Hogan Lovells US LLP
Columbia Square
555 Thirteenth Street, NW
Washington, DC 20004
T +1 202 637 5600
F +1 202 637 5910
www.hoganlovells.com

September 5, 2014

Adam Levi
Assistant General Counsel
District of Columbia Department of Insurance, Securities, and Banking
810 First Street, N.E. Suite 710
Washington, DC 20002

Re: GHMSI Responses to DISB's Third Scheduling Order

Dear Mr. Levi:

Enclosed please find GHMSI's responses to Questions 2-13 and a partial response to Question 15 raised in DISB's Third Scheduling Order. In accordance with GHMSI's request dated August 19, 2014, which request was granted, GHMSI will address Questions 1 and 14-15 in its October 1 and October 17 briefs, respectively.

GHMSI and the Blue Cross Blue Shield Association request that Attachments B and C be treated as confidential and not be posted on the website or otherwise shared.

Sincerely,

/s/ E. Desmond Hogan

E. Desmond Hogan

Partner
desmond.hogan@hoganlovells.com
D 202-637-5493

GROUP HOSPITALIZATION AND MEDICAL SERVICES, INC.'S
RESPONSES TO QUESTIONS IN THE THIRD SCHEDULING ORDER

Group Hospitalization and Medical Services, Inc. ("GHMSI" or the "Company") respectfully submits these responses to the questions posed to GHMSI by the Department of Insurance, Securities, and Banking ("DISB") in its Third Scheduling Order.

Introduction

As GHMSI will more fully address in its October 17 post-hearing brief, the statutory interpretations offered by D.C. Appleseed ("Appleseed") are inconsistent with the text, history, and intent of the Medical Insurance Empowerment Amendment Act ("MIEAA"). The MIEAA was never intended to require GHMSI to maintain surplus below an actuarially sound level, and Appleseed's focus on how much surplus could be "extracted" from GHMSI is inappropriate.

The Scope of DISB's Review. Section 31-3506, where the MIEAA is codified, does not authorize DISB to set a hard-and-fast dollar figure for GHMSI's community giving, as Appleseed has suggested. Nor does it authorize DISB to somehow "balance" GHMSI's community giving against its surplus level. "Community reinvestment," as referenced in the statute, and community giving are not the same. Under the MIEAA, "community reinvestment" includes rate moderation, and GHMSI meets this requirement by maintaining lower rates, to the extent feasible. GHMSI fully *reinvests* in the community when it keeps an actuarially sound level of surplus, but no more – because that means that GHMSI is maintaining low rates to the extent that it can do so without jeopardizing its financial soundness. GHMSI also engages in significant community *giving* as part of its non-profit mission, but it cannot be forgotten that it is GHMSI members and policyholders who must fund that giving.

The MIEAA instead requires a narrower and more technical focus for this proceeding: The Commissioner must look backward to determine whether GHMSI's surplus was "excessive"

at a specific point in time - year-end 2011. *Id.* § 31-3506(e). If GHMSI's surplus was not excessive at that time, this proceeding is at an end. *See id.* If the surplus was excessive, the Commissioner must determine what portion of that surplus is attributable to the District of Columbia, the Commissioner must confer with Maryland and Virginia, and GHMSI would develop a plan to address any excess surplus attributable to the District. *Id.* § 31-3506(e) & (g). The MIEAA is very clear that GHMSI's plan may consist entirely of rate moderation benefiting GHMSI's subscribers. *Id.* § 31-3506(g)(2).

MIEAA's Statutory Test. The excessiveness inquiry is straightforward and less complicated than Appleseed wishes it to appear. Under the MIEAA, GHMSI's surplus can only be excessive if it is both unreasonably large and GHMSI does not "engage in community health reinvestment to the maximum feasible extent consistent with financial soundness and efficiency." D.C. Code §§ 31-3506(e), 31-3505.01. As the Court of Appeals explained, GHMSI should moderate rates or otherwise engage in community reinvestment only to the extent that it can do so "*without undermining*" its financial soundness or efficiency. *D.C. Appleseed Ctr. For Law & Justice, Inc. v. DISB*, 54 A.3d 1188, 1214 (D.C. 2012) (emphasis added). Thus under the MIEAA, GHMSI must retain enough surplus to be sound (i.e., not create an unreasonable risk of insolvency) and efficient (i.e., not set subscribers up for future unnecessary costs and rate fluctuations). GHMSI has met that obligation when it maintains its surplus at or below the target produced by a fair, unbiased actuarial analysis conducted using sophisticated actuarial models – the same methods that have been used to gauge an insurer's financial soundness both before the MIEAA and since, in this jurisdiction and elsewhere.

Throughout this review process, both in meetings and in formal letters to the Commissioner or Rector, Appleseed appeared to agree with this commonsense reading of the

MIEAA and expressly agreed with Rector's development of a fair actuarial analysis utilizing a 98% confidence level (i.e. development of a level of surplus at which DISB could be 98% confident that surplus would not fall to the 200% RBC-ACL level within three years).[1] However, once it became clear that this fair and unbiased analysis was going to support GHMSI's current surplus level, Appleseed changed its tune. Now, Appleseed asks the Commissioner to apply the MIEAA in ways that are inconsistent with the text of the statute, the Court of Appeals decision, and the legislative history.

For example, Appleseed argues that the word "efficiency" in the MIEAA operates as a limit on GHMSI's surplus. Although this is a new argument for Appleseed (which it did not make in the earlier surplus proceedings or before the Court of Appeals), it was a major driver of Appleseed's pre-hearing brief and presentation at the hearing. Appleseed is simply incorrect—indeed, it has things exactly backwards. The MIEAA uses the term "efficiency" to limit the amount of *community reinvestment* in which GHMSI may engage, not its surplus: "A corporation shall engage in *community health reinvestment* to the maximum feasible extent consistent with financial soundness *and efficiency*." *See* D.C. Code § 31-3505.01 (emphases added). Under the MIEAA, GHMSI cannot be required to engage in any additional community reinvestment (whether giving or rate moderation), if it would make GHMSI less efficient to do so. The Court of Appeals recognized this, concluding that the D.C. Council's "twin objectives" in drafting the MIEAA were "(1) obligating GHMSI to reinvest in community health "to the maximum feasible extent," (2) *without undermining GHMSI's* 'financial soundness and

[1] For example, on January 18, 2013, Appleseed wrote, "[t]here appears to be agreement that the primary element the model should measure is the amount of GHMSI surplus needed to avoid falling below 200% RBC/ACL with 98% confidence." *See* Letter of January 18, 2013 from Appleseed to S. Schroeder, available at http://disb.dc.gov/sites/default/files/dc/sites/disb/publication/attachments/11813DCACLettertoDISB.pdf. There are three other letters on the DISB website from Appleseed or its actuary to the same effect.

efficiency.'" D.C. Appleseed, 54 A.3d at 1214 (emphases added). The legislative history similarly confirms that "efficiency," like "soundness," is a cap on the Company's reinvestment obligation, not a further downward driver on its surplus. *See, e.g.*, D.C. Council Report at 13. In trying to use the concept of "efficiency" to drive GHMSI's surplus down, Appleseed turns the MIEAA on its head.

