 had earlier agreed that that was all right for you
18 to apply, Mr. Commissioner, in this context, you, of
19 course, have your own statutory responsibility to
20 determine for yourself what is the right number
21 irrespective of what the rest of the parties may
22 have agreed to.
23 So let me just say one other thing. We
24 are very concerned not only about the approach to
25 the model that was taken, which in our view didn't

1 comply with the statute, but we're very concerned
2 about the numbers that came out of the model. We
3 think that recommending a range of 958 to 1,040
4 means -- and here I'm going to disagree with
5 Mr. Perella -- means that this company would not be
6 required by your decision to spend any dollars at
7 all on community reinvestment. I applaud the fact
8 that they're doing it now and they have for some
9 time. In our view it's not nearly enough. $22
10 million a year, as against what we think is excess
11 surplus, is quite a small number.
12 So if you hold that they can permissibly
13 under the statute go to as high as 1,040 RBC, it is
14 the equivalent of determining, given where their RBC
15 is now, they are not required to spend any money on
16 community reinvestment. And in our view, that
17 outcome is so wildly out of keeping with what the
18 history of this process has been that it ought to
19 give you pause.
20 We are looking at a surplus that going
21 back to Larry Morrell's decision in 2005 when it was
22 500 million in 2005 and he wrote in his opinion that
23 it was already too high at that level and that the
24 company could afford to spend down significant
25 amounts from what was then a $500 million surplus.

1 When the company didn't spend it down, ultimately,
2 as the court said, dissatisfied with that state of
3 affairs as the surplus continued to rise, the
4 council acted and passed MIEEA -- that's what we
5 call it, sorry, the statute -- and passed the
6 statute. And that was in the face of a surplus that
7 was then at the $700 million level.
8 Then when the previous commissioner
9 issued her decision, she set a ceiling at that point
10 of $687 million. And even that decision the Court
11 of Appeals found was insufficient to apply the
12 statute. Now we're another 300 million higher. The
13 surplus has continued to rise and now Rector &
14 Associates have come in and said it can be another
15 100 million higher still. We believe this is out of
16 keeping with what the council expected, with what
17 the Court of Appeals expected, and in our view does
18 not fairly meet the primary requirement of the
19 statute to maximize dollars available for community
20 reinvestment.
21 Okay. So I'm done presenting a legal
22 case. And Mr. Shaw is now going to speak a little
23 further from his actuarial expertise.
24 MR. SHAW: Good afternoon. I'd like to
25 begin by introducing myself and give a little bit of

1 my background in terms of credentials and
2 experience. I'm Mark Shaw. I'm a senior consulting
3 actuary for United Health Actuarial Services, Inc.
4 I'm a fellow of the Society of Actuaries, a member
5 of the American Academy of Actuaries, a Chartered
6 Enterprise Risk Analyst of the Society of Actuaries,
7 and a fellow of the Life Management Institute.
8 From an experience standpoint, I'm in my
9 35th year as a practicing actuary. I've been a
10 senior officer of three different Fortune 500
11 insurers as either the chief actuary or chief risk
12 officer. I've served as the appointed actuary for
13 various companies over the last 25 years and I've
14 been a consulting actuary for the last six years,
15 and in that role, I am currently the appointed
16 actuary for two different insurers.
17 I have worked on various relevant
18 industry committees over the years, including
19 leading the Society of Actuaries' Enterprise Risk
20 Management Task Force for three years. For the last
21 few years, I have actively participated in the
22 American Academy of Actuaries health solvency work
23 group. I have authored a paper published in October
24 2012 by the health section of the Society of
25 Actuaries on whether underwriting cycles currently

1 exist in health insurance, and my firm and I are
2 employed by CMS as the actuarial experts to review
3 all medical rate filings that are presumptively
4 unreasonable for states that lack actuarial
5 expertise. I'm regularly employed as an expert
6 witness and have testified as such in Federal Court,
7 State Court, administrative law hearings and in
8 arbitration proceedings between two insurers.
9 I have been involved with this case, as
10 Walter mentioned, since 2009. And since my report
11 submitted on June 10 was a little over 60 pages, I'm
12 not going to try and recite that report to you. I'm
13 going to hit a few highlights and I'm going to
14 respond to some of the comments that were made
15 earlier today.
16 The first actuary to testify today was
17 Jim Toole, FTI Consulting, who supported Rector in
18 their work. And Jim's first testimony was about the
19 Actuarial Standard of Practice 41 and whether it was
20 applicable to his work in this proceeding. He made
21 several points that it only applies to individuals,
22 not firms, and I agree with that point.
23 And one thing you may not know is that
24 when you perceive that there is a violation of an
25 Actuarial Standard of Practice as an actuary, you

1 have an obligation to report it to the Actuarial
2 Board for Counseling and Discipline. I have had
3 those discussions with the Actuarial Board for
4 Counseling and Discipline with regard to Mr. Toole,
5 Ms. Doran and the other three signatories to the
6 Milliman report and I have been asked to file a
7 formal complaint. I have postponed that until I
8 asked -- and they've agreed to let me postpone that
9 formal complaint until after this hearing because
10 that's not really the focus of this hearing, but it
11 is something they will have to answer to.
12 The Actuarial Standard of Practice by the
13 way that we refer to talks about stating the actual
14 findings, identifying the methods, procedures,
15 assumptions and data used by the actuary --
16 (Interruption.)
17 MR. SHAW: -- requires that actuaries
18 state the actuarial findings, identify the methods,
19 procedures, assumptions and data used by the actuary
20 with sufficient clarity that another actuary
21 qualified in the same practice area could make an
22 objective appraisal of the reasonableness of the
23 actuary's work.
24 The offense that I -- and Ms. Doran
25 submitted testimony today in that GHMSI is her

1 client and intended user. However, this is
2 something I discussed with the Actuarial Board for
3 Counseling and Discipline. Her report as well as
4 her testimony today is being made in a public forum
5 and the public is an intended user as well as the
6 District -- DISB.
7 So in any case, I didn't come up here to
8 really rail on that particular subject, but it is
9 important to this proceeding that you understand
10 that -- what the impact of what I'm complaining
11 about is. A model is -- one thing that we agree on
12 is that Mr. Toole testified to and Mr. Burrell and
13 Phyllis testified to earlier is that the assumptions
14 are what's important in this proceeding. A model is
15 only as good as the assumptions that go into it.
16 Flawed assumptions produce flawed results and that's
17 what we're dealing with here. The assumptions that
18 go both into the stochastic model and the pro forma
19 model need to be well rounded based on facts.
20 Neither Milliman nor Rector cite the
21 specific sources for their stochastic model
22 assumptions or in the words of the Actuarial
23 Standard of Practice, none of them cite the data or
24 the procedures that -- or methods that they used to
25 derive their assumptions. They did cite the

1 assumptions. And using strictly the assumptions, I
2 was able, as they have testified to today, were able
3 to replicate the model that Milliman and Rector
4 used. However, given that the assumptions are
5 what's the important part of that model, being able
6 to determine whether those assumptions are
7 appropriate consistent with factual experience is
8 the part that is missing.
9 That brings me to the next step of -- a
10 point I wanted to make which is on validation. This
11 is a critical step in determining whether key
12 outcomes are appropriate and whether a model
13 generates reliable outcomes. Rector and Milliman
14 provided very little validation for either
15 assumptions or results. Today we arrived at the
16 hearing after having questioned FTI Consulting and
17 Rector repeatedly over the last few months about
18 what validation they did. We got one written
19 response, which didn't go to any of the assumptions,
20 but only went to validating the model as a whole.
21 And that validation produced a result that was one
22 standard deviation below the actual results.
23 As I talk about in my report, one
24 standard deviation below median, if you then do a 98
25 percentile down compared to there is actually a 99.8

1 percent confidence level. Not a 98 confidence
2 level. So that's not an acceptable validation. But
3 again, in the report, they do not -- they provide a
4 number of reasons, for example, that they change the
5 rating adequacy and fluctuation factor. However,
6 when queried, they were unable to explain how any of
7 those factors changed the assumptions that they
8 make.
9 They had started with a Milliman -- we
10 started with the Milliman factor. They ended with
11 the Rector factor, but we didn't have a roadmap of
12 how to get from A to B. They listed a portfolio of
13 assumptions that they said impacted and caused them
14 to make that change, but there was no specificity,
15 no methods, no procedures, no data that supported
16 their changes.
17 One of the other things that I did for
18 this process is I looked at a number of GHMSI peers,
19 and that's come up during this hearing today. First
20 let me say that the reason that we agreed that
21 looking at peer level of RBC ratios was not
22 important is that there has not been anybody, in
23 general, regulating RBC for Blues.
24 As an industry, the Blues have
25 substantially raised surplus levels over the last

1 decade or so and there are actually questions and
2 proceedings going on in various jurisdictions now
3 about whether or not the surplus levels are too
4 high. So comparing GHMSI's surplus level to other
5 surplus levels from other Blues which are high does
6 not really give you any perspective. So that's one
7 of the reasons that we agreed that that was not a
8 particularly valid approach to things. But what I
9 did do was I used the -- I think my mike went out.
10 From the 2009 work that was done, there
11 were a number of Blues' peers that were identified
12 by Rector, but Invotex, and perhaps by others. I
13 used those same peers, ten of them, I threw out two,
14 which Ms. Doran complains about, not because they
15 had results that I didn't like, but because from a
16 size standpoint, they were not comparable to GHMSI.
17 They were less than half the size of GHMSI and I
18 didn't think that their scale was sufficient to make
19 them a peer worth comparing to.
20 But I looked at what has happened as
21 reported in their financial statements over the last
22 five or six years and GHMSI has been an inefficient
23 insurer in terms of how much they spend on dollars
24 to administer claims and other administrative
25 expenses. Discussion earlier today from GHMSI was

1 that during the time period that Chet Burrell has
2 been present, they have had very thin margins.
3 Well, the other thing that has happened
4 is their expenses have increased every year. Well,
5 I don't say every year. They increased steadily
6 during that time period and have consistently been
7 25 to 30 percent higher than their average peer.
8 They are not an efficient company from the
9 standpoint of administrative and claim experience.
10 And this is important because when GHMSI
11 is up here telling you that they operate on razor
12 thin margins, their average expense levels are 3.69
13 percent higher than their average of these ten peers
14 that I identified -- actually were identified in
15 previous reports. And if you add that margin to the
16 .66 percent they said that they've run over the last
17 five years, they would have had a very healthy
18 profit margin, 4.35 percent pretax as opposed to
19 .66. So it makes a substantial difference.
20 The testimony today by GHMSI referenced
21 some Blue Cross/Blue Shield expense study. They
22 have not shared any data from that. They have not
23 identified companies who they described as middle of
24 the road in their expenses, middle of the road as
25 compared to other insurers. But what I have looked

1 at is I looked at the peer companies that were
2 previously identified four years ago in the
3 proceedings and such is not the case.
4 Walter has already talked to you a little
5 bit about premium growth assumption. It's
6 inconceivable to me that a company that has averaged
7 2.5 percent over the last -- or 2.8 percent over the
8 last five years would say that there's no
9 probability, no chance whatsoever that an expense --
10 I'm sorry, the premium growth would be less than 8
11 percent going forward. How can there be no
12 probability when there has been no occurrence in the
13 last five years that's nearly as high as 8 percent?
14 I think this is an example of an
15 assumption that is unreasonable on its face. And as
16 Walter has testified already, when I run the revised
17 premium growth assumptions through the model, it
18 makes a 200 percent difference at the 98th
19 percentile, 206, and it makes an even bigger
20 difference if you look at different confidence
21 levels.
22 GHMSI raised concerns about the potential
23 negative impacts of the Affordable Care Act and then
24 today, they testified that they believe that they
25 may or may not get some of the relief from the three

1 Rs that were designed to help mitigate increased
2 risk to underwriting margins. But I would ask you:
3 Does that mean if there's -- should there be no
4 accounting for these? Should we value them at zero
5 because they think that there is some chance that
6 the federal government won't fully fund them? I
7 don't think that's a reasonable result.
8 And by the way, when Phyllis in her
9 written comments says that I applied them
10 incorrectly, I will just mention now that when I ran
11 these -- my ACA adjustments through my recreated
12 model, I found that it affected my results almost
13 none. In fact, the -- the impact on the RBC that
14 came out the other end was less than 10 basis
15 points. And the reason for that is because of where
16 I was in my loss distribution on the risk adequacy
17 and fluctuation factor.
18 If I had been running an RAF factor in
19 the 18 to 20 percent range, similar to what Milliman
20 and Rector did, it would have had a large impact.
21 But when my maximum loss, again, based on historical
22 experience from these 11 companies, 135 years of
23 combined experience, it made very little difference.
24 So we could easily conceive that for my model it
25 didn't make a difference, but I will tell you that I

1 have rerun it with their model and tried to apply it
2 to their loss distributions and it makes a
3 substantial difference. And they did not even
4 account for that.
5 We found out today that Rector
6 actually -- FTI had recreated the model -- or at
7 least one of the models that Milliman had. We
8 didn't hear whether they recreated the stochastic
9 model or the pro forma model or both. I'd be
10 interested in knowing that. But the -- you know, it
11 comes as quite a shock to us to find that out at
12 this late moment when we queried them repeatedly
13 about what they did to do validation and they never
14 mentioned the fact that they had created a model to
15 validate the results.
16 One of the other points I wanted to make
17 a model validation, by the way, is what they tried
18 to model was the median -- let me see if I can quote
19 the exact words here -- "FTI states that validated
20 pro forma results are one standard deviation above
21 the historical median surplus change." Well, if the
22 whole purpose of the Rector model and the Milliman
23 model was to protect against results that were
24 extreme outlier results, they're not trying to
25 protect against what results happened at the median,

1 the 50th percentile. They're trying to protect
2 against whatever confidence level that the
3 Commissioner selects, whether that's 90 percent or
4 95 percent or 98 percent.
5 And this makes a very big difference. If
6 you had -- and I'll make a very simple
7 distribution -- if you had three distributions, one
8 was negative 1 percent, 1 percent and 3 percent and
9 the other was negative 100 percent, 100 percent and
10 plus 100 percent, those would have very different
11 implications for the confidence level result even
12 though they have identical medians. So I think that
13 that's an important thing to recognize.
14 Commissioner, earlier you said that -- in
15 one of your questions to Rector that 12 to 15 years
16 of GHMSI experience we complained that that was too
17 much. We didn't do that. Actually, that's the
18 thing that we recommended. We felt like going back
19 to 1986 and getting experience from companies back
20 then, which is what we have been told, even though
21 we didn't know what companies, we don't know what
22 results are in that grouping, 19 -- just to paint
23 the picture for you, those of us who were practicing
24 actuaries back in 1986 said the group market was the
25 Wild West. Things were up and down. There was a

1 clear underwriting cycle that went on. There were
2 no risk-based capital requirements yet in the
3 industry and things were fluctuating wildly.
4 The risk-based capital requirements came
5 in in the mid 1990s and since then, things have
6 stabilized. There is no more Wild West out there.
7 There's no dramatic ups and downs in company
8 surplus. And therefore, we think that the period
9 that ought to be examined is the period that's
10 represented by the end of the Wild West; that is,
11 the period post RBC regulations that reflects now
12 that companies are required to be more responsible
13 in the management of their surplus and capital.
14 So when they -- the one thing that we did
15 like about what Rector did -- or FTI did in
16 validation was they used the period 1999 to 2012.
17 We support that. And actually, when we ran our
18 results, for example, for the rating adequacy and
19 fluctuation factor, we used the period 1999 through
20 2013. And so I would ask you this: What would be
21 more important to having your distribution of
22 results that you're examining for appropriateness to
23 have the results from 2010, '11, '12 and '13 or to
24 have the results from the 1980s, '86, '87, '88, '89,
25 '90?

