

**DISTRICT OF COLUMBIA COURT OF APPEALS**

**No. 20-OA-8**

IN RE D.C. APPLESEED CENTER FOR  
LAW AND JUSTICE, INC.,

*Petitioner.*

**DC APPLESEED CENTER FOR LAW AND JUSTICE’S RESPONSE TO STATUS  
REPORT FILED BY DEPARTMENT OF INSURANCE, SECURITIES, AND BANKING**

DC Appleseed Center for Law and Justice (“Appleseed”) filed its petition on June 24, 2020 for issuance of a writ of mandamus in this longstanding case to “compel agency action unlawfully withheld or unreasonably delayed,” D.C. Code § 2–510, by the D.C. Department of Insurance, Securities, and Banking (“DISB”) under the Medical Insurance Empowerment Amendment Act (“MIEAA”). *See* Appleseed Petition for Mandamus at 4, *In re D.C. Appleseed Ctr. for Law & Justice, Inc.*, No. 20-OA-8 (D.C. June 24, 2020) (hereinafter, “Appleseed Petition”). In response to Appleseed’s petition, on August 10 this Court issued an Order saying “we share Appleseed’s concern about DISB’s failure to take timely action” and directing the agency within 90 days to file a status report with the Court. Order at 1, *In re D.C. Appleseed Ctr. for Law & Justice, Inc.*, No. 20-OA-8 (D.C. Aug. 10, 2020). DISB’s status report, filed November 9, demonstrates that the agency has still not taken timely action. Accordingly, the Court should grant Appleseed’s petition and order relief bringing this case to an end.

The D.C. Council enacted MIEAA eleven years ago to alleviate pressing health concerns in the District and ensure that Group Hospitalization and Medical Services, Inc. (“GHMSI”) fulfills its charter obligation to “engage in community health reinvestment to the maximum feasible extent consistent with financial soundness and efficiency.” D.C. Code § 31-3505.01.

To date, years-long delays have stymied achievement of MIEAA's community health purpose for more than a decade. *See* Appleseed Petition at 2–5. Indeed, Appleseed's November 9, 2020 Status Report further demonstrated that DISB's delays are continuing notwithstanding this Court's expression of concern with that delay, and both DISB's and GHMSI's November 9, 2020 Status Reports confirm the necessity of prompt action by this Court.

DISB has failed to take adequate action toward resolving the issues remanded by this Court in August 2019. This Court should now take action to bring the administrative review of GHMSI's year-end 2011 surplus to a conclusion. The Court should (1) order immediate expenditure of the \$51 million excess surplus no longer in dispute, (2) order payment of interest on that excess surplus as a matter of law; (3) appoint a mediator; and (4) direct DISB to issue an expedited schedule for briefing and resolution of the discrete issues that the Court previously remanded to DISB.

**I. THIS COURT SHOULD END DISB'S CONTINUING PATTERN OF DELAY AND FAILURE TO ENFORCE MIEAA.**

MIEAA directs DISB to assess whether GHMSI's "surplus is 'excessive'" and, if it is, "to order that any excess surplus be reinvested in the community." *DC Appleseed Ctr. for Law & Justice, Inc. v. D.C. Dep't of Ins., Sec. & Banking (Appleseed I)*, 54 A.3d 1188, 1194 (D.C. 2012). But DISB has failed to comply with its statutory obligations even with the benefit of two merits decisions from this Court further clarifying MIEAA's directives. *See id.* at 1192–98; *DC Appleseed Ctr. for Law & Justice, Inc. v. D.C. Dep't of Ins., Sec. & Banking (Appleseed II)*, 214 A.3d 978, 982–85 (D.C. 2019). Although this Court issued its second decision—*Appleseed II*—in August 2019, DISB has taken little concrete action toward completing review of GHMSI's excess surplus consistent with this Court's thorough decision narrowing the issues for administrative review.