Appleseed also misleads when it contends that the MIEAA "was passed because the Council thought GHMSI's surplus was *already too high*," Appleseed Report at iii, or because the D.C. Council "perceived that this was a company that the council thought had capability to do much more than it was doing," Tr. 282:13-17 (Testimony of W. Smith). In fact, the legislative history shows the opposite. In deliberations over the MIEAA, Council members repeatedly emphasized that they had *not* concluded that GHMSI's surplus was too high, but instead that it was an issue that should be regularly examined with the assistance of responsible experts. *See* Public Hearing on Bill 17-934, Medical Insurance Empowerment Act of 2008, Oct. 10, 2008, at 12:9-15; *id.* at 102:8-11. D.C. Council members also made clear that their foremost priority was to ensure that GHMSI remained strong and sound, and that the MIEAA should never be read to undermine those goals. *See* D.C. Council Report at 13; Public Hearing at 158:8-12; *id.* at 39:13-20; *id.* at 11:14-19; *id.* at 37:10-16; *id.* at 193:20-22.

GHMSI will further address the statute and Appleseed's misinterpretations in its October 17 brief. The answers below, however, should be addressed by DISB in the correct context, and without Appleseed's repeated misrepresentations and misconstructions of the MIEAA.

Answers to Questions in Third Scheduling Order

Question 1 - Please provide your recommendations regarding how the Commissioner should determine the amount of GHMSI's surplus that is attributable to the District in accordance with 26A DCMR § 4699.2.

In accordance with GHMSI's request dated August 19, 2014, which request was granted by DISB, GHMSI will address apportionment of surplus in its October 1, 2014 brief.

Question 2 - Please address if and how post-2011 results should be factored into the review of GHMSI's 2011 surplus.

Consistent with D.C. Code § 31-3506, DISB is conducting this review to determine whether GHMSI's year-end 2011 surplus was excessive at that time. As a practical matter, DISB can only determine the adequacy of surplus at a given point in time and DISB must, therefore, assess the risks and potential financial and market scenarios faced by GHMSI as of December 31, 2011. To the extent that Appleseed has argued that the 2011 surplus is excessive because catastrophic events or other risks did not occur in 2012 and 2013, Appleseed is wrong. GHMSI would have been required in 2011 to account and to prepare for many risks that did not in fact occur, just as GHMSI today must continue to prepare for contingencies and adverse events that, hopefully, will not arise. The actual post-2011 results are only one of many possible scenarios, and the Commissioner's review should not discount the significance of the full range of potential risks faced by GHMSI. In this sense, therefore, post-2011 financial results are not directly relevant to the key questions before the DISB.

At the same time, however, post-2011 events and results do have some indirect relevance to the Commissioner's analysis. First, when GHMSI's expert actuaries recommended a surplus range, in 2011, that would adequately protect GHMSI's subscribers, the actuaries incorporated some of the risks associated with the then brand-new implementation of the Affordable Care Act ("ACA"), as those risks were understood at the time. Experience under the ACA thus far

demonstrates that the concerns of the GHMSI's actuarial experts were well-founded—GHMSI suffered significant underwriting losses in 2012 and 2013, and is projected to lose money in 2014, even after including GHMSI's 50% ownership interest in CareFirst BlueChoice ("BlueChoice"). *See* GHMSI's Answer to Question No. 5, below. And despite these facts, GHMSI's requested individual market rate increases for 2015 were cut nearly in half in the District and Maryland. The Commissioner can certainly consider the actual implementation of the ACA and its attendant risks when assessing GHMSI's surplus.

Second, if the Commissioner were to determine that GHMSI's surplus was "excessive" in 2011, D.C. Code § 31-3506(e), that does not mean there is "excess" now, *id.* § 31-3506(g)(1). GHMSI's current surplus ratio of 932% RBC-ACL at year-end 2013 is lower than its 2011 year-end ratio of 998% RBC-ACL, and GHMSI continues to face significant market and ACA implementation risks. GHMSI's current surplus and the risks currently facing the company would be central in assessing whether there is, in fact, any "excess" surplus left today that would be subject to a plan under Section 31-3506(g)(1). Thus, even if the Commissioner were to determine that GHMSI's surplus was excessive in 2011, which it was not, the Commissioner would have ample discretion to determine that further reductions in surplus would be inappropriate.

<u>Question 3</u> - Please explain with specificity the consequence to GHMSI as a Blue Cross Blue Shield Association licensee if its surplus falls below either 200% RBC-ACL or 375% RBC-ACL, distinguishing in each case between discretionary and mandatory actions on the part of the Association. In particular (but without limiting the scope of the foregoing question):

a) Does a surplus below 200% RBC-ACL result in automatic loss of GHMSI's license to use BCBS trademarks or does the Association have discretion to revoke the license?

b) Please provide the written terms of your license for the BCBS trademarks and any materials relating to the Association's right to revoke the license, place

GHMSI under financial scrutiny or take any other actions due to the financial status of GHMSI, including any guidelines the Association would apply in determining whether to take such actions.

Applicable Terms Of The Controlled Affiliate License Agreements. The relationship between GHMSI and the Blue Cross and Blue Shield Association ("the Association") is governed by two Controlled Affiliate License Agreements between GHMSI and the Association, one for the Blue Cross Name and Mark and one for the Blue Shield Name and Mark (collectively "the License Agreements"), and the Brand Regulations, Standards, Guidelines, and Protocols promulgated by the Association in order to enforce the License Agreements. Copies of the Controlled Affiliate License Agreements are attached at **Attachment A**.[2]

Among other requirements, the License Agreements require GHMSI to meet performance standards set by the Association. The relevant standards include Standard 6(H), which states that "[a] Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers"; Standard 6(D), which requires GHMSI to "ensure its financial performance in programs and contracts of an inter-licensee nature"; Standard 6(I), which requires GHMSI to file required reports with the Association; and Standard 8, which requires GHMSI to follow the Association's "Performance Response Process Protocol" when "addressing Controlled Affiliate compliance problems identified hereunder." These standards form the contractual basis for the Association's monitoring of Plan surplus levels, and its imposition of protocols, action plans, and ultimately termination for a Plan that does not meet them.