1 Well, if you try to inflate your surplus,
2 you've got to use the results from the late '80s.
3 But if you're trying to be responsible and calculate
4 an appropriate amount of surplus, the latest four
5 years of experience are more appropriate to be used
6 than long ago experience when regulations were
7 different.
8 I did have a few other points that I
9 wanted to make in response. You know, today, we
10 heard a lot of comments about how GHMSI has
11 intentionally lowered margins from the last three
12 years, '11, '12 and '13. At the same time, they had
13 said that they were -- had had a tremendous loss of
14 capital during that time period, 15 percent they
15 said, catastrophic loss, 15 percent. Well, they
16 intentionally lowered their rates. They brought the
17 rates down. What did they expect would happen?
18 Moreover, they say that they've adopted a
19 board range of 1,000 to 1300 percent RBC. They've
20 been under that range for the last three years and
21 yet they are still every year claiming that they're
22 intentionally lowering rates to make them
23 inadequate. There's an inconsistency here.
24 Furthermore, then they say that they are
25 under a mandate from the Maryland Department to

1 raise their surplus by 200 percent. And yet again,
2 they say that they are reducing intentionally their
3 rates for 2011, 2012, and 2013. Which is it? Are
4 they suffering losses or are they intentionally
5 lowering their surplus? I don't think they can have
6 it both ways.
7 Again, FTI talks about how a significant
8 part of the work is adjusting key assumptions as a
9 matter of judgment and what was known at the time.
10 Well, again, we would like to see the basis for
11 their judgment; the data that they used; the methods
12 they used to make the judgments. Those are all
13 requirements of Actuarial Standards of Practice and
14 I think this would be of interest to the
15 Commissioner in making his decision.
16 They talked about there were -- upon
17 questioning about what the biggest factors were in
18 the model. And the first one he identified was the
19 rating adequacy and fluctuation factor. Well, that
20 probably should be the biggest one. But when I ran
21 the model that I replicated from their assumptions,
22 it wasn't the biggest one. The biggest one was the
23 equity portfolio asset value. That came as quite a
24 tries surprise to me. And then I looked at it more
25 closely, and the fact of the matter is they assumed

1 that there's a loss on the equity portfolio asset
2 factor 53 percent of the time, whereas the rating
3 adequacy factor only has loss about 33 percent of
4 time. So it's no wonder it has a bigger impact.
5 But generally, I think the rest of those
6 things they've listed were correct. The rating
7 adequacy factor, I think, was the second biggest of
8 the assumptions that go into the stochastic model.
9 The premium growth and years' trends obviously are
10 important.
11 You asked what standards were used for
12 assumptions, and Walter talked about -- and he
13 incorporated the MIEEA standard into my work. And
14 clearly, that started with the assumptions. And
15 when we had the discussion with Neil Rector and we
16 talked about 98 percent, it was as he characterized
17 it today under the assumption that they were going
18 to be right down the middle of the fairway, not
19 overly conservative or aggressive.
20 As we reviewed the assumptions, again, we
21 had very little data on where their assumptions came
22 from, but as we looked at the historical record to
23 try and create assumptions, what we found is the
24 assumptions for Rector and Milliman were apparently
25 very conservative. And that conservativeness is not

1 appropriate for -- when you're trying to balance the
2 multiple purposes of the MIEEA.
3 I think I will stop and let you guys ask
4 questions. Thank you.
5 COMMISSIONER McPHERSON: Thank you,
6 gentlemen. Now, according to the script that I have
7 here, Associate Commissioner Barlow is supposed to
8 go first, but as you will all know as you get to
9 know me better, that oftentimes I have tons of
10 questions based on presentations, and so I have a
11 few questions for you gentlemen, if you don't mind.
12 MR. SMITH: Sure.
13 COMMISSIONER McPHERSON: Walter, I'd
14 like -- Mr. Smith, I'd like to start with you.
15 MR. SMITH: Okay.
16 COMMISSIONER McPHERSON: So the issue of
17 the confidence level, you know -- should know by now
18 is very significant to me. And I'm curious as to
19 what should be the basis of selecting the confidence
20 level. Is it based on statistical numbers? Is it
21 based on the mathematical formula? I mean -- or is
22 it a judgment call?
23 MR. SMITH: I think it's a judgment call.
24 I think it's a judgment call guided by the legal
25 requirements that were set out in the court's

1 decision. I think up to now, the other actuarial
2 experts have picked 98, which Milliman calls virtual
3 certainty, without regard to what I'm calling the
4 calibration and balance that's required by the
5 court.
6 The court said not only do you have to
7 explain these very high confidence levels, but you
8 have to take the community reinvestment requirement
9 into account when you pick the confidence level.
10 That's why we put up the charts. So you could see
11 the relationship between the confidence level and
12 the impact on community reinvestment.
13 But the answer to your question is it's a
14 judgment call. I don't think it turns on actuarial
15 expertise. I think it turns on a legal judgment
16 about how best to apply the competing demands that
17 appear in the statute.
18 COMMISSIONER McPHERSON: So could there
19 be an appropriate surplus using a 100 percent
20 confidence level, assuming that the assumptions were
21 appropriately defined?
22 MR. SMITH: I don't think so, no, because
23 at 100 percent you -- I don't believe you are
24 calibrating the confidence level in light of the
25 requirement of the statute to maximize community

1 reinvestment. Now, I'm not an actuarial expert, but
2 if you use 100 percent, I don't know where that's
3 going to end up --
4 COMMISSIONER McPHERSON: Either do I.
5 MR. SMITH: -- but it's going to be quite
6 a large number. It's going to be quite a large
7 number.
8 MR. SHAW: You would basically be
9 protecting against the worse possible scenario in
10 every risk factor in the model to use 100 percent.
11 COMMISSIONER McPHERSON: Is that a bad
12 thing to do as a regulator for the insurance
13 companies?
14 MR. SMITH: I think it's a bad thing to
15 do in that it's not in keeping with the requirement
16 of the statute. See, in our view, Mr. Commissioner,
17 this statute set a brand-new standard. It's
18 different. It's different from the approach that
19 was used by all the previous actuarial experts. It
20 has elevated the importance of community
21 reinvestment. In this city, maybe not in Maryland,
22 but in this city now it's more important than it
23 ever was. And the confidence level itself has to be
24 selected in light of the impact on community
25 reinvestment.

1 COMMISSIONER McPHERSON: Okay. You have
2 spoken about calibration as --
3 MR. BARLOW: Sorry about that. Sorry, I
4 just -- before we get off on a different subject I
5 had a question related to that. So as I understand
6 it, I mean, there's -- there's the assumptions which
7 have an actuarial nature to them and then there's
8 the confidence interval, which is a judgment
9 determination. Is that -- I mean --
10 MR. SMITH: Not the way I would put it.
11 I think your approach to the assumptions --
12 MR. BARLOW: I'm talking about general.
13 So the assumptions -- I mean, you said, just so I'm
14 clear, you seem to indicate that the determination
15 of a confidence level is not an actuarial
16 determination, it's a -- it's a judgment call.
17 MR. SMITH: I think that's -- I think it
18 can be guided by actuarial experience, but
19 ultimately, it's a legal judgment that has to be
20 implemented in light of the statutory requirements
21 as interpreted by the court.
22 MR. BARLOW: Okay. And so the
23 assumptions are -- so the assumptions have an
24 actuarial basis to them.
25 MR. SMITH: They do. Except your

1 approach to the development of the assumption has to
2 be guided by the efficiency requirement of the
3 statute.
4 MR. BARLOW: Okay. I got that. So --
5 but as I understand this process, I mean, at the
6 beginning, whether you say it's settlement
7 discussions or whatever, you seemed to agree that
8 the judgment part of this, that 98 percent was --
9 was an appropriate determination. I mean, that's --
10 I mean, I heard your caveats earlier, but you did --
11 but I'm confused. If that's the judgment part of
12 the determination, then why would that change based
13 on what you feel about the assumptions?
14 MR. SMITH: Well, because when I thought
15 we were in a compromise, let's work out something
16 and put in place a model we all can live with, we
17 knew there was going to be some give and take and
18 compromises reached and consensus reached. We also
19 had -- let me be real frank with you -- we also had
20 a pretty good sense of where this would go. If in
21 fact you use 98, but reasonable assumptions, we had
22 a pretty good idea of what surplus you were going to
23 get. Now that we're not using the kinds of
24 assumptions that we thought we were going to be
25 using and we have no guarantee that the commissioner

1 is going to set column A, column B, column C from
2 what we have offered, we're telling you what we
3 think is a strong legal basis for reducing the
4 confidence level and having a completely different
5 approach to the assumptions.
6 MR. BARLOW: All right. So I'm still a
7 little bit confused.
8 MR. SMITH: Okay. Sorry.
9 MR. BARLOW: So you seem -- you seem to
10 keep saying that your objection is to the
11 assumptions. And if you have a problem with the
12 assumptions, then I think we address those through
13 the assumptions. I don't -- I'm unclear how your
14 problem with the assumptions changes your
15 determination from a 98 percent confidence interval
16 back, when you said before, to a 90 percent --
17 MR. SMITH: Okay. Let me see if I can
18 help. I think that the Commissioner is going to
19 have to make two different legal determinations in
20 order to apply the statute. He's first going to
21 have to select a confidence level in light of the
22 requirements in the statute. He is then going to
23 have to pick an approach to the assumptions in light
24 of the efficiency requirement in the statute. And
25 given that we're now in a contested proceeding, we

1 are making the strongest argument we can about both
2 of those selections in light of the statute.
3 If we had not come to this hearing, but
4 instead, we had all agreed on a workable model that
5 we thought would produce fair results that were easy
6 to apply, there was a moment early in the process
7 when we thought we could work with 98, even though
8 we thought there was a legal argument against it,
9 but we could work with it if we were confident, 98
10 percent confident, that we were going to get an
11 approach to the assumptions that we thought were in
12 compliance with the statute. We got neither, as it
13 turned out, so we're now challenging both.
14 COMMISSIONER McPHERSON: Okay. I had
15 made a note to myself to make a joke about actuaries
16 because until today, I thought they were a smart
17 people, but I'm learning that just like lawyers, we
18 have differences of opinion with respect to how well
19 credentialed they are. So I think we're all in good
20 company. Phil, right?
21 So Walter, back to your calibration court
22 standard/legal standard, I read it over and over and
23 again, I spent a fair bit of yesterday when I got
24 home trying to see if I could wrap my mind around
25 how it would work. And I must confess that I'm

1 still a little bit confused.
2 So can you kind of provide some guidance
3 from your perspective as to how the calibration
4 would work per the court's decision? And was this a
5 holding of the court or was this dicta? I don't
6 recall from reading --
7 MR. SMITH: No, I think it's pretty clear
8 the court's opinion. We tried to lay it out in our
9 filing.
10 COMMISSIONER McPHERSON: Okay.
11 MR. SMITH: I mean, the court reversed
12 the last commissioner decision, in our view, because
13 the last decision didn't fairly apply either the
14 community reinvestment requirement or the efficiency
15 requirement. And as you know, as I'm sure you've
16 read it several times now, the court talks about the
17 community reinvestment requirement in several
18 different contexts in the opinion.
19 But the part that I'm focusing on when I
20 talk about calibration is the part of the opinion
21 where the court was critical of the fact that the
22 confidence levels that were selected were not
23 selected in light of the community reinvestment
24 requirement. And so if that's what's required --
25 and that's how we read the court's opinion -- then

1 if you're going to calibrate the confidence level in
2 light of the community reinvestment requirement, I
3 think you need to do something like we have done in
4 these charts.
5 You need to see what the impact is on
6 community reinvestment when you balance the two.
7 You need to see if at 97 percent or 96 percent, you
8 find that you can commit more dollars to community
9 reinvestment than you could at 98 and still feel
10 confident that financial soundness had not been
11 undermined. That's the balancing and calibration I
12 think the court is talking about.
13 COMMISSIONER McPHERSON: All right.
14 Thank you. I also noted where I believe it was you
15 that said just now, and I believe I got the
16 impression that you were supportive of 98 percent
17 provided the assumptions were correct and had a
18 valid basis.
19 MR. SMITH: That was only in the context
20 of the conversation where we weren't going to
21 litigate this thing. But now, having said that --
22 COMMISSIONER McPHERSON: So a hearing
23 precludes a 98 percent confidence level and the
24 assumptions?
25 MR. SMITH: No, Mr. Commissioner, we're

1 here challenging 98. We believe 98 is too high as a
2 matter of law and that -- for the reasons we've
3 tried to explain, you need to reduce --
4 COMMISSIONER McPHERSON: So we were
5 having this discussion in the context of back in the
6 office outside of the hearing, 98 percent would have
7 worked.
8 MR. SMITH: In a compromise conversation
9 where we were going to develop an agreed model that
10 we all were going to --
11 COMMISSIONER McPHERSON: So why can't we
12 develop an agreed model pursuant to the outcome of
13 this hearing? I mean, are you precluded from
14 presenting --
15 MR. SMITH: Certainly not. And we're not
16 precluded even now if we all want to say in the
17 light of this can't we all agree. But if we're
18 going to litigate it, then we are saying that we
19 believe 98 percent confidence level given the
20 court's decision is, as a matter of law, too high.
21 COMMISSIONER McPHERSON: Okay. Clearly,
22 there is some difference of opinions as I go through
23 this. And I do want to be mindful that Phil has a
24 number of questions prepared. But again,
25 ultimately, I have to make the decision, so I want

1 to get some comfort before we leave today while I
2 have you.
3 Let me ask you this: Is a targeted RBC
4 within the context of the court's ruling, would that
5 be exclusive of community reinvestment or could
6 there be a targeted RBC that includes the concept of
7 community reinvestment?
8 MR. SMITH: I'm not sure I know the
9 difference, but let me say what I think's required.
10 I think the surplus target, and we think it has to
11 be a number, has to have taken into account the
12 community reinvestment requirement. It has to be
13 part and parcel of the surplus level you find
14 permissible.
15 COMMISSIONER McPHERSON: So do we arrive
16 at a number where a formula includes a factor that
17 is equal to community reinvestment or do I arrive at
18 a number and only if I exceed that amount, then I
19 include the factor for community reinvestment?
20 MR. SMITH: No. I think you need to
21 determine permissible surplus in light of what
22 surplus level maximizes community reinvestment. I
23 don't think it can be let's first figure out a
24 target surplus level and then see how much that
25 allows for community reinvestment.