In the fourteen-month period since *Appleseed II*, Appleseed has repeatedly requested that DISB move forward with its administrative proceedings consistent with the remand from this Court. Appleseed first proposed a schedule for administrative proceedings before DISB, and Appleseed then submitted its opening administrative brief on the remand issues in order to expedite proceedings. *See* Appleseed Petition at 3–4; *In the Matter of Surplus Review and Determination for GHMSI*, Order No. 14-MIE-012, Brief for D.C. Appleseed (D.C. DISB May 14, 2020) (attached as Exhibit 1 hereto). When DISB still failed to initiate proceedings, Appleseed filed a mandamus petition with this Court. Only then—ten months after *Appleseed II*—did DISB take the “single specific action” of asking Maryland and Virginia insurance regulators “to review a 2016 order by DISB in the case and get back to” DISB. Order at 1, *In re D.C. Appleseed Ctr. for Law & Justice, Inc.*, No. 20-OA-8 (D.C. Aug. 10, 2020). That limited step *did not* “establish any timeline for completing the [DISB] proceeding on remand,” nor did DISB take any other “concrete actions . . . since remand” in *Appleseed II*. *Id.* at 2.

Despite this Court’s resulting August 10, 2020 Order “sha[ring] Appleseed’s concerns about DISB’s failure to take timely action on remand and DISB’s failure to adequately respond to Appleseed’s requests for action,” *id.*, DISB has failed to take any concrete action toward resolution of the administrative proceedings enforcing MIEAA. *See* Appleseed Status Report at 1–2, *In re D.C. Appleseed Ctr. for Law & Justice, Inc.*, No. 20-OA-8 (D.C. Nov. 9, 2020). That DISB has now failed to act in light of the Court’s August 10 Order—failing, for example, to set a timetable for administrative briefing and proceedings as Appleseed requested more than a year ago—further compounds the already unreasonable delays and failure to enforce MIEAA.

Rather, DISB indicates that it has spent another four months engaged in off-the-record communications with Maryland and Virginia insurance regulators focused on the latter’s

requests for information regarding DISB's prior orders on GHMSI's surplus and "the procedures by which the three jurisdictions' commissioners will coordinate the review of GHMSI's surplus." DISB Status Report at 1–2, *In re D.C. Appleseed Ctr. for Law & Justice, Inc.*, No. 20-OA-8 (D.C. Nov. 9, 2020). These communications violate this Court's requirement that DISB's coordination with Maryland and Virginia regulators be "placed on the record." *Appleseed II*, 214 A.3d at 989. At any rate, DISB's report, at most, suggests that the Maryland and Virginia regulators intend to "submit their comments to DISB" by December 21, 2020. *See id.* at 3. Even crediting DISB's vague, off-the-record actions, administrative proceedings on the issues remanded by this Court will not **begin** until **at least** sixteen months after *Appleseed II*, six months after Appleseed filed its mandamus petition, and four months after this Court voiced its concerns with DISB's continuing delays. The fact that notwithstanding this Court's remand decision on August 29, 2019, and notwithstanding this Court's August 10, 2020 Order, DISB has still not issued a briefing order and schedule for deciding the issues remanded by this Court is inexplicable and unjustifiable. It is even more inexplicable and unjustifiable given that Appleseed expressly proposed a briefing order and schedule to DISB **last November**.

DISB's continuing delay is inconsistent with MIEAA's purpose and directives and with this Court's decisions directing DISB to enforce MIEAA on remand. Indeed, during these long delays, GHMSI's excessive surplus has only grown while the excess has not been "reinvested in the community," as required by MIEAA. In December 2014, the DISB Commissioner determined that GHMSI's year-end 2011 surplus was excessive by roughly \$268 million, equal to a risk-based capital ("RBC") level of 721%. *See In the Matter of Surplus Review and Determination for GHMSI*, Order No. 14-MIE-012, Dec. 30, 2014 Decision and Order at 1 (D.C. DISB Dec. 30, 2014) (attached as Exhibit 2 hereto).

GHMSI's most recently reported surplus, however, is more than \$1.5 billion, *see* Health Quarterly Statement as of June 30, 2020 of the Condition and Affairs of GHMSI, [https://content.naic.org/prod\\_serv\\_financial\\_home.htm](https://content.naic.org/prod_serv_financial_home.htm) (last visited Nov. 11, 2020), equal to approximately 1088% of RBC. Applying the 721% RBC level established by the Commissioner to GHMSI's current surplus results in an excess of more than \$578 million. In short, during a global pandemic in which healthcare expenditures are critical, GHMSI's surplus has expanded by hundreds of millions of dollars beyond the level found excessive by the Commissioner in 2014. In these circumstances, further delay in reinvesting the excess in the community directly undermines MIEAA's community health purpose.