[2] In addition, CareFirst, Inc. has entered into two master license agreements with the Association, with additional terms that CareFirst and its affiliates must meet. GHMSI's Controlled Affiliate agreements are subject to the master agreements between the Association and CareFirst, Inc., but the capital and reserves requirements discussed in response to this question are imposed directly upon GHMSI under the terms of the Controlled Affiliate License Agreements.

If GHMSI fails to comply with these standards, it is subject to license termination under Paragraph 7 of each agreement, upon a vote by the Association's Board of Directors. Paragraph 7(C) provides for termination of GHMSI's license if it cannot meet the minimum capital and liquidity requirements imposed by the Association:

> Notwithstanding any other provision of this Agreement, this license to use the Licensed Marks and Name may be forthwith terminated by the Plan or the affirmative vote of the majority of the Board of Directors of BCBSA present and voting at a special meeting expressly called by BCBSA for the purpose on ten (10) days written notice to the Plan advising of the specific matters at issue and granting the Plan an opportunity to be heard and to present its response to the Board for: (1) failure to comply with any applicable minimum capital or liquidity requirement under the quality control standards of this Agreement; or; (2) "impending financial insolvency…."

Paragraph 7(D) applies if GHMSI fails to comply with any other of the Association's requirements relating to capital and surplus except for the minimum capital or liquidity requirement as described above. In addition, paragraph 7(E) provides for automatic termination under certain circumstances such as the primary licensee no longer having control over the licensed affiliate, a bankruptcy filing, or various other matters. Paragraph 7(D) allows termination, upon a vote of the Association's Board of Directors, if a Controlled Affiliate breaches any of the provisions of the license agreements and fails to cure the breach within 30 days of receiving notice of non-compliance.

The Association's RBC Thresholds. The Association has adopted three relevant RBC levels for purposes of meeting Standards 6(H) and 6(D), and implementing the Plan Performance Response Process (PPRP) Protocol:

- ***The Early Warning Stage – 375% RBC-ACL.*** A Plan with surplus below 375% RBC-ACL falls below the early warning threshold and is subject to the PPRP. At this stage, the Association imposes additional reporting requirements to the Association and other procedures on a Plan, which are more fully set out in **Attachment B.** The administrative expense burden to comply with these additional procedures may be significant.

In addition to reporting to the Association, the Plan must make extensive disclosures of its financial condition to all providers and to group and individual policyholders. A Plan that is subject to the PPRP for financial reasons must distribute a disclosure brochure to all providers, accounts, and direct pay subscribers that informs those individuals about the Plan's role as a licensee within the Blue Cross and Shield System and that informs them of the Plan's financial condition. This disclosure must be made before entering into a new contract with a provider, group or individual policyholder. Competitors, brokers, and potential customers would be well aware of GHMSI's financial problems.

- ***Concern Stage – 300% RBC-ACL.*** A Plan with surplus below 300% RBC-ACL or less than 1.5 months of liquidity moves to the Concern Stage of the PPRP. A Plan would be required to provide letters of credit or financial guarantees in order to remain active in Blue programs, such as Blue Card, to ensure that members' out-of-area claims are paid.

- ***Plan minimum surplus – 200% RBC ACL.*** The BCBSA licensure minimum is 200% RBC-ACL. Under the PPRP, a Plan that falls below 200% RBC-ACL is out of compliance with Standard 6(H) and subject to termination under Paragraph 7(C) of the License Agreements.

Attachment B to these Answers sets forth additional detail regarding the procedures followed by the Association at each level. The Association and GHMSI request confidential treatment for Attachment B.

Consequences of Termination of the License. If the Blue Cross Blue Shield licenses for GHMSI were terminated, and if as a result CareFirst did not have a controlled affiliate to operate as the Blue licensee in GHMSI's vacated Blue service area, the Association would also terminate CareFirst's license rights in GHMSI's Blue service area. The Association would then select a new Blue licensee for the vacated Blue service area. The impacts to GHMSI from termination of its license would include a significant loss of membership that would make GHMSI non-viable:

- **BCBS Federal Employee Program**: GHMSI has approximately 365,000 members through the Association's Federal Employee Program ("FEP"), which is discussed in greater detail in response to Question 9. Those members, which represent 33% of GHMSI's

total enrollment, would be allocated to the new Blue Licensee as the Par Plan for FEP in the service area.

- **National Accounts**: GHMSI has approximately 290,000 National Account members, representing 26% of its total enrollment. Most of this business would transfer to the new Blue Licensee in the service area or other Blue Licensees in other states.

- **Member Access to Blue System Services**: All 1.1 million GHMSI members would lose access to more than ½ million participating providers in Blue Cross and/or Blue Shield networks worldwide, which provide members with "hold harmless" protection and ability to obtain services without up-front payments; Away From Home Care for retirees, students and others; and Blue Distinction Centers for Transplants.

The Association Has Acted In The Past To Enforce Its Licensure Requirements. While Appleseed has posited that the Association would not terminate the license of a carrier that falls below 200% RBC-ACL, that suggestion has no basis whatsoever. Certainly, Appleseed has put nothing in the record to support its claim, and the Association itself indicates the opposite. In a letter filed in this proceeding, Association President and CEO Scott Serota states that "[i]f a Plan's HRBC ratio were to fall below 200 percent, BCBSA's Board of Directors (composed of the CEOs of all 37 Plans and BCBSA) would immediately commence actions to terminate that company's license to use the Blue Brands," and that the BCBSA's goal "to ensure that its Brands carry a clear connotation of financial strength and brand integrity . . . would be compromised if a BCBSA-licensed company's capital level were to fall below the NAIC's Company Action Level." *Letter to Hon. Chester A. McPherson from Scott P. Serota of June 24, 2014.*

The Association has acted forcefully in the past to enforce its brand standards and financial requirements. For example, in 2003, after Maryland enacted reform legislation that

applied to GHMSI and other CareFirst affiliates, the Association deemed the licenses to have been automatically terminated. On May 21, 2003, the Association filed suit in the United States District Court for the Northern District of Illinois, seeking a permanent injunction that would have prohibited GMHSI and other CareFirst affiliates from using the Blue Cross, the Blue Shield, the name "CareFirst" and any other marks that have been associated with the Blue brands. *See* Complaint filed May 21, 2003 in *Blue Cross and Blue Shield Association v. CareFirst, Inc., et al.*, Case No. 1:03-cv-03422 (N.D. Ill.). That suit was only withdrawn after the State of Maryland made significant concessions regarding how its legislation would be applied.