1 COMMISSIONER McPHERSON: So if there were
2 a new entity, a new nonprofit, subject to the same
3 rules, the same legal standard, am I hearing you say
4 that in their operations in their business model,
5 they would have to set their rates such that they
6 have a margin to support community reinvestment or
7 could they set their rates such that they arrive at
8 a surplus that's efficient without doing any
9 community reinvestment at all?
10 MR. SMITH: No, I think they have to -- I
11 think they have to set a surplus level that at one
12 and the same time maximizes community reinvestment,
13 but does so without undermining financial soundness.
14 COMMISSIONER McPHERSON: Okay. And I
15 promise you, Phil, I'll take just another 20 minutes
16 or so before you --
17 MR. BARLOW: Take as much time as you
18 want.
19 COMMISSIONER McPHERSON: Okay. So I did
20 make a joke earlier -- well, I did attempt to make a
21 joke about the differences of opinion that lawyers
22 may have and actuaries may have. And so, Mr. Shaw,
23 this is for you. I will say that I was somewhat
24 taken aback and caught a little off guard by your
25 comment about a formal complaint. And so whereas

1 that's not the nature of today's inquiry, I would be
2 less than honest if I didn't go on record to say
3 that I was somewhat disturbed by that because we do
4 have professionals here who are providing their
5 opinions and their advice. Lawyers have differences
6 of opinion all the while. That's why we have the
7 courts, that's why we have the Supreme Court, and
8 I'm not sure you will ever have a unanimous decision
9 always.
10 So I wondered if -- is it reasonable
11 because there is a difference of opinion between
12 actuaries that they ought to be reported to the
13 equivalent of the Bar? I'm not quite sure what
14 you've got.
15 MR. BARLOW: The Actuarial Board.
16 COMMISSIONER McPHERSON: The Actuarial
17 Board of Counseling.
18 MR. BARLOW: And Discipline.
19 COMMISSIONER McPHERSON: I just want
20 to -- and feel free to respond, but --
21 MR. SHAW: I'd be happy to respond. The
22 reason to report them is not because of a difference
23 of opinion. The difference -- actuaries can have
24 differences of opinion and both opinions be
25 reasonable. That's not the issue at hand. The

1 issue is that the code of conduct, professional code
2 of conduct for actuaries requires that there be
3 disclosure of assumptions, methods, procedures and
4 data supporting their opinions sufficient that
5 another actuary practicing in their field could
6 replicate the results. In this case, we don't have
7 data from them.
8 COMMISSIONER McPHERSON: Okay. So I
9 think I understand the issue from your perspective
10 except that when I was reading last night, I could
11 almost swear that I saw somewhere where you said you
12 were able to replicate the model used by Milliman
13 and/or Rector. So again, that did cause me some
14 concern. So how do you address that?
15 MR. SHAW: Indeed. And I was able to use
16 their assumptions to replicate the model. I agree
17 with that. However, I'm not able to replicate their
18 assumptions because they didn't disclose the basis
19 for their assumptions or the data behind them.
20 COMMISSIONER McPHERSON: Is there the
21 concept of privileged and confidential information
22 within the world of actuaries such as it is in the
23 world of the lawyers?
24 MR. SHAW: Yes. But when information is
25 being presented in a public forum like this, then

1 they can't claim confidentiality.
2 COMMISSIONER McPHERSON: All right.
3 Again, I'm going off script, so please bear with me
4 a few seconds. It'll only be another 20 minutes or
5 so.
6 I do want to apologize if I may have
7 misinterpreted something you said about the range.
8 Even though you made mention of 1999 to 2012 as
9 being somewhat appropriate, but then I think two
10 sentences later, you said something to the effect we
11 should use or one should use the latest four years
12 of experience, and that totally left me confused
13 again.
14 So could you -- how do you reconcile use
15 the last four years versus avail yourself post RBC
16 development in creating assumptions?
17 MR. SHAW: Okay. Let me clarify the
18 different time frames. And first of all, can I just
19 again repeat on the previous question that you were
20 having some difficulty with the formal complaint?
21 My discussions were directly with the general
22 counsel for the ABCD, and they're the ones that told
23 me that I had a duty -- a duty to make a formal
24 complaint. So they have seen documents, they know
25 about the process we're under, and they informed me

1 I had a duty to make that. So -- I have never made
2 a complaint against another actuary in 35 years.
3 COMMISSIONER McPHERSON: I won't get into
4 the facts of what happened. I'm just saying what my
5 judicial response and reaction was to learning of
6 that information.
7 MR. SHAW: The four years has to do with
8 premium growth. When you're a small company and
9 you're growing, it's easy to grow at double-digit
10 rates. As -- the bigger you get, the more difficult
11 it is to grow your base. And, in fact, as you get
12 very penetrated in the market -- and as GHMSI
13 testified earlier today, in the DC market, they have
14 72 percent of the individuals and 75 for the small
15 growth, it's difficult to continue to have growth
16 rates that were similar to ten years previous.
17 So what I was looking at that entire time
18 range for, I was looking at that for the
19 underwriting results as opposed to the premium
20 growth rate. And I think for underwriting results,
21 using that time frame was fine, but looking at
22 premium growth rates, a shorter time period, and I
23 believe I said the last five years, is what I would
24 recommend.
25 COMMISSIONER McPHERSON: Okay. Thank

1 you.
2 All right. Phil, the moment you've been
3 waiting for.
4 MR. BARLOW: Thank you. Walter, in your
5 report, you state multiple times that unless
6 CareFirst loses 700 million of its surplus by the
7 end of 2014, the Rector projection is not valid and
8 that money should be available for community health
9 reinvestment. Can you explain what you mean by
10 that?
11 MR. SMITH: Sure. Sure. We're looking
12 at the period of '12 through '14, since you're
13 assessing permissible surplus as of the end of '11.
14 So it's a forward-looking number from the end of '11
15 to take you through the end of '14, at which point
16 you'll do another one as of the end of '14.
17 The 958 RBC is based on the proposition
18 that there is a risk -- a small one, but a risk that
19 because the company can lose $700 million over that
20 next three years, it needs to be at 958 RBC to
21 protect itself against that loss. Of course right
22 now, we're at June of the third year and we know
23 that they haven't experienced anything like that
24 loss. But in order for 958 to be valid as of the
25 end of '11 going forward three years, you would have

1 to believe that it's creditable, you need 958 to
2 protect against losing $700 million by the end of
3 this year.
4 MR. BARLOW: So -- just so I understand
5 this, so you seem to indicate that there was a
6 possibility that they could lose 700 million over a
7 period of three years.
8 MR. SMITH: No, I don't concede that at
9 all. I mean, we don't think 958 is a good number.
10 It's just that it's even worse --
11 MR. BARLOW: You don't think that there
12 is a possibility for them, no matter how small, to
13 lose $700 million over a period of three years?
14 There's no scenario where that's possible?
15 MR. SMITH: No, I'm sorry, I'm not
16 making -- that's not our position at all.
17 MR. BARLOW: Okay. So there is a
18 possibility.
19 MR. SMITH: Yes, there is --
20 MR. BARLOW: Got it. Okay.
21 MR. SMITH: -- depending on what
22 assumptions and confidence levels you use and that's
23 how we get to the 700 million. It presumes their
24 assumptions are right.
25 MR. BARLOW: I understand. Okay. So the

1 fact that they do not lose 700 million over one
2 three-year period doesn't preclude the fact that it
3 is possible for them to lose 700 million over a
4 three-year period.
5 MR. SMITH: Do that one more time.
6 MR. BARLOW: I mean, you're saying --
7 you're saying that the end of the world, so to
8 speak, for CareFirst did not and is not happening
9 between 2011 and 2014 means that it cannot happen,
10 and I don't understand that. That doesn't --
11 MR. SMITH: No. No. The proposition
12 that you need 958 RBC as of the end of '11 to
13 protect against losing $700 million over the next
14 year -- next three years, we think is implausible.
15 But we think it's even more implausible as we stand
16 at June of '14, given that $700 million over three
17 years presumes on average losing 275 or whatever it
18 is per year for three years, which we know has not
19 happened. So at June of '14, the idea that they
20 would lose $700 million before the end of this
21 three-year period is even more implausible.
22 MR. BARLOW: But not -- I mean, it
23 doesn't mean that it's --
24 MR. SMITH: But the tradeoff -- but let
25 me make this point because it's important to the

1 conversation I was having with the Commissioner.
2 The tradeoff, if you credit that proposition,
3 implausible though it is, the result is you're
4 prepared to say they cannot be required to spend any
5 money on community reinvestment. That's the
6 important point.
7 MR. BARLOW: I'm just trying to get an
8 understanding of what happens -- you know, what's
9 the meaning of a "projection" and a "worse case
10 projection."
11 So on page 43 of your report, you have a
12 little table and it indicates that the surplus
13 needed for the long-term protection of GHMSI's
14 policyholders is 205 percent of authorized control
15 level RBC; is that correct?
16 MR. SHAW: Let me address that because
17 it's in my report and not his.
18 MR. BARLOW: It's in his report.
19 MR. SMITH: We redid this chart.
20 MR. BARLOW: I'm reading his report.
21 MR. SMITH: Are you? Okay. Well, we can
22 both address it.
23 MR. BARLOW: You can both address it, I
24 don't really care, but it's --
25 MR. SMITH: Okay. I mean, you're --

1 that's the question, please explain that?
2 MR. BARLOW: Yeah. Well, I'm -- I mean,
3 that's what it says, right?
4 MR. SMITH: It does.
5 MR. SHAW: That is a mathematical result.
6 You will notice that we didn't create the model. We
7 recreated the model. We duplicated the model. The
8 testimony we had earlier today from Rector and
9 Milliman is that we successfully did that based on
10 the results. And if you change the assumptions and
11 you'll note that in the 90 percentile that
12 corresponds to that 205, there's actually the
13 expectation of a gain. So if you have an
14 expectation of a gain, not a loss, plus you have
15 that number from the stochastic model, plus then in
16 the pro forma model you have net investment income,
17 you have gains from your MVP operations, then it
18 doesn't take much surplus to protect against a loss.
19 It's a mathematical result.
20 MR. BARLOW: So 205 percent is the
21 surplus that's necessary for GHMSI to protect its
22 policyholders?
23 MR. SHAW: Well, you'll notice that
24 neither one of us recommended that amount.
25 MR. BARLOW: Well, I understand you

1 didn't recommend it, but that's what your report
2 says.
3 MR. SHAW: It's a mathematical
4 calculation. We ran all of the calculations at the
5 different confidence levels and it just fell out.
6 MR. SMITH: But can I add something?
7 It's misleading to suggest that we were endorsing
8 that number. This process, as we understand it, was
9 one where the Milliman model was going to be used to
10 inform the Commissioner about the surplus he ought
11 to hold permissible given the guidance in the
12 statute. So we worked with the Milliman model, and
13 in two respects, as we've said, we thought the
14 Milliman model was not being used consistent with
15 the statute, either as to the confidence level or as
16 to the assumptions in the model.
17 So in an effort to correct the use of
18 this model to bring into compliance with the statute
19 as we read the statute, we want to show the choices
20 that became available. In some ways, to us, this
21 suggests that the model may not be the best way to
22 proceed. But we're using it because we think it's
23 what the Commissioner intends to rely on.
24 But it's important to add to that, as
25 Mark just said, we have not recommended and are not

1 recommending today a 205 RBC. We were simply
2 showing you what the model does when you make
3 corrections in compliance with the statute.
4 MR. BARLOW: So when you make corrections
5 to the model that you believe should be made and
6 adjust the confidence level that you believe should
7 be made, you come out with 205 percent.
8 MR. SMITH: If you go all the way down to
9 90 and you make all the corrections. But on the
10 other hand, if you stay at 98 and you make the
11 assumption corrections, you get a much higher
12 number. If you don't make any of the assumption
13 corrections, but you do correct the confidence
14 level, you get a higher number. So it's in some
15 ways our effort to show you the menu of choices that
16 the Commissioner has to make if he's going to rely
17 on the model and what RBC you get, depending on what
18 choices you make.
19 COMMISSIONER McPHERSON: In your view,
20 what are the consequences for GHMSI should it fall
21 to 205 RBC down to 200 RBC?
22 MR. SMITH: Well, as we've said in our
23 paper, we do not think it's catastrophic. But we
24 think it's serious and to be avoided, which is why
25 we've talked about 95 and 90 percent confidence

1 levels. But it is not imminent insolvency as some
2 of the descriptions are in GHMSI's paper. Two
3 hundred RBC begins a process. Two hundred RBC means
4 they still have $200 million in addition to the
5 dollars in their reserves, which reserve itself has,
6 we understand it, an additional cushion. So 200 RBC
7 is serious, but it is not a catastrophe.
8 COMMISSIONER McPHERSON: Do you think
9 that as the regulator, we would be serving the best
10 interests of the District of Columbia were we to
11 allow GHMSI's surplus to approach 200 RBC?
12 MR. SMITH: Absolutely not. And I cannot
13 conceive of that happening because of the role that
14 you will be playing and the role that the management
15 will be playing. And Rector made a very good case
16 in the 2009 proceeding that management intervention
17 would weigh heavily against them ever approaching
18 200, never mind 375. I don't think it's going to
19 happen under any circumstance.
20 COMMISSIONER McPHERSON: So as I consider
21 the information that I'm receiving today, again, I'm
22 just trying to, you know, figure out in my mind what
23 would be an appropriate RBC level. So what I'm
24 hearing you say is that I really shouldn't work
25 towards 200 as a target.