## **II. ACTION BY THIS COURT IS WARRANTED NOW TO EXPEDITE THE ADMINISTRATIVE PROCEEDINGS AND ACHIEVE MIEAA'S PURPOSES.**

Given DISB's repeated failures to comply with its statutory obligations, action by this Court is necessary now to ensure enforcement of MIEAA. As detailed below, at least two actions are available to expedite the administrative proceedings on remand and fulfill MIEAA's purpose to ensure the expenditure of excess surplus attributable to the District toward community health in the District.

### **A. The Court Should Direct The Immediate Expenditure Of The Excess Surplus Of \$51 Million That Is No Longer Subject To Dispute And Should Determine The Amount Of Interest As A Matter Of Law.**

This Court may direct DISB to order GHMSI immediately to reinvest excess surplus that is not subject to dispute in the remanded administrative proceedings. In *Appleseed II*, this Court affirmed much of DISB's interpretation and application of MIEAA to GHMSI's year-end 2011 surplus, and narrowed the issues for consideration on remand. *See Appleseed II*, 214 A.3d at 986–96. *See also id.* at 996 (“[W]e affirm the Commissioner's orders in part, vacate in part, [and] remand for further proceedings.”).

The substantive issues remanded in *Appleseed II* relate only to DISB's ***understatement*** of GHMSI's excess surplus attributable to the District. Therefore, resolution of these issues ***cannot decrease*** the \$51 million in excess surplus originally found by the Commissioner. *See* December 30, 2014 Decision and Order at 1, 66; *In the Matter of Surplus Review and Determination for GHMSI*, Order No. 14-MIE-012, Aug. 30, 2016 Decision and Order at 25–28 (D.C. DISB Aug. 30, 2016) (attached as Exhibit 3 hereto). The remand process is limited to five issues, none of which would decrease the \$51 million of excess surplus attributable to the District under DISB's prior decision. These issues concern DISB's failures to:

- (1) adequately address the impact of equity portfolio risk on needed surplus in response to Appleseed's showing that DISB overstated the risk and need for surplus, *see id.* at *Appleseed II*, 214 A.3d at 992–93;
- (2) adequately address the attribution of excess surplus among the District, Maryland, and Virginia, taking into account the Court's guidance on that issue with respect to Appleseed's showing that DISB understated the attribution to the District, *see id.* at 993–95;
- (3) consider the addition of interest to the excess surplus as of year-end 2011, *see id.* at 995–96;
- (4) consider reimbursing Appleseed for its actuarial fees, *see id.*; and
- (5) determine the appropriate form for reinvestment of GHMSI's excess surplus, *see id.* at 996.

In contrast to its order directing DISB to consider the surplus-increasing issues raised by Appleseed, this Court rejected every one of GHMSI's challenges that could have decreased the excess surplus subject to community reinvestment below \$51 million. *See id.* at 991 (rejecting

GHMSI’s challenge to the confidence level in DISB’s statistical model); *id.* at 992 (rejecting GHMSI’s argument that DISB erred in assessing GHMSI’s surplus against a fixed value rather than a range); *id.* at 994 (upholding DISB’s rejection of GHMSI’s challenge to “the reasonableness of allocating a portion of its surplus”). Because GHMSI did not preserve its argument that DISB failed adequately to coordinate with Maryland and Virginia regulators in determining that GHMSI held \$51 million in excess surplus attributable to the District, any future coordination is restricted to consideration of the remaining issues for “proceedings on remand.” *See id.* at 986–87. Even in this limited form, the Court made clear that MIEAA’s coordination requirement does not dictate agreement among the jurisdictions; DISB need only explain any conclusions that diverge from those of the Maryland or Virginia regulators. *See id.* at 989.

Taken together, \$51 million is now the minimum excess surplus that GHMSI must reinvest on community health under MIEAA. The Court should immediately direct that amount to be reinvested in accordance with MIEAA.