Question 4 - Beyond GHMSI's own surplus, to what resources does GHMSI have access to protect against insolvency?

GHMSI's surplus is, by far, its most significant resource. GHMSI cannot issue stock, and it is unlikely that GHMSI would be able to borrow if it were already in financial trouble.

In theory, GHMSI potentially could receive assistance from CareFirst of Maryland, Inc. (CFMI) under the terms of the filed and approved Fourth Intercompany Agreement. However, it is likely that if GHMSI were in extreme financial difficulty, CFMI and CareFirst BlueChoice (BlueChoice) would be in similar straits. Further, any transfers of assets to GHMSI from another CareFirst affiliate would require approval by the Maryland and DC Insurance Commissioners. It is unlikely that the Maryland Insurance Commissioner would approve a transfer of funds that would threaten the stability of CFMI or BlueChoice.

While in theory, GHMSI could seek help from the Association or other Blues Plans, such as the Surplus note used in the 1990s to stabilize GHMSI's solvency, it is unlikely that other plans would be able or willing to provide such financial support in the present environment. It is far more likely that any such "assistance" would only be offered if GHMSI were to undergo

financial restructuring and takeover of GHMSI by another plan (which could, potentially, be a for-profit carrier rather than a hospital and medical service corporation).

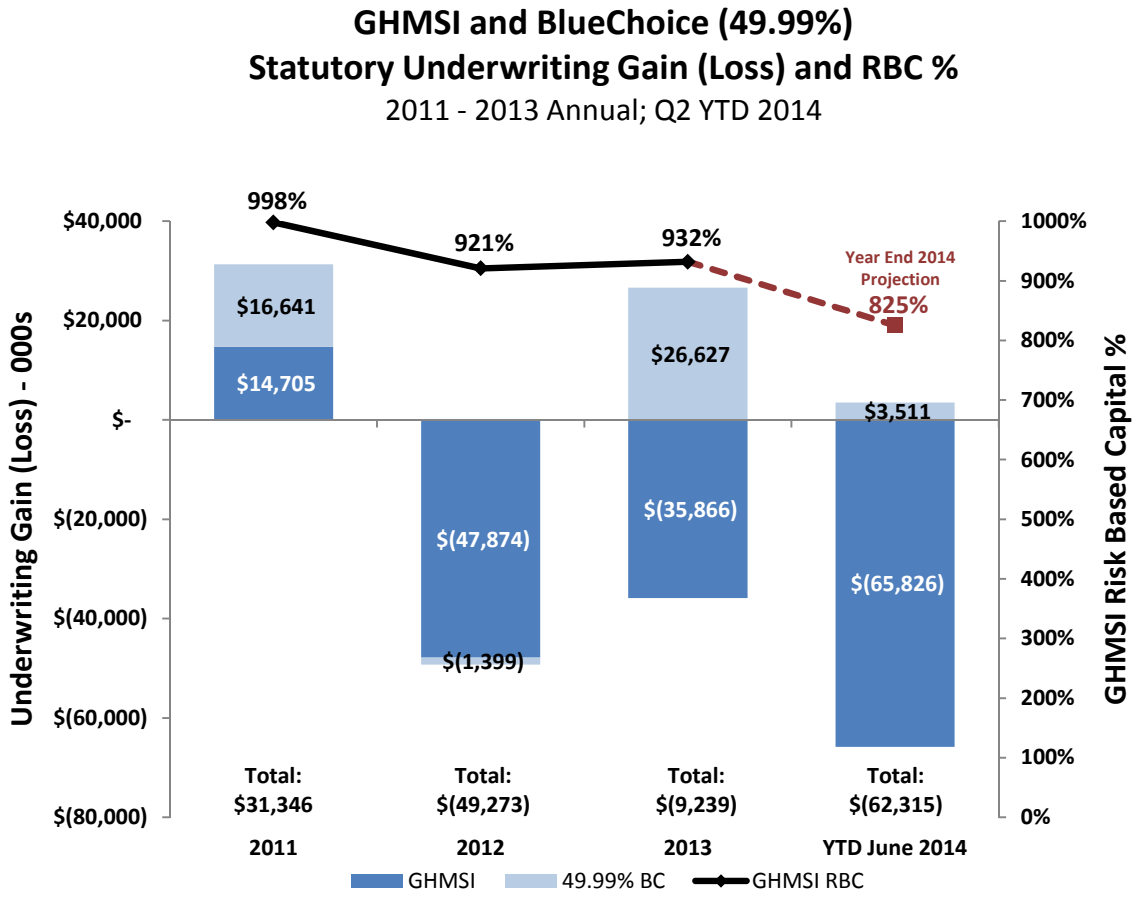
GHMSI's ultimate protection from insolvency would be to receive adequate rate increases before financial problems threatened. Such rate increases, however, would likely be insufficient by themselves if GHMSI were in severe financial trouble. GHMSI would be limited by potential rebates under the medical loss ratio rules and by competitive pressures from significantly increasing rates simply to build surplus.

<u>Question 5</u> - Please provide any information available to support the projection, asserted at the hearing, that GHMSI's RBC may drop as much as 80 to 100 basis points in 2014. See Transcript at 129.

GHMSI is providing DISB, under separate cover, with a copy of its confidential three-year plan for 2014, which was approved by the Board in December 2013. That plan provides GHMSI's financial projections for 2014, including its projected reduction in GHMSI's RBC-ACL Ratio. In CareFirst's annual planning process, the financial performance of each legal entity (including CFMI, GHMSI, and CFBC) is modeled for the following calendar year, and projected for two additional years. A forecast of Statutory Surplus, Risk Based Capital-Authorized Control Level, and the Risk Based Capital Ratio is included in this model and set out in the plan. The projected Risk Based Capital Ratio for GHMSI is expected to decline by 80 to100 basis points in 2014 as a result of the many factors discussed in GHMSI's Report on ACA Impacts at Exhibit 2 to GHMSI's Prehearing Brief.

GHMSI's results in 2014 thus far show that its projections are well warranted. As shown in the chart below, GHMSI suffered underwriting losses in both 2012 and 2013, even with 50% of the BlueChoice results included. To date in 2014, GHMSI has suffered more than $65 million

in underwriting losses, which are only partially offset by a $3.5 million gain from GHMSI's 50% share in BlueChoice and reflect statutory accounting principles.



Even without such losses, GHMSI's surplus would have been expected to decline in 2014 as a percentage of RBC-ACL, simply because of increased premiums, increased medical costs, and changes in enrollment.