1 MR. SMITH: Oh, no. No, no, no. We are
2 quite supportive of you measuring the model as
3 against what RBC do you need to have to avoid
4 falling to 200 RBC.
5 COMMISSIONER McPHERSON: Is 375 a
6 legitimate baseline?
7 MR. SMITH: We think it's not as useful a
8 measure as we've said in our papers, but we've also
9 in our papers given you the number that we think you
10 get and --
11 COMMISSIONER McPHERSON: How about 500
12 RBC?
13 MR. SMITH: You mean figuring out what
14 RBC you need to avoid falling to 500? You could do
15 that.
16 COMMISSIONER McPHERSON: Yeah.
17 MR. SMITH: You could do that.
18 MR. BARLOW: I think you're trying to --
19 I think he's trying to ask a different question.
20 He's trying to understand where -- I mean, you said
21 that it's not possible for them to fall below 200 or
22 something to that effect.
23 MR. SMITH: I don't think it's going to
24 happen.
25 MR. BARLOW: Okay. And I think he's

1 trying to figure out from where you think they need
2 to start. Is that --
3 COMMISSIONER McPHERSON: Yeah. I guess
4 I'm trying to understand what would be the lowest
5 RBC that you think would be prudent as a regulator
6 for GHMSI?
7 MR. SMITH: We have recommended in our
8 paper, and I think this was in our June 10 filing,
9 that notwithstanding what the chart that Phil was
10 talking to me about shows at the lower end, that we
11 thought to be conservative, given what the Milliman
12 model shows when you use the right confidence level
13 and the right assumptions in compliance with the
14 statute, we recommended that you pick a number
15 somewhere between 400 and 500 RBC.
16 COMMISSIONER McPHERSON: So that's your
17 ultimate recommendation --
18 MR. SMITH: That is our recommendation.
19 COMMISSIONER McPHERSON: Okay. Thank
20 you. Phil?
21 MR. BARLOW: What do you think of GHMSI's
22 point that because of their structure, if their
23 surplus fell to a low level, they would have a
24 difficult time, particularly under the ACA, I guess,
25 building it back up?

1 MR. SMITH: Well, first of all, that
2 argument assumes they're at the right surplus level
3 now such that the level to which they fall is one
4 that they need to climb back from. It assumes that.
5 Of course, we think they're already way too high.
6 So that if what Mr. Burrell says happens next year,
7 which is they fall 80 to 100 points next year, we
8 think they're still way too high.
9 But on the proposition that has been
10 advanced that the only way they can rebuild their
11 surplus is through premiums, it's not so. It's in
12 Mark's testimony today, his testimony shows that the
13 vast majority of the dollars that have built surplus
14 for this company since 1999 comes from that
15 investment income, not from the underwriting gains.
16 So the proposition that that's the only way they can
17 get the money back is from premiums is not so.
18 MR. BARLOW: Okay. In your report, you
19 raised an issue with a range around 958 percent.
20 Would you consider a range appropriate if the range
21 were applicable for multiple years?
22 MR. SMITH: No. And let me say why. I
23 think the statute requires the Commissioner to
24 determine the maximum allowable surplus in order to
25 implement the requirement of maximum feasible amount

1 being committed to community reinvestment, not plus
2 or minus 83 million, which is what a range -- the
3 range that Rector has proposed. You would no longer
4 be picking the amount that will maximize community
5 reinvestment dollars, you'd be picking it plus or
6 minus 83 million. And the difference between the
7 top of that range and the bottom of that range is --
8 COMMISSIONER McPHERSON: If I may
9 interject, I thought Phil's question was not the
10 appropriateness of Rector's range as recommended,
11 but the appropriateness of using a range for
12 purposes of this exercise, and would that range --
13 or could there be such a range that would be valid
14 for three years, or is it that one picks an absolute
15 number and that becomes a fixed number until the
16 next review cycle.
17 MR. SMITH: We think the statute requires
18 you to pick a number, not a range. We acknowledge,
19 as Rector said in its paper, that when you pick a
20 single point, there will be moments when they're
21 above or below it, to which we said they should work
22 to get back to the point. Because otherwise, I
23 don't think, if you pick a range, especially one as
24 large as has been recommended by some of the
25 actuarial experts here, I don't think you are

1 picking a number as the statute requires you to
2 pick. You can't really say this will give me the
3 maximum feasible amount if in fact you say the
4 maximum feasible amount plus or minus whatever is
5 the size of the range.
6 MR. BARLOW: Okay. In your report, you
7 state that small group policies have been guaranteed
8 issue since the early 1990s. I believe the
9 implication is to be that this is saying that the
10 ACA has no impact on small group policies. Is that
11 what you --
12 MR. SHAW: I'm sorry, that's not the
13 implication. It's that there's no risk from the
14 guaranteed issue in the small group market. I mean,
15 as there will be changes in the rating practice
16 because they're required to be community rating and
17 there wasn't before.
18 MR. BARLOW: Okay. Thank you. So you do
19 agree that the world changed for small group
20 policies in the District of Columbia with the
21 introduction of the amount of ACA.
22 MR. SHAW: Correct.
23 MR. BARLOW: Okay. The way I read it in
24 your report, you seem to be saying that there was no
25 impact, so I misunderstood.

1 MR. SHAW: No, just addressing a specific
2 point that had been made by them that -- they
3 specifically cited guaranteed issue in the small
4 group or that had already been the case. If they'd
5 said rating practice would be different in small
6 group, I would agree with that.
7 MR. BARLOW: Okay. So I know we've had
8 some discussion of this, so let me -- maybe if you
9 could, without -- in some short period of time,
10 maybe if you can address, if you had gotten whatever
11 additional information that you wanted from Rector,
12 GHMSI, Milliman, whoever that was from, how would it
13 have affected the information that you provided in
14 your report?
15 Again -- you know, again, I see your
16 report and I see what you're saying is that at 205
17 percent RBC is a conceivable point at which they
18 could not be considered to have excess of surplus
19 and I'm just trying to understand how that might
20 change if --
21 MR. SHAW: Okay. We -- again, that chart
22 that includes the 205 simply reproduces their model,
23 the different assumptions and the results that come
24 out.
25 The things that were missing, by the way,

1 that we would have liked to have had were the basis
2 for the various assumptions, and that's the primary
3 thing from my standpoint, and then for the pro forma
4 model, we were not provided any detail on the
5 expense or membership projections that were used in
6 the pro forma model. So those were the things we
7 needed to make an exact replica of the pro forma
8 model similar to what we made an exact replica of
9 the stochastic model.
10 MR. BARLOW: I mean, if you'd gotten that
11 information, how would it have --
12 MR. SHAW: Well, it would have changed
13 the chart somewhat. We replicated the stochastic
14 model results because of the four cells we adapt
15 for, but we present a lot more than four cells
16 there. And maybe with the full model there as
17 opposed to an approximation of the pro forma model,
18 maybe that 205 would have been 250, 300. I don't
19 know what it would have been, but it could have been
20 different.
21 MR. BARLOW: It could have gone lower?
22 MR. SHAW: I don't think it would go
23 below 200.
24 MR. BARLOW: I don't think it can either,
25 but -- I mean, I don't think realistically it can.

1 I don't know about the modeling. The model could
2 churn out whatever it churns out, right?
3 MR. SHAW: That's true.
4 MR. BARLOW: All right. So I just wanted
5 to -- just have a couple of questions so I'm clear
6 about the Actuarial Standards of Practice, because
7 you've said some stuff and then you -- so it's
8 individuals that are subject to the Actuarial
9 Standards of Practice?
10 MR. SHAW: It is.
11 MR. BARLOW: And individuals who are
12 members of US actuarial --
13 MR. SHAW: Someone earlier mentioned five
14 membership organizations. In particular, the
15 American Academy of Actuaries and the Society of
16 Actuaries are the ones that are applicable in this
17 regard.
18 MR. BARLOW: Okay. But then you
19 continued to say, as you talked about it, that
20 Rector didn't do this and Rector didn't do that and
21 I don't know if you were talking about Rector the
22 firm or Rector the individual.
23 MR. SHAW: I'm talking -- if I said
24 Rector, it would have been their actuarial support,
25 which in this case was FTI Consulting.

1 MR. BARLOW: Okay. But FTI is not a --
2 MR. SHAW: And -- but now, every method
3 that we have from FTI is from Jim Toole. So it was
4 Jim Toole specifically.
5 MR. BARLOW: So all of the things in your
6 report -- I mean, it really should have said -- it
7 really should have identified an individual actuary
8 in your report as opposed to the firms and not --
9 non-actuary firms?
10 MR. SHAW: Well, I could have identified
11 the individuals, that's true. It would have been
12 four individuals with Milliman. It wasn't meant to
13 specify these are the people that I'm going to
14 complain about or that I'm obligated to complain
15 about is a better way to put it.
16 MR. BARLOW: And then in my experience
17 when -- and in all of the language that I see about
18 the Actuarial Standards of Practice, they really
19 talk about an apparent violation until the Actuarial
20 Board of Counseling and Discipline has made a
21 determination. But it sounds like you have not
22 yet -- you've not yet even formally made a complaint
23 to the Actuarial Board of Counseling and Discipline.
24 MR. SHAW: That's correct. I have not
25 made the formal complaint. I've had discussions

1 with their general counsel whose advised me that I'm
2 obligated to make a formal complaint, but I've not
3 done that yet.
4 MR. BARLOW: I get that. So -- but it's
5 only the Actuarial Board of Counseling and
6 Discipline that determines that there was a
7 violation.
8 MR. SHAW: That's correct.
9 MR. BARLOW: So really what you -- what
10 you are saying is there is an apparent violation.
11 So --
12 MR. SHAW: I agree.
13 MR. BARLOW: The statements in your
14 report and the statements today that there were
15 violations was kind of premature or at least --
16 COMMISSIONER McPHERSON: Strong.
17 MR. BARLOW: -- strong because there has
18 been no such determination yet.
19 MR. SHAW: That's correct.
20 MR. BARLOW: Okay. I'll give it back to
21 Chester, then.
22 COMMISSIONER McPHERSON: All right.
23 Thank you.
24 So we may have made up some time, so
25 maybe let's go a little longer. How do you

1 recommend we meet the reconciliation aspect of the
2 statute in that we were supposed to coordinate with
3 Maryland this review process? Do you have any
4 recommendations for me to consider?
5 MR. SMITH: Well, I do. I think it's
6 perfectly appropriate that you be doing the
7 coordinating that I think you're already doing with
8 the commissioners in the other two jurisdictions.
9 And if you find excess surplus, which of course we
10 think you should, it will be appropriate to
11 coordinate the next steps under District law as to
12 what happens once you find excess surplus.
13 Of course, if you find excess surplus,
14 you are first going to determine what the allocable
15 share of that is in the District. You're not going
16 to tell Maryland or Virginia what they have to do.
17 You're going to determine how much in the District
18 that's allocable to the District that you believe is
19 excessive.
20 I do think it's possible that Maryland
21 and Virginia will be interested in participating in
22 the proceeding that I think you will then conduct to
23 review the proposed spend-down plan. And they may
24 have views about what they think of the spend-down
25 plan, they may have views about your allocation

1 decision. I think all of that can be and should be
2 done in coordination with the other two
3 jurisdictions.
4 But can I just say one other thing about
5 that? Your statute is different from Maryland's
6 statute, and it is not a surprise if you find excess
7 surplus for GHMSI when they did not, because this
8 statute is a much stricter, tougher statute with
9 regard to maximizing community reinvestment. So the
10 mere fact that Maryland found GHMSI's surplus to be
11 permissible at a higher range or point than you
12 might is not -- would not be a surprise to us.
13 COMMISSIONER McPHERSON: Okay. I don't
14 believe I have any more questions.
15 MR. BARLOW: Sorry, I have one more
16 question that I forgot. So, just -- Mark, in your
17 testimony, you made a statement that -- and I think
18 I got this right -- that no one regulates RBC for
19 the Blues.
20 MR. SHAW: No one is actively managing
21 it.
22 MR. BARLOW: What do you mean by that?
23 Because I know that I review the RBC for at least
24 one Blues plan and I am a regulator, so I just want
25 to understand if you're -- I don't think you're

1 saying --
2 MR. SHAW: No. I'm saying that nobody
3 has been actively trying to maintain surplus levels
4 at a lower level. It's always in the interest of
5 the commissioner and the safety of the public to
6 have a higher level despite the fact that we don't
7 think it's likely that they could loss from 958
8 percent down to 200 percent in a three-year period.
9 There is a possibility, however small. So what I'm
10 saying is that there's no incentive for anyone or
11 has been no incentive for anyone to limit the amount
12 of surplus in general for Blues plans.
13 MR. BARLOW: Okay.
14 COMMISSIONER McPHERSON: Gentlemen, I
15 want to thank you for your presentation. The time
16 is now approximately 3:55 p.m. We will take a
17 break. We will reconvene at 4:15, after which there
18 will be additional presentations from the public
19 followed by closing remarks by Appleseed, followed
20 by closing remarks by GHMSI. And I may have
21 additional questions sometimes during that process.
22 So see you back at 4:15.
23 (Recess taken.)
24 COMMISSIONER McPHERSON: Time is 4:15,
25 the same day we started. We are now back on the

1 record. Now we will hear from public witnesses. I
2 have a statement from Peter Rosenstein. He wasn't
3 able to be with us, so he left his testimony that
4 will be added to the record.
5 Next, I'd like to call Cheryl Parcham
6 from Families USA, Sally Tyler from AFSCME, Margot
7 Aronson from Greater Washington Society, Maria Gomez
8 from Mary's Center, and Vincent Keane from Unity
9 Health.
10 So I should have one, two, three, four --
11 five witnesses, if I can count correctly. So Cheryl
12 Parcham here?
13 MS. PARCHAM: Yes.
14 COMMISSIONER McPHERSON: Sally Tyler?
15 (No response.)
16 COMMISSIONER McPHERSON: Sally Tyler?
17 (No response.)
18 COMMISSIONER McPHERSON: Okay. So that's
19 who's missing.
20 Okay. Witnesses or members of the
21 public, if you don't mind raising your right hand so
22 I can swear you in.
23 Whereupon,
24 CHERYL PARCHAM, MARGOT ARONSON,
25 MARIA GOMEZ and VINCENT KEANE,