While the remand issues may not decrease GHMSI’s reinvestment obligation, the Court may itself direct DISB to impose interest on the \$51 million excess surplus to be reinvested in community health. This Court has made clear that where, as here, money was owed at an earlier date but not paid, denying interest “would deny full compensation to [those entitled to the payment] while allowing the recalcitrant party to take advantage of his own wrong and become the richer for it.” *Riggs Nat’l Bank v. District of Columbia*, 581 A.2d 1229, 1253 (D.C. 1990). DISB did not challenge the imposition of interest during *Appleseed II*. While GHMSI disputed the availability of interest, *see DC Appleseed Ctr. for Law & Justice, Inc. v. DISB*, Nos. 16-AA-895, 16-AA-967, 18-AA-178, GHMSI Intervenor Brief, at 28 (D.C. Oct. 31, 2018), it cited

authority explaining that in the “absence of unequivocal prohibition,” a Court looks to multiple factors, including legislative purpose, to determine whether to include interest. *Rodgers v. United States*, 332 U.S. 371, 373–74 (1947). Here, there is no “unequivocal prohibition” against the imposition of interest in MIEAA, and MIEAA’s purpose was promptly to reinvest excess surplus “to the maximum feasible extent” to benefit subscribers and the community. D.C. Code § 31-3505.01. This is an issue of law and therefore within the competency and authority of the Court to resolve.

The calculation of interest is likewise a matter for the Court. By statute, this Court must calculate interest based on an established 6% rate. *See* D.C. Code § 28-3302(a). *See also, e.g., Naccache v. Taylor*, 199 A.3d 181, 184 (D.C. 2018) (interpreting the plain language of § 28-3302(a) to indicate D.C. Council's intention to set a fixed 6% prejudgment interest rate); *Burke v. Groover et al. P.C.*, 26 A.3d 292, 306 (D.C. 2011) (applying statutory rate for award of post-judgment interest under common law); *District of Columbia v. Pierce*, 527 A.2d 306, 310 (D.C. 1987) (applying D.C. Code § 28-3302(a) statutory rate of 6% for grant of prejudgment interest under D.C. Code § 15-108 in the absence of a contractual provision specifying otherwise); *Cobell v. Jewell*, 260 F. Supp. 3d 1, 21 (D.D.C. 2017) (applying statutory rate for grant of prejudgment interest).

Because no further factual development or administrative discretion is required, this Court should direct DISB to require GHMSI’s immediate reinvestment of \$51 million in excess surplus plus the statutorily prescribed 6% interest—equal to \$35.4 million as of December 31, 2020—consistent with MIEAA’s purpose and *Appleseed II*.



**B. The Court Should Direct Administrative Proceedings On Remand To Proceed Expeditiously On An Established Schedule, And The Court Should Appoint A Mediator To Attempt To Assist In Resolution Of The Matter In A Parallel Effort Due To The Excess And Continued Delays.**

The Court should direct DISB, GHMSI, and Appleseed to proceed expeditiously toward resolution of the remand issues on an established schedule that DISB is to set immediately. Appleseed also respectfully requests that the Court appoint a mediator to attempt to assist the parties to reach a mutually agreed resolution. The administrative proceedings and mediation should proceed in parallel so that mediation does not become a mechanism to delay again compliance with MIEAA's statutory requirement for reinvestment of excess surplus in the community health of the District.

Given the benefits of a mutually-agreed resolution, the Court should appoint a mediator to work with GHMSI and Appleseed to reach a settlement of the issues remaining in dispute on remand. *See supra* pp. 6–7. Since the Court's decision in *Appleseed II*, GHMSI and Appleseed have twice conferred regarding the possibility of settlement. Contrary to DISB's suggestion, *see* DISB Status Report at 3, *In re D.C. Appleseed Ctr. for Law & Justice, Inc.*, No. 20-OA-8 (D.C. Nov. 9, 2020), no further discussions between Appleseed and GHMSI are currently scheduled, and Appleseed does not know whether further settlement-related communications will take place. At this stage, the appointment of a mediator pursuant to the Court's mediation program may better inform the parties' positions as to whether settlement is possible. To alleviate the continuing delays in these proceedings and in light of the parties' longstanding familiarity with the remand issues, the Court should establish a 45-day deadline for any mediated settlement.