<u>Question 6</u> - GHMSI's hearing testimony discussed the relationship of GHMSI and CareFirst BlueChoice.

a) BlueChoice appears to have had a significantly larger operating gain percentage over the past five years as compared to GHMSI; please explain the reason for the difference.

The difference in operating gains between GHMSI and BlueChoice arise from significant differences between the two businesses. These differences include:

1. BlueChoice offers HMO products with more cost-effective, value based product offerings, which are increasingly popular among younger and healthier members, while GHMSI offers PPO products with more open access features.

2. The two carriers operate in different market segments (i.e. individual insured, small group, large group, self-insured, and FEP/FEHBP), which produce different margins and operating gain percentages. This varied "mix of business" will produce varied operating performance over time. As of December 2013, GHMSI had approximately 600,000 contracts of which about 25% are Individual and Commercial Risk Groups; about 35% are FEP Risk Group contracts and the remaining 40% are non-risk contracts.[3] BlueChoice had about 310,000 contracts, of which 92.5% are Individual and Commercial Risk Groups and 7.5% are the FEHBP Risk contracts

3. Financial results vary between different jurisdictions, and each carrier maintains separate rating pools for its different market segments in each jurisdiction. The prices and margins of each carrier will vary depending upon the relative ages and health of the members in each rating pool, and similar factors.

4. GHMSI's financial results include a $5 million annual contribution to the DC HealthCare Alliance.

b) Please describe how the BlueChoice results are reflected in the Milliman model.

The foundation of the Milliman model is the historical and projected financial performance of GHMSI and about 50% of BlueChoice. GHMSI's share of the BlueChoice results are integrated into the Milliman model in the same way as GHMSI's own results.

[3] The term "contracts" as used here refers to individual market policyholders and, in the group market, to individual employees (who may have coverage for themselves and for dependents). The total number of members in a plan is usually about double the number of "contracts."

First, Milliman adds each of the income statement line items for GHMSI and 50% of BlueChoice together to create a proforma consolidated income statement. Milliman includes GHMSI and 50% of BlueChoice in each element of this financial projection. In other words, annual premiums, claims, administrative expenses, investment income, and other items in the Milliman projection are all based on projections of GHMSI results plus 50% of BlueChoice results, rather than on GHMSI alone.

Second, Milliman identifies probability distributions that address how actual results may vary from expected gains or losses in the future (i.e. how likely is it that actual expenses would be higher or lower than assumed in premium rates, or that return on investments would differ from expectations) and applies those probabilities to the baseline financial data. Many of those probability distributions are based on factors unique to the carrier that is being evaluated – such as the risk of underwriting losses or assumptions regarding premium growth. Milliman uses the combined results of GHMSI and 50% of the results of BlueChoice when developing each probability distribution.

Milliman provides further information on the development and implementation of its model in its May 31, 2011 Report, which has been filed in these proceedings.

c) In the Milliman model, do the gains from BlueChoice show up through operating gains or through investment gains?

As noted above, 50% of BlueChoice's operating gains or losses are included in the Milliman model as operating gains or losses, not as investment gains or losses.

d) Were the operating gains from BlueChoice, whether included in operating gains or investment income, validated in the Milliman model?

Yes. The baseline pro forma model values were validated to the company's 2011 forecast. In fact, in the development of Milliman's model, the assumptions used were

comparable to historical averages but higher than recent results. The use of these higher historical averages increased the projected financial performance of GHMSI and BlueChoice and, as a result, reduced the target surplus required to remain above 200% RBC-ACL.

e) Does the Milliman model assume BlueChoice percentage gains will continue to be greater than GHMSI gains?

Yes. The Milliman model projects forward the experience of GHMSI plus 50% of BlueChoice, and that projection assumes that the mix of business at GHMSI and BlueChoice will continue to differ and BlueChoice will continue to have operating gains that are higher than GHMSI.

Question 7 - GHMSI's testimony indicated that (1) CareFirst participated in an analysis of Blues plans to better understand administrative efficiency; see, e.g., Transcript at 125; (2) there was information gathered from BCBS and an analysis performed by the Sherlock Company, see Transcript at 141, and (3) GHMSI looked at comparisons to publicly traded carriers (United, Cigna, Humana). See Transcript at 143.

a) Is the analysis performed by the Sherlock Company, the same analysis of the BCBS plans mentioned earlier in GHMSI's testimony as discussed above? If not, please respond to the two questions below for each analysis.

i. Does the analysis examine CareFirst as a whole or does it address the separate operating companies?

ii. Please provide a copy of the most recent report, the report for 2011 and the report for 2008.

The analysis performed by the Sherlock Company is the analysis mentioned above.

b) Please provide a copy of the most recent comparison done to publicly traded companies, and the comparison for 2011 and 2008.

GHMSI has enclosed, at **Attachment C**, a copy of its most recent annual analysis, conducted as of the end of 2013, in which CareFirst assesses its operating expenses as compared to those of for-profit companies. This analysis contains confidential and proprietary information belonging to CareFirst and its affiliates, and has been marked as proprietary and confidential.

c) Please describe how expenses are allocated between GHMSI, BlueChoice, CFMI and CareFirst Inc.

Costs and expenses are allocated among GHMSI and other CareFirst affiliates in accordance with governing law and approved cost allocation agreements. Section 31-706 of the DC Code requires that charges or fees for services performed within a holding company system must be "reasonable," and that "[e]xpenses incurred and payment received shall be allocated to the insurer in conformity with customary insurance accounting practices consistently applied." D.C. Code § 31-706. Maryland and Virginia have similar rules. To meet these requirements, costs are allocated among GHMSI, BlueChoice, CFMI, and other affiliates under the terms of an Administrative Services Agreement dated January 1, 2009, which was filed with and approved by the DISB and the Maryland Insurance Administration ("MIA"). Under that agreement, when GHMSI or CFMI provides a service to the other or to any other CareFirst affiliate, GHMSI or CFMI is reimbursed in amounts that are determined under Generally Accepted Accounting Principles, Cost Accounting Standards, Federal Acquisition Regulation Cost Principles, Blue Cross and Blue Shield Cost Accounting practices and techniques, any applicable external contractual requirements (such as rules related to the Federal Employee Health Benefits Program) and any allocation methodologies required by insurance regulators.

CareFirst implements these rules through its Cost Accounting System, a control mechanism built upon an Oracle Hyperion Essbase database and which uses statistical data to allocate administrative expenses among CFMI, GHMSI and BlueChoice. The Cost Accounting System develops monthly allocated administrative expenses among CareFirst entities and market segments using a full absorption costing approach, meaning that all administrative costs are allocated to (i.e. absorbed by) products and services related to those costs. Administrative expenses are consistently captured and allocated based on a unique cost driver or specific set of

cost drivers which are specific to a cost center based on the activities performed. For example, costs incurred by a CareFirst claims processing cost center would be allocated based on the number of claims paid for various CareFirst entities.