1 having been duly sworn by Acting Commissioner
2 McPherson, gave testimony as follows:
3 COMMISSIONER McPHERSON: Thank you. If
4 you have copies of your testimony, we would
5 appreciate if you could share those with us. And
6 again, before you start your presentation, if you
7 could just state your name and your affiliation.
8 Based on the list that I have here, Ms. Parcham --
9 am I pronouncing --
10 MS. PARCHAM: Parcham, Cheryl.
11 COMMISSIONER McPHERSON: Parcham.
12 MS. PARCHAM: Yes.
13 COMMISSIONER McPHERSON: My apologies.
14 If you could go first.
15 MS. PARCHAM: Thank you. Good afternoon.
16 I'm Cheryl Fish-Parcham and I am the private
17 insurance program director at Families USA. I'd
18 like to offer brief comments on the surplus held by
19 GHMSI and protection the insurers receive against
20 unforeseen costs under the ACA as emergent community
21 benefit needs.
22 Families USA is a national nonprofit,
23 nonpartisan organization dedicated to the
24 achievement of high quality affordable health care
25 for all Americans, and we concur with DC Appleseed

1 that GHMSI has far more in uncommitted benefits than
2 it needs and should be required to spend more on
3 community health reinvestment.
4 First, I'd like to talk about surplus and
5 why we question the targeted surplus level is so
6 much higher this year than in 2009. GHMSI's surplus
7 level is higher than the RBC levels held by many
8 health insurers around the country. For example,
9 the Colorado Insurance Commissioner's 2013 annual
10 report to the General Assembly showed that from 2007
11 to 2011, most insurers in that state had a five-year
12 average RBC, lower than 800 percent and that the RBC
13 for Anthem Blue Cross in that state averaged 445
14 percent.
15 In Vermont, a state with roughly a
16 comparable population to DC and two dominant
17 insurance carriers, Vermont Legal Aid serves as the
18 state's healthcare advocate and represents the
19 public in rate hearings. Vermont Legal Aid informs
20 us that Blue Cross/Blue Shield of Vermont strives
21 for an RBC between 500 to 700 percent, and at the
22 end of 2012, the RBC was 587 percent and at the end
23 of 2013, it was 575 percent.
24 As a layperson in this proceeding, I have
25 questions about why the RBC in the District would

1 need to be higher than in those states and I would
2 ask if that's an appropriate question, if you would
3 ask that in follow to today's hearing.
4 There was testimony about -- from GHMSI
5 that the Affordable Care Act has dramatically
6 altered the markets in which GHMSI must operate and
7 poses significant new risks to the company. While
8 it's true that ACA has dramatically altered the
9 market, we want to point out that ACA has done a lot
10 to protect companies from increased risk. These
11 mechanisms include risk adjustment, which allows
12 GHMSI enrollees to -- GHMSI to receive relief if the
13 risk of its enrollees is higher than in other health
14 plans, reinsurance and risk corridors. These were
15 mentioned earlier, but I also wanted to note that
16 the MLR requirements in the -- under the Affordable
17 Care Act allow for state-specific adjustments were
18 there to ever be a need.
19 So I know GHMSI testified that if its
20 surplus fell below acceptable levels, the MLR
21 requirements would prevent it from regaining those
22 surplus levels. But, in fact, you could request
23 that there be a state-specific adjustment to the MLR
24 levels in that case to try to recover any risk that
25 came to be.

1 The District small businesses and
2 residents do need help continuing to afford health
3 insurance. And in its recent filing for small group
4 rates for 2013, GHMSI proposes to increase rates by
5 8 percent in 2015, with some products increasing by
6 9.5 percent. GHMSI proposes to contribute an
7 additional 1.6 percent of premium dollars to
8 reserves. Given its additional -- already high
9 reserve levels, we believe that this should be
10 disallowed.
11 GHMSI also proposes to raise rates for
12 individual coverage by 12.1 percent with pricing
13 increases for some products ranging as high as 15.3
14 percent. Though the insurer does not plan to
15 contribute to reserves through the price increases
16 in individual products, we request that if reserve
17 levels are found to be too high, that these price
18 increases also be disallowed.
19 The last thing I want to mention is some
20 community health reinvestment needs. As GHMSI and
21 District officials plan how they can best meet
22 community health needs in the future, we wanted to
23 draw several needs to your attention. We know and
24 support that CareFirst provides support to community
25 clinics and that they play a critical role in

1 serving the District's population and continue to do
2 so.
3 In the past, GHMSI/CareFirst has
4 maintained an open enrollment program to serve
5 people with preexisting conditions who were excluded
6 from other coverage, and this product was subsidized
7 through other GHMSI resources. Since ACA now allows
8 individuals to enroll in any plan regardless of
9 their preexisting conditions and their needs for
10 this program have changed, but other needs have
11 emerged. And an emerging need that some of the
12 newly insureds will face is help with cost sharing
13 and also help if they get behind in premiums.
14 The District protects people with incomes
15 up to about 210 percent of the poverty level from
16 all the nominal costs for Medicaid, and the
17 Affordable Care Act protects people by providing
18 some cost-sharing relief to people up to 250 percent
19 of the poverty level. But that is only $39,325 a
20 year for a family of two. So adults with incomes
21 near or over this level may have a lot of difficulty
22 affording care until they have reached their plan
23 deductible levels.
24 CareFirst Silver plans for an individual
25 have deductibles ranging from $1300 to $2500

1 annually and Bronze plans have deductibles ranging
2 from 3500 to $6,000 annually. But consumers could
3 avoid deductibles by buying a higher level of
4 coverage. We know that many consumers in the
5 District have tight budgets and will not do that
6 given the very high housing costs in the city.
7 Nonprofits such as GHMSI may want to
8 consider establishing a foundation to provide
9 further help to consumers who cannot afford their
10 cost sharing similar to patient assistance funds
11 that direct manufacturers have established or
12 working with the District to establish another sort
13 of wraparound assistance to lower Silver Plan
14 deductibles for those with financial needs.
15 The newly insured will need more help in
16 understanding their coverage. There have been past
17 efforts, particularly in the Medicaid arena, to help
18 with peer education. And some people are not
19 eligible for federal premium assistance because
20 their spouse's employer pays for the spouse's plan
21 and offers, but may not contribute to family
22 coverage. We're not sure how many people in the
23 District are affected by this problem, but if it is
24 found that GHMSI has a further community benefit
25 obligation, this is another place where help is

1 needed.
2 There are many other unmet health needs
3 of the District, and we hope the DISB will find that
4 GHMSI has a responsibility to reinvest more in the
5 community health and will consult with public
6 involvement relevant to the agencies about how best
7 to do that.
8 COMMISSIONER McPHERSON: Thank you, Ms.
9 Parcham.
10 If I may remind you to try to keep your
11 presentation to approximately five minutes, I would
12 really appreciate that.
13 Next, Ms. Aronson.
14 MS. ARONSON: Thank you, Commissioner. I
15 am Margot Aronson speaking for the Greater
16 Washington Society for Clinical Social Work. The
17 Society has 900 active members representing licensed
18 independent clinical social workers who practice in
19 mental health clinics, psychiatric hospitals,
20 medical facilities --
21 (Interruption.)
22 MS. ARONSON: The Society, 900 active
23 members, represents licensed independent clinical
24 social workers who practice in mental health
25 clinics, psychiatric hospitals, medical facilities,

1 family service agencies, schools and private
2 practice in the metropolitan Washington area, 4300
3 in the District.
4 We clinical social workers see at
5 firsthand the impact of lack of access to
6 affordable, quality health and mental health care.
7 And we commend the Commission, the Health Benefit
8 Exchange Authority and participating insurance
9 companies, including GHMSI, for the major positive
10 changes we're seeing in expanded coverage and access
11 to care in response to the ACA. Yet concerns remain
12 about the surplus issue.
13 CareFirst/GHMSI has a responsibility to
14 its subscribers and to the community at large for
15 the proper use of the excess. We applaud GHMSI for
16 its charitable giving to address unmet needs in the
17 District, and we hope this contribution will
18 continue and perhaps expand. However, this should
19 not in any way prevent GHMSI from addressing unmet
20 needs of its subscribers.
21 First, the premiums. Given the size of
22 the surplus, it is disturbing to learn that
23 CareFirst alone among the industry carriers has
24 proposed rate increases for all of its plans, with
25 individual and small business plans reflecting

1 increases greater than 10 percent.
2 Network adequacy. Timely treatment
3 depends on a network of available providers, and
4 this is a very serious problem in the mental health
5 area. It's something we hear about regularly from
6 subscribers. They find themselves unable to find
7 CareFirst providers who are available for new
8 clients. Unfortunately, inevitably, it's the most
9 vulnerable population that tend to give up the
10 search when they are the ones most in need.
11 The reality is that experienced providers
12 are leaving the CareFirst network unable to maintain
13 a practice at CareFirst contractual rate and
14 reimbursement. This is particularly true of the
15 BlueChoice panel, which is so popular because it's
16 affordable, which reimburses at a rate of less than
17 half of the already discounted Medicare rate and is
18 significantly less than the market rate. New
19 professionals are not signing up discouraged by the
20 financial disincentive.
21 Denial of benefits. When it comes to
22 denial of benefits, it is surely not the case that
23 denial of benefit is a deliberate effort on the part
24 of CareFirst to discourage use of benefits.
25 Unfortunately, however, that assuredly false

1 assumption is one we hear often from providers, from
2 subscribers, from former providers and former
3 subscribers. All too often when benefits are
4 denied, subscribers do not challenge or resubmit
5 their valid claims, feeling that CareFirst won't
6 listen to them or that the process of contacting a
7 helpful staff member will be too frustrating.
8 What kind of problems are there? We hear
9 of subscribers given incomplete or incorrect
10 information about preauthorization and what should
11 be a clear and easy path to resolution results in an
12 unexpected expense for the subscriber and/or a
13 significant loss of income for the provider. We
14 hear numerous complaints about the internal phone
15 menus to be navigated in order to reach a live human
16 being, and we hear about how frustrating the web
17 portal is, far from user friendly.
18 Providers and subscribers regularly share
19 stories about CareFirst errors that have been
20 corrected only after months and sometimes years of
21 calls and correspondence. This is unacceptable with
22 the kind of so-called "surplus" that GHMSI is
23 carrying.
24 Traditionally, the Blues have been
25 recognized as among the most venerable and respected

1 insurance carriers in our country, providing
2 thoughtful and caring health care. Clinical social
3 workers have been proud to participate as providers
4 and many lament having to leave CareFirst in order
5 to maintain a viable practice. We ask that the
6 commission hold CareFirst and GHMSI to its
7 obligations to the community and to its subscribers
8 and thank you for this opportunity to comment.
9 COMMISSIONER McPHERSON: Thank you,
10 Ms. Aronson.
11 Ms. Gomez?
12 MS. GOMEZ: Good afternoon. My name is
13 Maria Gomez and I am the president and CEO of Mary's
14 Center. Mary's Center is pleased to submit this
15 letter of support for CareFirst/Blue Shield -- Blue
16 Cross/Blue Shield. I'm sorry. We were founded in
17 1988. Mary's Center focuses primarily in changing
18 the economic paradigm of our most marginalized
19 families throughout the delivery of health care,
20 social services and education.
21 We have been a federally qualified health
22 center for the past ten years and disproportionately
23 see in the city a large number of uninsured patients
24 in the region. And so not just in DC, but in the
25 region. In 2013, we provided $6.9 million of free

1 care to individuals that were too poor to get
2 private insurance and not poor enough to qualify for
3 Medicaid; in other words, that is our working poor
4 in the city.
5 Some of the newly enrolled in the
6 commercial insurance through the health exchange
7 have started to tell us that they may not be able to
8 keep up with the premiums over time due to the
9 disparate expense of housing, food, childcare and
10 transportation in the city. For Mary's Center, this
11 means first, that we're not going to get the huge
12 windfall of commercial patients; second, that the
13 Medicaid patients that are now a commodity to cater
14 to by our industries such as MedStar and Johns
15 Hopkins to mention a few in the city. This, of
16 course, leaves Mary's Center in the same situation
17 in the future that we are right now, which is seeing
18 60 percent of 40,000 patients that are uninsured.
19 That is why I'm here today to be
20 testifying on behalf of CareFirst Blue Cross/Blue
21 Shield. They have been, and will continue to be, an
22 invaluable partner in achieving our goals. I
23 certainly hope so. That is, for us caring for
24 anyone that walks in our doors or anyone that calls
25 through our phone.

1 I am not an expert here today at all. I
2 am a nurse and a provider. I'm a manager of several
3 clinics, but I'm not here as an expert to -- on any
4 kind of resources that CareFirst should or should
5 not have. But I can tell you that they -- their
6 investment of $1.5 million in a brand-new site for
7 Mary's Center in Prince George's County has enabled
8 us to provide comprehensive health and social
9 services to over 15,000 patients in the last --
10 since 2010, focused primarily on the uninsured.
11 In order for Mary's Center to get ready
12 also for the new payment forms that's coming up in
13 2015, CareFirst initiated funding for the
14 patient-centered medical home chronic care
15 initiative, which Mary's Center received in 2011
16 close to $600,000. Over several years, CareFirst
17 funded a collaborative of clinics in the region for
18 the same thing, for this patient-centered medical
19 home. It enabled us, all of us to actually learn
20 from each other and help support the growth and
21 helped us through our challenges in this process,
22 which has not been easy. This is money that we are
23 now in the community who have been the safety-net
24 providers for, in this case, Mary's Center for 27
25 years are now having to compete with other systems.

1 As you see, the buses with all the names and all the
2 clinics that provide and are trying to compete with
3 this population, which I know will be helped with
4 the first visit and dropped back to our clinic.
5 So their intent, and that means
6 CareFirst, is that -- for the last meeting that we
7 had with them, is that they will stay with us to
8 actually support us in the coming few years to
9 actually leverage what they've already invested to
10 make sure that we are going to be able to sustain
11 and continue to be the primary care providers and
12 the safety net in the city.
13 In just this past year, because of our
14 large number of uninsured patients, CareFirst
15 awarded us 91,600 to support the wellness visits to
16 cover the uninsured once again.
17 While I speak of the support for the last
18 four years, CareFirst also has been there since 2004
19 when they gave us $124,000, 400 or so to -- in the
20 last several years to actually get us up to speed to
21 where we are today, to get us the strength to see
22 over 40,000 patients today, to have two sites in
23 Maryland, two sites in DC with very comprehensive
24 wraparound services for our families that addresses
25 health experience not only in this city, but also in

1 Prince George's County where so much of our
2 population is moving to because of the issues I
3 mentioned before, housing primarily.
4 I hope that I've given you a glance of
5 what Mary's Center is here today, why we're here.
6 If CareFirst is in a position to give more, it
7 should, certainly. I don't think that any of us
8 would disagree with that, although the city and the
9 surrounding Maryland area is healthy today because
10 Mary's Center has received over $2.4 million since
11 2004 from CareFirst to serve our marginalized
12 population. That, to me, is the community that it
13 goes in and out with the working force depending on
14 the season.
15 And so not only the money, but their
16 expertise because of who they are that they have
17 been able to provide to us. So I say I have all the
18 confidence and belief because of the record that
19 they've proven to us that if they have the money and
20 when they have the money, they should. And I don't
21 think that any of us providers would disagree that
22 they should invest in the community, but certainly
23 we have been benefitted from their -- their
24 expertise and their goodwill. Thank you.
25 COMMISSIONER McPHERSON: Thank you,

1 Ms. Gomez.
2 Mr. Keane.
3 MR. KEANE: Thank you, Commissioner.
4 Good afternoon, Commissioner, and members of the
5 Commission. My name is Vincent Keane. I'm
6 president and CEO of Unity Health Care. Unity, like
7 Mary's Center, is a nonprofit organization founded
8 in 1985. It is the largest private organization
9 providing primary and medical care to homeless, low
10 income, uninsured and incarcerated members of the
11 District.
12 Our patient population is racially ethnic
13 and diverse and largely minority. Substantial
14 health disparities and poor health outcomes among
15 this population demonstrates the need for accessible
16 and comprehensive primary care. We use a wholistic
17 approach to primary care, primary medical care and
18 social services among our population of underserved
19 residents of the District. We operate a large
20 network of health centers, homeless sites and other
21 programs. These sites and services are located
22 throughout the city in areas with large numbers of
23 people living in poverty to assure maximum
24 accessibility to our services.
25 Our institutional approach focuses on

1 ensuring that our programs are accessible, high
2 quality, culturally appropriate and responsive to
3 the needs of our clients. It is in this context
4 that I testify today. The context of our mission.
5 And I testify today to outline the commitment that
6 CareFirst has made to Unity over the past five
7 years.
8 The following is a summary of the funding
9 provided as well as the purpose for which this
10 funding was used. In 2009, CareFirst awarded Unity
11 a grant of $230,000 for the purchase and design of a
12 fully equipped 34-foot mobile medical outreach
13 vehicle. This mobile unit continued to -- contained
14 two built-in examining rooms, two social service
15 counseling areas and a waiting area. These mobile
16 facilities provide access to vital medical and
17 social services for those persons experiencing
18 homelessness in the District. In particular, we
19 access those who are either afraid or just through
20 mental illness do not seek shelter in our District
21 shelters.
22 In 2011 to 2013, CareFirst provided a
23 $375,000 grant to support the upgrading of our
24 dental suites with digital dental equipment and
25 software and to support vitally important adult

1 immunizations, ensuring patients across our network
2 have access to state-of-the-art services.
3 And in 2012 and 2014, like Mary's Center,
4 CareFirst supported Unity with 913,000, a grant for
5 our patient-centered medical home enhancement
6 initiative. This funding supports our efforts to
7 reduce excess emergency room utilization, which puts
8 a burden on our whole system, improves patient
9 outcomes through care coordination for patients that
10 have been lost to care and expand access and
11 increased utilization of extended and evening hours.
12 In addition to direct grant services,
13 CareFirst has supported Unity in its various
14 fundraising events, including a marketing initiative
15 with the Washington Redskins. This has been Unity's
16 experience over five years, which reflects the
17 community engagement of CareFirst in serving the
18 medically underserved in Washington, DC.
19 I am confident that this commitment will
20 continue into the future as Unity continues to fully
21 implement the new model of care that is called for
22 under the Affordable Care Act, a goal that I know
23 the leadership of CareFirst is likewise committed.
24 Just one observation that's not in my
25 testimony. At a recent meeting with leadership at

1 CareFirst in Baltimore, several of the health
2 centers that received this previously-made grant
3 indicated the challenges of getting wraparound
4 payment for services that are not actually
5 considered to be directly medical. The areas here
6 include social services, translation services and
7 others. It's very hard to put a target figure on
8 the cost of those services, but they cost money to
9 the provider. We have been assured by CareFirst
10 leadership that they will work with us in getting
11 experts to help us identify a cost methodology for
12 this effort. This is not a direct funding, but it's
13 a technical assistance that I know we all can
14 benefit from. Thank you for accepting my testimony.
15 COMMISSIONER McPHERSON: Thank you. Any
16 questions, Mr. Barlow?
17 MR. BARLOW: Sure, I have a few
18 questions. I will start with Ms. Fish-Parcham. You
19 talked about Vermont where they have -- they have a
20 target between 5 and 700 percent of authorized level
21 of RBC.
22 MS. PARCHAM: Right.
23 MR. BARLOW: Is that a statutory
24 requirement or is that a goal determined by the
25 organization, do you know?

1 MS. PARCHAM: I don't know. I can ask
2 the Vermont Legal Aid who's the source of that
3 information and get back to you.
4 MR. BARLOW: Okay. And then just -- this
5 maybe isn't so much a question, but a clarification
6 just for our consistency of use of terms. You
7 talked about the contribution to reserve and you
8 talked about reserves generally, and I believe what
9 you are talking about is what we have been generally
10 calling today "surplus."
11 MS. PARCHAM: Yes, I -- yes, that's
12 the -- the correction. Thank you.
13 MR. BARLOW: Okay. Just wanted to make
14 sure we made that distinction. And then you
15 identified several community health reinvestment
16 needs, and the -- a general gist of them seem to be
17 that they were -- they were sort of consistent with
18 GHMSI's position -- or maybe it's not GHMSI's
19 position. I think they referenced Maryland --
20 Maryland insurance commissioner's position that the
21 community health reinvestment should focus on
22 existing subscribers.
23 MS. PARCHAM: Yes. Now, I don't think
24 that it needs to exclusively focus on subscribers,
25 but I know that there have been -- the open

1 enrollment product was a product for subscribers
2 that may no longer exist after this year. And so in
3 terms of thinking of other community benefits that
4 subscribers might need and that are unmet, I wanted
5 to offer some suggestions about those.
6 We also have wider public health needs in
7 the District surrounding cancer and diabetes and
8 heart disease that go beyond the subscriber
9 population, and I do think it's important to invest
10 in both sets of needs.
11 MR. BARLOW: Okay. Thank you.
12 And then, Ms. Aronson, with my -- maybe
13 taking advantage to make comments rather than
14 questions, I will say that, you know, to the extent
15 that you are aware of people who have issues with
16 GHMSI or any health insurer in the District of
17 Columbia, we would certainly welcome them to file
18 complaints with the Department. We have a staff
19 that's dedicated to handling those kind of issues.
20 So, you know, we would like to be -- we would like
21 to be able to have an opportunity to do that.
22 MS. ARONSON: This is something that I
23 recommend to people on a regular basis, so I will
24 serve in talking to them and so forth. Thank you.
25 Yes.

1 MR. BARLOW: Okay. And then you said
2 something about a BlueChoice panel, and that's -- I
3 don't know exactly -- that sounds like maybe that's
4 a network within the Blue Cross/Blue Shield
5 organization.
6 MS. ARONSON: I'm sorry, sometimes we
7 refer to the network as a panel. You're paneled on
8 a network. It means you're one of the Blue Cross
9 providers, you're part of their -- you're one of the
10 ones that for BlueChoice, that someone who is a
11 BlueChoice subscriber would have to go to one of
12 these people in order to get service that is covered
13 by BlueChoice.
14 MR. BARLOW: Okay. So the BlueChoice
15 panel is the network of providers for the --
16 specifically for the HMO?
17 MS. ARONSON: BlueChoice is the HMO. And
18 as he said, the most popular, understandably, it's
19 the cheapest.
20 MR. BARLOW: Okay. And then my last
21 question for you, I think, is the -- you mentioned
22 that -- another thing that you mentioned that people
23 were having problems -- maybe I'm asking questions
24 that don't have anything to do with CareFirst
25 surplus in my role as a regulator maybe, but you

1 said people were having trouble with a web portal.
2 Is that the -- are you talking about DC Health Link
3 or are you talking about something --
4 MS. ARONSON: No, I'm talking about the
5 Blue Cross, trying to get information from them to
6 try to figure out what their benefits are, who's
7 available, those kinds of things.
8 MR. BARLOW: Okay. So it's getting the
9 information from Blue Cross/Blue Shield either on
10 the phone or through their -- or through their
11 website?
12 MS. ARONSON: Yeah.
13 MR. BARLOW: Okay. Just wanted to be
14 clear.
15 MS. ARONSON: Thank you for clarifying.
16 MR. BARLOW: Okay. And then, Ms. Gomez,
17 so it sounds like you have been, over the years, a
18 recipient of a number of donations. I don't --
19 MS. GOMEZ: Grants.
20 MR. BARLOW: Grants. Okay. Thank you.
21 Grants from -- from CareFirst.
22 MS. GOMEZ: (Nodding head up and down.)
23 MR. BARLOW: And do you have a -- do you
24 have a sense -- I mean, I -- these, obviously, I
25 don't think were the result of them being required

1 as a result of excess surplus determination. So
2 you -- you're supportive of contributions to the
3 community by CareFirst whether there is an excess
4 surplus determination or not?
5 MS. GOMEZ: Certainly. As a -- as a
6 safety net, I guess I have to wear my hat of Mary's
7 Center first and say yes. But I think that we
8 also -- you know, I think part of -- part of -- and
9 again, this is not my expertise, but, you know, for
10 someone like Mary's Center that has zero reserves,
11 just understanding that our organization has to
12 be -- and knowing that, you know, this is why I put
13 the statement in there about the health exchange. I
14 mean, the numbers of people that are going to drop
15 the -- their insurance because of their financial
16 situation is detrimental both to CareFirst, but
17 certainly to us as providers.
18 As the patient presents themselves, they
19 will tell you or not tell you or may not realize
20 that they missed three or four payments, they're
21 done, they're not insured anymore. And so it's a
22 problem.
23 I think one of the things that I also
24 want to say is there isn't another insurance company
25 that -- and believe me, we carry on hundreds and

1 hundreds of proposals a month that we apply to.
2 There aren't people that -- out there that are doing
3 that kind of generous gifts that are in their
4 ballpark. There are just not.
5 MR. BARLOW: And again, I know this is
6 not your expertise, but do you have any thoughts --
7 because I know you said if they could do more, they
8 should do more, to paraphrase. I don't know exactly
9 your words, but do you have any thoughts about, you
10 know, how they should determine the amount of giving
11 that they do?
12 MS. GOMEZ: I have to say that that's not
13 my expertise, but certainly, I can tell you that
14 their staff, whenever we have been in need, either
15 through money or through lending expertise of their
16 staff or their consultants or whatever to make sure
17 that the problem is resolved, to make sure that we
18 are whole. So how much, I can't tell you, but they
19 have never -- and this is one thing -- they have
20 never said to me, "I'm sorry to hear that this is
21 happening, but we can't do anything about it." It's
22 always, "Get back to you," and they're there for
23 you. So -- and it's not always about money. So
24 expertise and resources.
25 MR. BARLOW: So similar to Unity, you

1 get -- you get not only financial contributions, but
2 also expertise.
3 MS. GOMEZ: Expertise and knowledge. You
4 know, when it comes to, for instance, the shared
5 savings that we're all going to have to figure out,
6 you know. I mean, they've been very open and
7 saying, you know, right now we're busy with building
8 the health exchange, but when that's over, we'll be
9 there. So --
10 MR. BARLOW: And, Mr. Keane, I know -- I
11 know you have some experience with health insurers.
12 MR. KEANE: I was afraid you were going
13 to ask.
14 MR. BARLOW: So really -- I mean, again,
15 it sounds like you have been the recipient of
16 contributions from CareFirst over the years. And so
17 really, I have the same questions, I think, for you
18 as for Ms. Gomez. You obviously think they should
19 do that whether they have excess surplus or not.
20 And do you have any thoughts on how the level of
21 giving that they do should be determined?
22 MR. KEANE: And I would certainly respect
23 the decision of whoever makes the decision at
24 CareFirst. I think where we continual present to
25 them in the future as what are the needs, and some

1 have been articulated by folks to my left and by
2 Maria, and I presume they will be very responsive to
3 that.
4 Recently, one of my staff talked about
5 the specific issue regarding access to a handheld
6 medical record, iPhones or larger -- iPad type
7 things and, you know, they immediately jumped to
8 that, that's something we may be able to look at.
9 In the scheme of things, it's probably small, but
10 they are immediately willing to address those needs.
11 What that presented should be I do not
12 know. But as somebody who ran and as you know,
13 Mr. Barlow, didn't do very successfully in the end,
14 and Medicaid or the HMO, and one of the things that
15 caused our problem was risk-based capital. So I'm
16 not saying here what that should be.
17 Obviously, it was less with HealthRIGHT
18 than it was with CareFirst, but, you know, as a
19 person committed to the mission, I have to be also
20 committed to the business. And the business model
21 of health care today is becoming more challenging
22 even for safety net and federally-qualified health
23 centers.
24 So I respect that business challenge they
25 have, but I also respect and will continue to

1 encourage them, on the mission side, of improving,
2 which is really the job of all insurance carriers,
3 improving the health and building healthier
4 communities in our neighborhoods.
5 COMMISSIONER McPHERSON: Oh, I guess Phil
6 is through. He's looking at me.
7 MR. BARLOW: I ran out of people.
8 COMMISSIONER McPHERSON: Okay. Well,
9 thank you, panel. We appreciate your announcement.
10 Thank you for spending the day with us, for
11 listening and providing your feedback. And feel
12 free to respond to any additional questions that we
13 may have that we will present in writing. So thank
14 you.
15 MR. KEANE: Thank you very much.
16 MS. ARONSON: Thank you very much.
17 COMMISSIONER McPHERSON: I think at this
18 time, unless there is significant protest for a
19 break, that we will have closing statements by first
20 Appleseed. So this is your opportunity to wrap up
21 for the day.
22 MR. SMITH: All right.
23 COMMISSIONER McPHERSON: You may proceed.
24 MR. SMITH: All right. Thank you. So I
25 won't need 30 minutes. I'm going to be brief here.