Over the years since the affiliation of CFMI and GHMSI, the appropriateness of costs allocated to CFMI, GHMSI and BlueChoice has been consistently reviewed by various external auditors including Ernst & Young, the DISB, and the MIA. Each year, Ernst & Young reviews CareFirst's transfer pricing to ensure that the prices allocated between the carriers reflects industry standard, arms-length pricing. In addition, because more than 20% of CareFirst's business is with the Federal Employees Program, the Office of Personnel Management ("OPM") performs extensive five year audits to ascertain that costs charged to the federal government are appropriate.

<u>Question 8</u> - GHMSI's testimony indicated that large employers ask direct questions about CareFirst's financial strength. See, e.g., Transcript at 127-128. Please provide representative correspondence from large employers or their advisors asking questions about CareFirst's financial strength during the process of acquiring or renewing coverage and a copy of the responses from CareFirst addressing the question.

Large employers frequently inquire as to the financial soundness of bidding carriers in requests for proposals ("RFPs") issued for self-insured or insured business. Such requests often ask for financial ratings, which utilize the same data used to calculate a carrier's RBC-ACL, such that a deterioration in GHMSI's RBC-ACL would be accompanied by a corresponding deterioration in its financial rating. Because GHMSI does not have a public rating, it supplies groups with its financial statements, which show its reserves. Below you will find an illustrative request (in boldface) and response from a recent RFP:

> **For the entity that will be underwriting this coverage, provide your most recent financial ratings or filings and effective dates of the ratings from each of the following agencies: A.M. Best; Standard & Poor's; Moody's; Fitch.**

> CareFirst, Inc., the parent company of Group Hospitalization and Medical Services, Inc., receives a limited private rating from Standard & Poor's in accordance with requirements set forth by the Blue Cross Blue Shield Association; both parties are restricted from releasing the results. In lieu of provision of the Standard & Poor's rating, CareFirst, Inc. has supplied, as requested, financial statements evidencing financial soundness, including substantial reserves and unassigned funds in addition to adequate provision for claims payment liabilities.
>
> If [RFP Issuer Name Redacted] requires the S & P results, please forward a request to [Employee name and e-mail address redacted] who will submit to Standard & Poor's.
>
> As a nonprofit organization without stockholders and virtually no external debt and subject to rigorous state regulatory oversight, CareFirst, Inc. has not participated with other recognized financial rating organizations, (A.M. Best, Moody's, Fitch, etc.).

Here is another example of language used in an RFP issued and responded to this year, by providing financial statements evidencing GHMSI's financial soundness and reserves:

> **Financial Capability** *(If identical information between Functional Areas, Offerors need only include one original response and set of copies for this Section if proposing to multiple Functional Areas.)* An Offeror must include in its Proposal a commonly-accepted method to prove its fiscal integrity. If available the Offeror shall include Financial Statements, preferably a Profit and Loss (P&L) statement and a Balance Sheet, for the last two (2) years (independently audited preferred).
>
> In addition, the Offeror may supplement its response to this Section by including one or more of the following with its response:
>
> a. Dunn and Bradstreet Rating;
> b. Standard and Poor's Rating;
> c. Lines of credit;
> d. Evidence of a successful financial track record; and
> e. Evidence of adequate working capital.

In addition to requests made through RFPs or other means, if GHMSI's surplus were to fall below 375% RBC-ACL, the Blue Cross and Blue Shield Association's "early warning" rules would affirmatively require GHMSI to inform every group of GHMSI's financial status before it

could enter into any new contract, and annually thereafter, for as long as GHMSI's surplus remained below the 375% threshold. *See* answer to Question 3, above.

Question 9 - GHMSI's testimony indicated that the FEHBP program has performance standards for GHMSI. See, e.g., Transcript at 140. Please provide a copy of the most recent performance standards promulgated for the FEHBP program applicable to GHMSI.

GHMSI and BlueChoice are involved in the FEHBP program in two ways. First, GHMSI serves approximately 365,000 members under the FEP, offered through the Blue Cross and Blue Shield Association. The Association contracts with the OPM to provide the FEP program. The Association then enters into a subcontract with each participating plan, such as GHMSI, to provide the FEP program within the plan's service territory. Second, BlueChoice serves approximately 56,000 members through its own HMO offering in the FEHBP program, and contracts directly with OPM to provide that offering.

In both cases, Section 1.9 of the OPM contract sets forth a list of performance standards that participating plans must meet. Copies of Section 1.9 of each contract are appended hereto at **Attachment D**. In addition, GHMSI must meet additional performance standards set by the Association as a condition of participation in the FEP program.

There are several additional points that should be considered relating to GHMSI's involvement with the FEHBP program:

- These performance standards do not address questions of financial soundness. However, OPM considers the financial soundness of a plan when determining whether a plan is eligible to participate in FEHBP. 48 C.F.R. § 1609.7001(a)(2) provides that a participating plan "must have, in the judgment of OPM, the financial resources and experience in the field of health benefits to carry out its obligations under the plans."

- Only Blue Cross and Blue Shield licensees may participate in the Association's FEP program. Thus, if GHMSI's surplus fell below 200% RBC-ACL, GHMSI would not just face termination from the Association, as described in response to Question 3, but would also be barred from further participation in FEP. This would result in GHMSI losing its approximately 365,000 FEP members, and in the Association finding a new licensee to operate the FEP program in GHMSI's service territory.
- GHMSI also has a 90% ownership share in the Service Benefit Plan, a subsidiary that provides administrative services to the Association and other FEP program plans. Other Blue Cross Blue Shield plans are capable of and interested in providing these administrative support services. Therefore, any concerns by the Association regarding GHMSI's financial soundness could result in a transfer of the Service Benefit Plan or its business to another Blue Cross Blue Shield company. GHMSI would lose this business if its license were terminated for falling below 200% RBC-ACL.

<u>Question 10</u> - GHMSI testified that it is under an order from the Maryland Commissioner of Insurance to increase its surplus by 200 points. See, e.g., Transcript at 103. What steps, if any, has GHMSI taken to respond to the Maryland order?

As Mr. Burrell testified, GHMSI is party to a consent order with Maryland under which GHMSI "agree[s] to strive to maintain an actual surplus position . . . at the midpoint of the surplus range[] approved by the Commissioner, and to move surplus to the midpoint in a gradual manner." 2012 Consent Order at 8, Exhibit 15 to GHMSI's Prehearing Brief. The Maryland Commissioner's approved range for GHMSI is 1000-1300% RBC-ACL, and therefore the midpoint is 1150% RBC-ACL—some 200 points above GHMSI's actual year-end 2013 surplus level.