1 It's already been a long day and you've already let
2 me talk a great deal.
3 COMMISSIONER McPHERSON: Yes.
4 MR. SMITH: Okay. First, let me tell you
5 this. I think the panel that you just heard from
6 illustrates a really important point for your
7 decision, Mr. Commissioner, and that is, that
8 CareFirst/GHMSI is doing things in the community
9 already. Not all of them premium reductions. They
10 are doing good things now. But I think this panel
11 also illustrates that the need for them to do more,
12 if they can, is quite large.
13 And it was that fact that led the council
14 to pass the statute which we call MIEEA in the first
15 place. It was because the council perceived that
16 this was a company that the council thought had
17 capability to do much more than it was doing. The
18 council saw the surplus of this company growing
19 significantly, but that its contributions to
20 community healthcare needs were not growing at the
21 same pace. And if you've seen the community print,
22 there were a lot of community healthcare needs that
23 the council was concerned about.
24 So they passed MIEEA. And MIEEA has
25 changed things dramatically with regard to how your

1 Agency should assess the surplus of this company.
2 And the ways it was approached before, which was
3 essentially let's calculate an optimal surplus that
4 will protect it against all the contingencies we can
5 think of, is no longer permissible. A new approach
6 is required under the statute, particularly now that
7 it's been interpreted by the Court of Appeals.
8 You have to take account of maximizing
9 community reinvestment and taking into account
10 whether the surplus itself is efficient. And I
11 won't go over that ground again, but in our view,
12 those are the two key things that you have to make
13 happen in this proceeding as a matter of law.
14 And if you do that, it's not going to be
15 a surprise to us that the reduction in surplus that
16 will result is significant. But the reason that is
17 so is that so many years have gone by when the
18 company has not been held accountable to the
19 standards that the council has not imposed. We are
20 now six years almost since MIEEA first was passed,
21 and to this day, GHMSI has not applied it.
22 So while the surplus reductions that we
23 have proposed pursuant to the law are large, they're
24 not a surprise to us. But implementing them, in our
25 view, would be a good thing because you're not going

1 to do it in a way that endangers the financial
2 soundness of the company, but you're going to do it
3 in a way that maximizes community reinvestment and
4 makes sure that the company is -- is defining its
5 surplus in an efficient way. And when you do that,
6 good things will happen.
7 Now, let me say one other thing. There's
8 been a good teal of talk about don't we need to
9 protect the company from the potential of losses or
10 a downturn and to be almost 100 percent sure that we
11 can afford that protection, even if there's only a 2
12 percent risk of a downturn. The more you insist on
13 a high confidence level and the more you insist on
14 protecting this company from remote contingencies,
15 the more you guarantee -- 100 percent guarantee that
16 you're not going to maximize dollars for community
17 reinvestment. That's the tradeoff that this statute
18 asked you to look at. And I think if and when you
19 do that, you will find that a significant reduction
20 in surplus can and should be made under the
21 requirements of this statute.
22 COMMISSIONER McPHERSON: Thank you.
23 Before you leave, I'm trying to think aloud as to my
24 closing question to you. So do you perceive the
25 community reinvestment mandate to be, if I may use

1 an analogy from a simple P&L -- a simple profit and
2 loss statement, would the community reinvestment be
3 almost like an expense that the company is required
4 to carry which affects its profit? Or does the
5 company at the end of the year -- say it makes
6 widgets. So do I calculate my profits on the sale
7 of my widgets and then if there's anything left, I
8 give to charitable causes or do I include in the
9 cost of making my widgets an assumption that 5
10 percent of the cost of my widget will go towards my
11 charitable causes? Does that help you understand
12 where I am in trying to understand how to apply --
13 MR. SMITH: It does. But I think the
14 analysis is different from that, Mr. Commissioner.
15 I think -- and Mr. Burrell, correct me if I'm
16 wrong -- I think that GHMSI is already making some
17 kind of calculation as to how much money it ought to
18 be committing to community reinvestment. And after
19 it does that, it has a certain -- he says over the
20 last five years, they had net income of 0.66, and I
21 assume they were making some estimates about how
22 much they could afford in community reinvestment and
23 still come out with some kind of small net income.
24 I assume it's that kind of calculation. That, to
25 me, is what's at play in your widget example.

1 I think what we're looking at here is
2 something very different. Wholly apart from
3 whatever they are committing on a year-by-year basis
4 because they think they can afford it with regard to
5 premium reduction or other kinds of community
6 reinvestment, what we're looking at here and what
7 the MIEEA statute was looking at is whether or not
8 this whole other pot of money over here on the side
9 called surplus is bigger than it should be and
10 should be spent down. We think it should be. But
11 that's a different calculation from an annual profit
12 and loss calculation, I believe. It's a whole other
13 analysis, which the actuarial experts have been
14 trying to engage in, that calculates what their RBC
15 needs to be. And once they know what their RBC
16 needs to be, they know how much surplus is
17 available.
18 So my answer to your question is some of
19 what you're talking about is involved in the annual
20 community reinvestment that I think they're doing,
21 but I think it's a different analysis from the one
22 you're now called upon to make under the MIEEA
23 statute.
24 COMMISSIONER McPHERSON: So -- and I
25 think I may have asked this question earlier. And

1 again, I'm going to try a different approach because
2 I'm really struggling with meeting the legal
3 standard.
4 MR. SMITH: Okay.
5 COMMISSIONER McPHERSON: So you are a new
6 company, a new nonprofit, and you're a health
7 insurer and you have the standard that you have to
8 do community reinvestment, and you have written your
9 first dollar of -- or you've collected your first
10 dollar of premium.
11 Do you immediately begin to undertake
12 your community reinvestment obligations once you
13 receive that first dollar of premium or do you wait
14 until the end of your first year of operations and
15 then you see if there's any surplus and then you
16 take a retroactive look and make a determination as
17 to your -- how to meet your community reinvestment
18 obligation?
19 MR. SMITH: Assuming the MIEEA statute
20 applies, did you ask that question?
21 COMMISSIONER McPHERSON: Yes. Yes,
22 uh-huh.
23 MR. SMITH: Well, I think that might be
24 harder for a company just starting, because
25 obviously, you want the company to meet all of the

1 requirements of MIEEA, the one you're thinking of,
2 and one of them is financial soundness. And I say
3 again, neither the council, nor we, nor anyone I
4 know of wants to urge that you to endanger the
5 financial soundness of the company. But a company
6 in year one might have a more difficult time --
7 because they have no surplus unlike this company.
8 They have no track record that lets them know what
9 to expect and how much they can afford.
10 So I think at year one, it would be
11 harder to figure out. But if MIEEA applied to them,
12 they would have to do the best they could to say
13 this is our plan for maximizing community
14 reinvestment.
15 But remember, we're looking at, I think,
16 in this proceeding the evaluation of a surplus
17 that's already been accumulated over many years and
18 determining whether or not that accumulated surplus
19 complies with the standard. I do think that's a
20 different analysis from the hypothetical you just --
21 both of the hypotheticals you just put. I think
22 it's different.
23 COMMISSIONER McPHERSON: I will concede
24 it's different, but to the extent that there are
25 charges against the surplus or the surplus is

1 reduced, how do you get back to where you need to be
2 for your -- to maintain your Prudential Standards
3 and still meet your community reinvestment? So I'm
4 not trying to think of this in a vacuum. I'm just
5 trying to think the present, the past, the future.
6 MR. SMITH: I hear you. Right. I will
7 still contend that the cases you're putting are
8 harder than the one you have here. This is a case
9 about a company with a long track record, with a
10 sizable surplus, that has been challenged over a
11 number of years, that has never been brought into
12 compliance with a set of standards that are legal
13 standards that have been interpreted by the Court of
14 Appeals.
15 And I do want to underscore, again, that
16 we think that if you're going to use the Milliman
17 model or some other comparable approach to determine
18 whether or not the company is in compliance with the
19 standards, the actuarial information you use itself
20 has to accord with those standards. And that brings
21 me back to the core point we've made today. We
22 don't think the actuarial reports that have been
23 presented to you in the past, including Rector's, as
24 presented, comply with the standards the court has
25 laid down.

1 COMMISSIONER McPHERSON: Okay. Well, I
2 want to thank you and your team for the work that
3 you've done today, for working with us over the past
4 year to get to where we are now. As I said -- Phil
5 is smiling, so that seems to be that you have a
6 question or two or a comment?
7 MR. BARLOW: Years.
8 COMMISSIONER McPHERSON: Speaking
9 personally. But thank you, Walter. Thank you to
10 Appleseed and to your team for the information that
11 you have provided. And I do look forward to working
12 with you and everyone here to hopefully figure this
13 out. So thank you again for your time today.
14 MR. SMITH: Thank you. Appreciate it.
15 COMMISSIONER McPHERSON: Okay. Without
16 further delay, we'll hear now from GHMSI. Thirty
17 minutes.
18 MR. BURRELL: We, too, will be brief.
19 There's a lot to respond to. I think the language
20 that we use is interesting. There's nothing, by the
21 way, that I get more pleasure from than actually
22 supporting the 300 nonprofit agencies that we
23 provide grants to. It's the single most pleasurable
24 part of my job. You heard from several.
25 The word "surplus" seems to carry with it

1 the meaning embedded within it that is close to
2 excess, that is, it's not needed, it is surplus, and
3 that what we have done is try to accumulate as much
4 as we can simply to accumulate it and to fail to use
5 it for legitimate needs in the community. And I
6 just want to be clear that "surplus" does not mean
7 automatically excess. And how would one look at --
8 I just want to read to you the language we have all
9 in a sense talked about today.
10 "A surplus cannot be excessive unless it
11 is both unreasonably large and inconsistent with the
12 corporation's obligation to engage in community
13 health reinvestment to the maximum feasible extent
14 consistent with financial soundness and efficiency."
15 What is financial soundness and
16 efficiency? How can you answer the question of what
17 is consistent with it if you cannot define it? So
18 analytically, what is that? And we have heard
19 testimony today, what we have had over a period of
20 years one actuarial analysis after another that has
21 looked at the surplus, both in the District and
22 outside the District, and concluded that it is not
23 excessive.
24 But the point I would make is this: To
25 be inconsistent with financial soundness and

1 efficiency would mean, I presume, that you'd have to
2 use that funding in a way that would make you less
3 sound and less efficient. If we were to give our
4 surplus to somebody or organization in the
5 community, however worthy that might be, that burden
6 is ultimately borne by the subscribers from whom the
7 surplus was, in fact, created. It is either their
8 premiums that created it, the amounts they paid us,
9 or the earnings off those premiums. Comes from no
10 other source.
11 So I go back to the point I started with
12 this morning. It is their money. It is for their
13 benefit. And the community health reinvestment
14 concept is -- is permitted under law to include
15 premium rate cuts or moderations for their benefit,
16 and solely that.
17 We cover tens of thousands, hundreds of
18 thousands of people in this community who struggle
19 to pay their premiums, as has been pointed out.
20 What is the good that is done by moderating those
21 premiums or cutting them has to be considered.
22 If -- I guess I would make the statement
23 as someone who has responsibility fiduciarily for
24 this company that I feel deeply a responsibility
25 that both you and I share, it is the duty of any

1 insurance regulator, and certainly true here, that
2 our premiums not be excessive so that people are
3 charged too much. Certainly, a 1 percent margin or
4 less over a multi-year period does not suggest we've
5 been charging too much.
6 It is also the duty to protect the
7 solvency and the soundness of the entity that
8 actually bears the risk on behalf of people who
9 can't bear that risk. To go to low levels of
10 confidence or to low levels of RBC would threaten
11 the financial soundness of the company and, I think,
12 fail to fulfill the fiduciary responsibilities we
13 have.
14 There are many, many problems that we see
15 in the actuarial analysis that was done. I don't
16 want to go into them all here, but we will comment
17 on them all. We have had -- the studies we have had
18 that have come from Rector this morning describing
19 that, in their view, financial efficiency and
20 soundness is best expressed as a targeted RBC number
21 with a range around it. Anything that takes us away
22 from that number, uses subscriber money in a
23 different way, gives it to some other organization
24 potentially makes it less sound and less efficient.
25 But let us take the case that excess were

1 found. What would happen? We would submit a plan
2 in such an event to cut premium; in other words, to
3 give that back to the people who paid the bill
4 because that's the place it came from. The only way
5 to take the surplus down, if you did that, is to
6 make the premiums less adequate, less than what it
7 actually cost to provide the service, produce a loss
8 and bleed it down. But it would be their money and
9 it would go back to their benefit. And that benefit
10 is the benefit of this community, the people who
11 work and live and receive coverage from us in this
12 community. If we did that, then the premiums would
13 have to come back to adequacy at some point.
14 I would argue to you two points about
15 efficiency. One aspect of efficiency would be not
16 to have subscribers experience cuts and then steep
17 increases to come back to adequacy. We've always,
18 as a long-term player, sought to keep stability as
19 much as possible. Not to accumulate excess, but to
20 keep stability.
21 The other aspect of efficiency is once
22 you lose it and your RBC goes down, do you have a
23 reasonable chance to get it back in the foreseeable
24 future? And I made the case earlier that what the
25 Affordable Care Act does is profoundly change the

1 landscape in that regard. There was an ability to
2 get it back in the past if you went too far; there's
3 much less of an ability to get it back now.
4 One other point. There were many factors
5 that were discussed regarding the actuarial
6 analysis, and the picture was conjured up that the
7 surplus level is calculated so conservatively that
8 it is principally seeking to protect against highly
9 unlikely events or a combination of events. But I
10 can tell you that the thing, as the CEO of the
11 company, that I worry about the most is two or three
12 things, and these were touched on.
13 One is that the rates turn out to be
14 wrong. Not because anybody sought to make them
15 wrong, but because it is impossible to know what the
16 future looks like. All the rules have changed and
17 the people that are coming into the products, we
18 think, have more adverse risk than the people who
19 have been in the products that we sell. How much
20 sicker, how much poorer, how much needier are they?
21 Could you get that 1 percent wrong, 2 percent wrong,
22 5 percent wrong even though you made your best
23 effort? You probably could.
24 I believe you could get it 20 percent
25 wrong. Each error of 1 percent for us on our scale