GHMSI recognizes that its RBC level is currently below the range approved by the Board and Maryland, and that under the consent order Maryland requires the Company to take steps to increase its surplus level. In the present environment, however, actually increasing GHMSI's surplus in any significant way is difficult, if not impossible, for reasons set forth in GHMSI's pre-hearing brief and at the hearing itself. The combined pressures imposed by the ACA—new coverage mandates, medical loss ratio ("MLR") rules, and heightened scrutiny on proposed rate increases, among others—have made it far more likely that GHMSI will suffer shortfalls this year and in the years to come than that it will have sufficient net revenue to contribute to surplus.

GHMSI has tried, at the very least, to maintain its current amount of surplus (although a diminishing RBC-ACL) in its rate filings, but GHMSI can only charge the rates that are approved by its regulators. The Maryland Commissioner recently entered an order requiring GHMSI and BlueChoice to reduce the morbidity factor in their 2015 individual market insurance rates, which effectively cut GHMSI's requested rate increases in half, and which GHMSI expects will cause it and BlueChoice to incur significant losses. The District also cut GHMSI's proposed individual market rate increases nearly in half.

At bottom, the Commissioner's question underscores the impossible position that GHMSI is in when it must operate under conflicting mandates from various regulators. For example, if DISB were to adopt Rector's proposed target of 958% RBC-ACL, there would be a 200 point difference between the Maryland and District of Columbia target points. GHMSI obviously can only fully comply with a single target point at any one time. This problem would be made even worse if the Commissioner were to adopt an even lower surplus target that would require GHMSI to reduce its surplus even farther. Such an order could result in action by Maryland to enforce its own consent order, potentially setting off an inter-jurisdictional struggle

that would benefit none of the parties and potentially could only be resolved in federal court. It is to prevent such struggles that the MIEAA requires the Commissioner to confer with other jurisdictions before taking action.

Question 11 - GHMSI's testimony indicated that it could break out the community giving for GHMSI alone. See, e.g., Transcript at 158.

a) For each year from 2008 through 2011, please provide a breakdown of the community giving for GHMSI only, including a list of recipients and amounts for each category Catalytic Giving, Targeted Health Giving Through Others, Programmatic Initiatives, Community Sponsorships, and Corporate Memberships) described in your pre-hearing report.

The requested breakdown is provided in the charts at **Attachment E**.

b) Please clarify whether, and if so why, you consider premium taxes paid to the District as a community health reinvestment.

Premium taxes do not fall within the definition of "community health reinvestment" set forth under the MIEAA. However, while GHMSI and CareFirst provide community reinvestment in *lieu* of premium taxes in other jurisdictions such as Maryland, in the District they provide community reinvestment *and* pay premium taxes. Given that GHMSI provides substantial support to the District of Columbia through the payment of premium taxes, GHMSI has included those taxes in its submissions to ensure that the Commissioner has the full picture of GHMSI's contributions to the District of Columbia.

Question 12 - GHMSI's testimony seemed to indicate that reducing a proposed rate in response to actual expenditures being less than projected would count as community health reinvestment. See, e.g., Transcript at 157.

a) Please clarify under what circumstances community heath reinvestment would be part of a rate filing and how it would be identified.

The CareFirst and GHMSI Boards, in consultation with independent actuarial experts, review and approve an Optimal Target Surplus Range, and GHMSI manages its surplus toward the middle of that range. If GHMSI's RBC ratio is determined to be near or above the top end of

the Board-approved range, the company will initiate a reduction or moderation in its filed rates. To put this into effect, the Company would reduce the "Contribution to Reserves" in its rate filing. A Contribution to Reserves of less than 0% would show that GHMSI expects that it will incur losses on the filing, and thus draw from surplus.[4] A reduction in Contribution to Reserves reduces the resulting rate – causing either rate moderation (i.e. a lesser rate increase) or an absolute rate reduction.

In 2010, management believed that GHMSI's surplus would be above or near the top of the Board-approved surplus range. Accordingly, GHMSI and BlueChoice both filed rate reductions and moderated rates in the District of Columbia, and elsewhere. As a result of this rate moderation, GHMSI's surplus fell from 1098% RBC-ACL at the end of 2010 to 921% RBC-ACL by the end of 2012 (and remained relatively stable in 2013).

GHMSI has identified approximately $27 million of reductions and moderations in the District of Columbia between 2010 and 2012, which GHMSI set out in a chart provided to Rector during its investigation and filed with DISB as Exhibit 9 to GHMSI's Prehearing Brief.

b) GHMSI's testimony stated that it would "moderate or cut rates to our subscribers if our surplus gets too high above a target point. And ... we did do that in 2010 going into ' 11." See Transcript at 157.

i. Please identify which rate filing was submitted with a reduction of rates in 2010 going into 2011.

The response to subsection (a) details GHMSI's decision to moderate rates beginning in 2010, and the chart filed as Exhibit 9 to GHMSI's Prehearing Brief identifies the filing periods in which rate moderation occurred. In particular:

[4] A contribution margin above 0% also may lead to a loss in surplus in terms of RBC-ACL, if the margin is not sufficiently large to cover new surplus needs of the carrier. If premiums are growing, medical costs are growing, and/or enrollment is growing, a carrier's surplus requirements also will grow, and an inadequate contribution to surplus would cause the company's RBC ratio to fall.

- In the fourth quarter of 2010 and the first quarter of 2011, the requested and approved rate increases for both GHMSI and BlueChoice resulted in a negative contribution to reserves in the D.C. individual and small group markets. This was a moderation of rates, rather than an absolute reduction.
- From the second quarter of 2011 through the second quarter of 2012 the individual market rates in the District of Columbia reflected an absolute reduction from the previously filed rates.
- From the second quarter of 2011 through the first quarter of 2012, the small group market rates in the District of Columbia reflected an absolute reduction from the previously filed rates.

ii. What was the target point referenced in GHMSI's testimony?

The "target point" for purposes of GHMSI's surplus management refers to the mid-point of the range approved by the CareFirst and GHMSI's Boards. For the period of 2008 through 2010, GHMSI utilized a target surplus range of 750% to 1050% RBC-ACL, with a target mid-point of 900% RBC-ACL. For 2011 through 2013, the GHMSI Board adopted a new range of 1000% to 1300% RBC-ACL, with a target mid-point of 1150% RBC-ACL, as a result of the advice of actuaries Milliman and Lewin, and incorporating the increased risks associated with the ACA.