1 is $40 million. That's one thing I worry about a
2 lot; rate error. And I would add to that that what
3 the Affordable Care Act does is make us propose
4 rates way in advance of when it is they're
5 effective. So you're projecting way out into the
6 future. Fifteen rates are filed now on which we
7 have scanty information. We're making projections.
8 It's easy to be wrong.
9 The other thing that I worry about is
10 that rates that are proposed that are needed are not
11 approved. They're only partially approved because
12 there is undeniable pressure, I think, envisioned in
13 the Affordable Care Act to hold rates down. But the
14 thing that drives the rates the most is the
15 experience of the people who come into the pool
16 which we're now just seeing. I worry about that.
17 I also worry about radical changes in the
18 financial markets that would affect the yield on the
19 portfolio that we have. The dollars that are earned
20 on that go to the benefit of subscribers today.
21 It's a lot of worry with the world turmoil, with the
22 financial roiling in markets and the slowness of
23 economic recovery that markets could change on us
24 dramatically. These are not farfetched. These are
25 not remote possibilities. These are concrete things

1 that have reasonable likelihood of occurring.
2 What the surplus calculation does is try
3 to take those and other things that are more remote
4 and in combination into effect, not with 100 percent
5 guarantee, but in this case with a 98 percent
6 confidence level that you don't fall so low that, in
7 effect, you're taken off the playing field.
8 If we were 5 percent wrong on rates
9 simply by error, we could lose $200 million a year
10 and we could be a lot more wrong than that because
11 no one has any experience with the pool that is now
12 emerging.
13 So in the analogy that I used at the
14 beginning, you can't stand as a layperson or as my
15 neighbor or as some other person and look at a
16 bridge and say I understand the stresses that are on
17 it and I conclude that it is satisfactory, that it
18 will bear the weight under all circumstances. A
19 complex problem to actually work that all out. I
20 myself wouldn't presume that I have the knowledge,
21 even though I've been 30 years in the business, to
22 fully understand that myself.
23 The models that have been developed are
24 the equivalent of the complex engineering that goes
25 into determining the stress on a bridge. We have

1 now nine studies that have largely overlapped. The
2 way we view the law is that the first thing you do
3 is you look at whether or not you understand what
4 financial efficiency and soundness really means
5 before you can determine whether you're consistent
6 or inconsistent with it, and then you determine
7 whether or not the amount of community health
8 reinvestment you've made is consistent with it, that
9 you don't take yourself away from financial
10 soundness or efficiency by the actions you take on
11 community health reinvestment.
12 We believe what the court said is you
13 cannot come to a final conclusion unless you
14 consider both of those things. You cannot consider
15 simply the one. We agree with that. We think
16 that's the right understanding and that's the right
17 balance.
18 As I said, we think there were many
19 things said that were erroneous characterizations of
20 the actuarial work that was done and even though our
21 administrative expense and a series of other things.
22 We will respond to that in our subsequent filings.
23 The points that I just made from a person
24 who sits in the seat of responsibility, fiduciary
25 responsibility for the company and its subscribers,

1 and I think more of the subscribers than I think of
2 the company, the duty is really to them and it is
3 their money, less about us. And are we adequate to
4 serve them and to be there for them in their need,
5 or have we given their money away? And in the
6 process, have we taxed them in effect to support
7 that when, in fact, they paid their premiums
8 believing that the amount of payment to us was for
9 their benefit and to cover their costs.
10 And I would argue to you that that is the
11 highest order of giving that we could give. And
12 that secondarily, you would give to worthy causes in
13 the community without undue burden on subscribers
14 and without destroying or moving away from financial
15 soundness and efficiency, without causing dramatic
16 rate fluctuations in the market that would also
17 damage individuals if that were to happen and small
18 groups, in particular, who are the sources of the
19 surplus.
20 So with that I would conclude my remarks,
21 Mr. Commissioner.
22 COMMISSIONER McPHERSON: Thank you, sir.
23 Phil, do you have any questions?
24 MR. BARLOW: (Shaking head side to side.)
25 COMMISSIONER McPHERSON: Mr. Shaw made a

1 comment earlier, and so to the extent that you are
2 able to answer this question -- or maybe you would
3 have to supplement afterwards. But are you able to
4 say on the average what percent of your existing
5 surplus is attributable to your investment yield
6 and/or the capital gains growth of your portfolio?
7 MR. BURRELL: Hard for me to say that off
8 the top of my head. We certainly can get back to
9 you on that. But I would say that given the ups and
10 the downs in the underwriting cycle, we have been in
11 operating losses over the last several years, we've
12 had gains before that. That may very well net out
13 very close to zero. So any gains we would have
14 would come from investment income in light of that.
15 To the extent that you take down surplus,
16 you take down the very base of that investment
17 yield. Less money to invest. And there's less
18 there for contribution to the benefit of the
19 subscribers. But we can get that number and we
20 certainly will.
21 COMMISSIONER McPHERSON: Okay. And
22 again, being not an actuary, I'm not quite sure if
23 I've exactly stated in the question form the issue
24 he presented, but I glean that based on the model
25 that he ran, he was under the impression that there

1 is a much more significant portion or a significant
2 portion of the surplus is probably attributable to
3 your -- the success of your investments rather than
4 the accumulation to the small increments of your
5 margin over the years.
6 MR. BURRELL: Obviously, if you lose
7 three years in a row and you gain three years in a
8 row operationally from underwriting and you net out
9 at close to zero, the only other place to get income
10 from is from your investments. And that's been the
11 pattern. Those investment yields, which we pointed
12 out were by law required on very conservative
13 investments, fixed income and so on, all go to the
14 benefit of the subscribers. Were it not for the
15 fact that we had those yields, we would need more
16 premium income. We're glad that we don't. And so
17 the yield offsets that need for premium.
18 COMMISSIONER McPHERSON: You have also
19 mentioned the number of reviews that your surplus
20 has been subjected to over the years, and I want to,
21 you know, indicate that that may have been a good
22 thing and that probably is a good thing, but I think
23 we also have to acknowledge that we'd only gotten
24 legal clarity in 2012 from the DC Court of Appeals
25 as to how to apply the legal standard.

1 And so with that new information, it may
2 be worth considering, you know, have you really
3 taken those factors into consideration in our
4 current process of the analysis that we're
5 subjecting the surplus review to. So I just want to
6 indicate that we may have to, you know, look at this
7 from a new perspective, at least from a perspective
8 of the court's decision in 2012.
9 MR. BURRELL: I certainly think the court
10 said clearly you need to consider community health
11 reinvestment and financial efficiency and soundness
12 in tandem. That seems clear.
13 COMMISSIONER McPHERSON: Okay.
14 MR. BURRELL: But what is the measure of
15 financial soundness and efficiency? Where do you
16 start? What is that? How do you know you're
17 consistent with it or inconsistent with it if you
18 can't define the "it"? And we believe that what
19 Rector and others have done is describe the "it."
20 And then the question is with community
21 health reinvestment, does it take you away from
22 that, make you less consistent, less sound or more
23 so? And that question has to be answered, and they
24 have to be answered together because you couldn't
25 come to a final conclusion unless you answered both.

1 That's the way I think we see that. I think that's
2 what the court asked to be done.
3 COMMISSIONER McPHERSON: Okay. And I'm
4 not sure if this is a question, a commentary or a
5 hybrid, but I will say that I do applaud the fact
6 that you are currently engaged in community
7 reinvestment as demonstrated by the panel that we
8 heard from earlier. And, you know, I don't believe
9 that there is a criticism that GHMSI currently
10 engages in community reinvestment. I think that
11 that's appreciated. I think the issue really is are
12 you doing as much as you could subject to the
13 Prudential Standards of safety and soundness. So
14 again, question, commentary, feel free to comment if
15 you wish.
16 MR. BURRELL: I would agree with what you
17 just said. That is the question. I would urge that
18 you consider that part of the answer, perhaps all of
19 the answer to that question, is what is done to
20 benefit the subscribers who pay the premium to begin
21 with. If we could reduce premium $5 for 100,000
22 subscribers because that's what we used for
23 community health reinvestment, which is completely
24 contemplated and permitted and allowed under the
25 law, I can tell you the subscribers would hope we

1 would do that.
2 Or should we take that money and not do
3 that, make them pay higher and go give it to
4 somebody else who undoubtedly has a need. There is
5 insatiable need, unlimited need that we give as far
6 as we can. But I would argue to you that the higher
7 order need is for the subscriber to feel that we're
8 doing everything we can to control the cost of their
9 premium. And so which is the higher order for
10 community health reinvestment? Helping them to
11 stabilize or reduce their premium, if we could knock
12 it down $1, $5, $10, or give it to some organization
13 where you can't do that because you gave it to
14 somebody else.
15 Any subscriber of ours would say, "Apply
16 it to me. I'm the one that's paying the bill. And
17 by the way, I'm having a real hard time paying the
18 bill because it's so high." We're very, very
19 sensitive to that. And so when we look at community
20 health reinvestment, that is what we have in mind.
21 And how many people is that? 784,000. How many
22 people can we touch in community health reinvestment
23 despite the tens of millions we give? Not 784,000.
24 And so the focus we have, and we think it
25 is directly contemplated and permitted in the law

1 and has been the subject of one commissioner's
2 ruling after another if you go all the way back a
3 decade, you will see that the statement was made
4 that it is not only permissible, but totally
5 appropriate to use surplus to help stabilize or
6 reduce premium and certainly allow that first and
7 foremost to benefit the people who paid the premium.
8 We feel that accountability deeply.
9 And these people are the backbone of this
10 community in every business, in every walk of life,
11 in every small and large employer. What about their
12 needs and what about what they pay? And why
13 wouldn't surplus be used first and foremost for that
14 before we said we'll take your money and go give it
15 to somebody else? Why? And that's the question we
16 think that's most central. And if we gave it to
17 somebody else, do we become less sound? And if we
18 became less sound, how would we have to correct
19 that? We have only one way, which is to increase
20 the premium. On who? The subscriber, who can't pay
21 it as it is. Should we do that?
22 When we say we give $60 million or $50
23 million or $40 million, we take their money. By
24 right, they had the expectation that it would go to
25 their benefit. And you said, well, we're not going

1 to give it for your benefit, we're going to give it
2 for somebody else's benefit. You bear the burden.
3 And if that means we have to add 2 to 5 percent in
4 the rate, we'll have to add it. We have no other
5 way to get the money. And then if we cut down our
6 investment portfolio because we bleed it out that
7 way, then there's less income on that to go to their
8 benefit as well. And you get into this vicious
9 downward spiral.
10 And so when we talk about confidence
11 levels being too low and taking risks of the type
12 that have been described in disregard of what nine
13 actuarial studies have shown all around a central
14 tendency and say, well, don't -- that doesn't fully
15 apply anymore. If we get into a downward spiral, we
16 don't have to wait till we get to 200 percent RBC.
17 The market will be reacting way before that.
18 COMMISSIONER McPHERSON: Well, I don't
19 think Mr. Barlow will allow you to get to 200 RBC.
20 Any final comments? Any final questions?
21 (No response.)
22 COMMISSIONER McPHERSON: Okay. Hearing
23 none, before I read any concluding remarks,
24 Mr. Burrell and your team, I'd like to thank you
25 very much for being here today, for working with the

1 Agency as we worked through this, for working with
2 Appleseed, for working with Rector, and for your
3 willingness to continue to work with us as we try to
4 honor our statutory obligation, which is to
5 hopefully bring some acceptable resolution to this
6 issue, which I'm hoping will not result in another
7 protracted set of legal discourses to even further
8 delay us resolving the issue. So that, too, I guess
9 can be somewhat circular.
10 Anyway, I'm going to get back on script
11 before I get into any further trouble. So if there
12 are no further questions, this will conclude our
13 formal hearing proceedings today. I want to thank
14 everyone who participated today, in particular, the
15 Department would like to acknowledge GHMSI and DC
16 Appleseed. We are aware that you have given much
17 time and much effort to developing the information
18 and arguments that were set forth in your written
19 submissions and presented today. We appreciate your
20 contributions to the hearing and examining so many
21 complex questions. So thank you once again.
22 As I stated this morning, we will place a
23 complete transcript of this hearing on our website
24 once it is available. All of the testimony that was
25 received today will also be posted to our website.

1 Our website is disb.dc.gov.
2 The regulations state that the hearing
3 record must remain open for at least seven days
4 after the hearing. Given the upcoming Fourth of
5 July holiday, the record will be closed on July 1st.
6 No, that's a joke. That's a joke. That's a joke.
7 I just could not resist. It's not in the script. I
8 just wanted to see the look on your faces.
9 Given the upcoming Fourth of July holiday
10 and the complexity of the matters involved, as well
11 as the fact that I may need to ask follow-up
12 questions to one or more of the presenters today, I
13 will leave the record open for at least 60 days, but
14 the precise deadlines will be in the scheduling
15 order that I will issue after the hearing. Anyone
16 wishing to submit written testimony or rebuttal
17 statement may do so in writing on or before the
18 deadline listed in the scheduling order.
19 After the record is closed and after
20 review and analysis of all the submissions in the
21 entire record, I will make a final written
22 determination as to whether GHMSI's surplus
23 attributable to the District is excessive, including
24 whether GHMSI is in compliance with its community
25 health reinvestment obligations within the meaning

1 of the applicable laws and regulations. I will make
2 a determination as soon as reasonably possible in
3 light of the already large record and the complexity
4 of the issues presented.
5 If I determine the surplus is not
6 excessive, then this surplus review will be
7 concluded. If I determine the surplus is excessive,
8 then the next step under the law is for GHMSI to
9 submit to the Department a plan for dedication of
10 the excess to community health reinvestment in a
11 fair and equitable manner.
12 If there are no further issues, this will
13 formally adjourn our hearing. The time is 5:35 p.m.
14 on the day we started, June 25, 2014. Thank you for
15 your time. The record remains open subject to the
16 scheduling order.
17 (Whereupon, the proceedings were
18 adjourned ended at 5:36 p.m.)
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1 CERTIFICATE OF SHORTHAND REPORTER - NOTARY PUBLIC
2 I, Rebecca L. Stonerock, Registered Professional
3 Reporter, the officer before whom the foregoing
4 proceedings were taken, do hereby certify that the
5 foregoing transcript is a true and correct record of
6 the proceedings; that said proceedings were taken by
7 me stenographically and thereafter reduced to
8 typewriting under my supervision; and that I am
9 neither counsel for, related to, nor employed by any
10 of the parties to this case and have no interest,
11 financial or otherwise, in its outcome.
12 IN WITNESS WHEREOF, I have hereunto set my hand
13 and affixed my notarial seal this 2nd day of
14 July, 2014.
15 My commission expires:
16 October 14, 2017
17
18
19 ________________________
20 NOTARY PUBLIC IN AND FOR
21 THE District OF COLUMBIA
22
23
24
25

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& 2:12,14,15,22 5:7 5:8 10:9 12:18 13:14 61:3 137:4,14 179:6 181:2 199:13

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