The 2012 Order issued by the MIA regarding GHMSI's surplus adopts the same approach, requiring GHMSI to manage its surplus towards the center of this range. That Order was filed with DISB as Exhibit 15 to GHMSI's Prehearing Brief.

iii. Please provide examples of any other rate filings submitted in response to a high surplus.

The chart provided as Exhibit 9 to GHMSI's Prehearing Brief addresses the rate moderation in which GHMSI and BlueChoice engaged during the period of time relevant to this review, and the period in which GHMSI determined to reduce its surplus in accordance with its Board-approved range and target.

Question 13 - Please describe (or provide a copy of) GHMSI's current policy(ies) for determining (a) the amount to give each year to charitable organizations, (b) when and how much to reduce rates, and (c) charitable giving relative to rate reduction.

In 2008, the CareFirst and GHMSI Boards adopted the *Policy of CareFirst BlueCross BlueShield Regarding Community Giving in the Context of its Role as a Not-For-Profit Health Plan*, a copy of which is attached at **Attachment F**. GHMSI's approach to rate reduction is addressed in the answer to Question 12.

Question 14 - Please address any questions, comments or criticisms in Rector's pre-hearing brief or hearing testimony that you wish to address that have not been addressed in your responses to the requests above.

In accordance with GHMSI's request dated August 19, 2014, which request was granted by DISB, GHMSI will respond to Rector's brief or testimony in GHMSI's October 17, 2014 brief.

Question 15 - Please address any questions, comments or criticisms in Appleseed's pre-hearing brief or hearing testimony that you wish to address that have not been addressed in your responses to the requests above.

In accordance with GHMSI's request dated August 19, 2014, which request was granted by DISB, GHMSI will respond to Appleseed's brief and testimony in full in the Company's October 17, 2014 brief. However, it is appropriate in this filing to highlight a few of Appleseed's serious errors.

First, Appleseed fundamentally misinterprets the MIEAA. As discussed in the introduction, Appleseed's interpretation of the word "efficiency"—which drives much of its brief—is demonstrably wrong. *See supra* at 2. The Commissioner also should be particularly concerned about Appleseed's claim that the MIEAA's "maximum feasible extent" standard requires the DISB's actuary to *distort its own calculations* by, for example, arbitrarily lopping off portions of the results it gets when running numbers through the models. *See* Appleseed Pre-hearing Br. at 5 & 21. This amounts to an argument that the Commissioner should ignore risks to the Company, and paint a factually distorted and unduly rosy future for GHMSI, for the sole purpose of forcing GHMSI's surplus down below what a *responsible* actuarial analysis would require. That is directly contrary to the MIEAA itself, which makes clear that GHMSI cannot be required to lower surplus if doing so would undermine the Company's soundness and efficiency. The only sensible way to determine how much surplus GHMSI *in fact* needs to be sound and efficient is to conduct an unbiased actuarial analysis—one that chooses assumptions and correctly applies the actuarial calculations to the result. That is exactly what Rector did.

Second, Appleseed now advocates in favor of a 90% confidence level—arguing that the Commissioner should force GHMSI into a position where it would have a one in ten chance of insolvency. On at least four occasions, in this proceeding and in letters to the Commissioner, Appleseed and its actuary agreed that 98% was the appropriate confidence level at which to analyze GHMSI's surplus. They were right to do so. 98% is the figure accepted by Rector, Milliman, RSM McGladrey Inc. ("McGladrey"), and the Maryland Insurance Administration ("MIA"), whose finding deserves particular weight. *See* D.C. Code § 31-3506(e). And it is in line with, if not below, confidence levels used by leading industry analysts in analogous contexts, as GHMSI will document in its October 17 brief. By contrast, there is a total dearth of

actuarial or industry support for a confidence level anywhere near 90%. Appleseed itself only began advocating this new position once it became clear that any responsible actuarial analysis would support GHMSI's current surplus level.

Third, Appleseed's actuarial analysis contains numerous conceptual and analytical mistakes, which will be fully addressed in a post-hearing report by Milliman Inc. These mistakes include sloppy double counting of pension returns, omission of values related to BlueChoice, application of ACA provisions to incorrect market segments, cherry picking "comparable" companies that are not comparable to GHMSI at all, and utilizing uncharacteristically favorable time periods when doing so serves Appleseed's predetermined result.

The result of Appleseed's analysis is absurd. According to Appleseed's own chart, its calculations generate a surplus target of ***205% RBC-ACL***. No serious expert or party would advocate for such a target. By statute in D.C. and elsewhere, 200% RBC-ACL is a level to be strenuously avoided—one that signals deep financial distress. Under D.C. Code § 31-2003, an insurer whose surplus even starts to approach 200% RBC-ACL must file a report with the DISB proposing corrective actions. And yet that is the figure Appleseed's analysis generates as a *cap*.

In fact, Appleseed's "target" of 205% actually fails to include one of its own recommended downward adjustments. Appleseed apparently forgot to include its proposed adjustment for "efficiency." When that adjustment is included, Appleseed presents the Commissioner with a proposed surplus target ***below 100% RBC-ACL***. In other words, if the Commissioner were to adopt Appleseed's legal reasoning and actuarial testimony, his only option would be to force the distribution of nearly all of GHMSI's surplus, and then immediately place GHMSI in receivership because of inadequate surplus.

Fourth, Appleseed dramatically underestimates the downward pressure the ACA will impose on GHMSI's surplus. Appleseed even suggests that the ACA will have no negative impact on the Company's surplus, and might actually enhance surplus. But to reach that surprising conclusion, Appleseed and its actuary simply ignore the features of the ACA that increase risks for carriers – for example, the guaranteed issue requirement that likely will drive up the Company's medical claims costs; stricter rate-review requirements that will make it difficult for GHMSI to obtain rate increases to match those cost increases; new MLR rules that serve as a one-way ratchet to drive surplus down; and massive new taxes and implementation costs. *See* GHMSI Prehearing Br. at 16-19 and Exhibit 2. Indeed, GHMSI's inability to get requested and necessary rate increases for 2015 (as discussed above) underscores these problems.

Appleseed's actuary then misapplies the few provisions of the ACA he does consider, as will be discussed in detail in GHMSI's October 17 brief and Milliman's post-hearing report. As with its other assumptions and positions, Appleseed's portrayal of the ACA is contrary to the industry's uniform understanding of the ACA's effects, and to any responsible analysis. Instead, it is driven by Appleseed's goal in this proceeding—to extract surplus from GHMSI—regardless of the consequences for GHMSI subscribers or anyone else.