At the same time, the Court should direct DISB to issue immediately a briefing schedule on the remand issues—to proceed simultaneously with mediation—in the event that a settlement cannot be reached. Indeed, GHMSI's Status Report indicates that “GHMSI will be prepared to

respond to DC Appleseed's [administrative] brief on a schedule established by the Commissioner." GHMSI Status Report at 1–2, *In re D.C. Appleseed Ctr. for Law & Justice, Inc.*, No. 20-OA-8 (D.C. Nov. 9, 2020). Setting a schedule will both advance resolution of the administrative proceedings on the merits of the remand issues, and promote the potential for meaningful settlement discussions based on Appleseed's and GHMSI's mutual knowledge of the parties' respective positions on the merits. To those ends, the schedule should further require DISB to reach a final decision on the remand issues within sixty days after any conclusion of mediation without a settlement.

### CONCLUSION

DISB has unreasonably delayed and failed to meet both its statutory obligations under MIEAA and now its obligations under this Court's remand order to require that GHMSI's excess surplus be spent to address District community public health needs. Consistent with MIEAA and the Court's prior orders, the Court should (1) order immediate expenditure of the \$51 million excess surplus that is no longer in dispute; (2) direct payment of appropriate interest on that excess payment as a matter of law; (3) appoint a mediator; and (4) direct DISB to issue an expedited schedule for briefing and resolution of the issues remaining on remand.

Respectfully submitted,



---

Marialuisa Gallozzi

(D.C. Bar No. 413874)

Beth Brinkmann

(D.C. Bar No. 477771)

Bradley K. Ervin

(D.C. Bar No. 982559)

Covington & Burling LLP

One CityCenter, 850 Tenth Street, NW

Washington, D.C. 20001

Tel: (202) 662-6000

Fax: (202) 662-6291

mgallozzi@cov.com

\*Walter Smith

(D.C. Bar No. 238949)

D.C. Appleseed Center for Law & Justice, Inc.

1111 Fourteenth Street, NW,

Suite 510

Washington, D.C. 20005

Tel: (202) 289-8007

Fax: (202) 289-8009

wsmith@dcappleseed.org

Richard B. Herzog

(D.C. Bar No. 17731)

Harkins Cunningham LLP  
1700 K Street, NW, Suite 400,  
Washington, D.C. 20006  
Tel: (202) 973-7602  
Fax: (202)973-7610  
rbh@harkinscunningham.com

*Counsel for Appleseed*

## CERTIFICATE OF SERVICE

I certify that on this 11th day of November, 2020, I caused one copy of the foregoing to be sent by electronic mail to the following:

Adam Levi, Assistant General Counsel  
D.C. Department of Insurance and  
Securities Regulation  
810 First Street, NE, Suite 701  
Washington, D.C. 20002  
Phone: 202-442-7759  
adam.levi@dc.gov

Loren AliKhan  
James McKay  
Office of the Solicitor General  
Office of the Attorney General for the  
District of Columbia  
441 4th Street, N.W., Suite 630  
Washington, D.C. 20001  
loren.alikhan@dc.gov  
james.mckay@dc.gov

Lisa Hertzner Schertler  
SCHERTLER & ONORATO, LLP  
1101 Pennsylvania Ave., N.W.  
Suite 1150  
Washington, D.C. 20004  
lschertler@schertlerlaw.com

Michelle S. Kallen  
Office of the Attorney General of Virginia  
202 North Ninth Street  
Richmond, VA 23219  
mkallen@oag.state.va.us

I also caused one copy of the foregoing to be sent by U.S. mail to the following:

Virginia Bureau of Insurance  
P.O. Box 1157  
Richmond, Virginia 23218-1157

Maryland Office of the Attorney General  
200 St. Paul Place  
Baltimore, MD 21202

Maryland Insurance Administration  
200 St. Paul Place, Suite 2700  
Baltimore, MD 21202

  
Marialuisa Gallozzi

# **Exhibit 1**

**GOVERNMENT OF THE DISTRICT OF COLUMBIA  
DEPARTMENT OF INSURANCE, SECURITIES AND BANKING**

---

IN THE MATTER OF

Surplus Review and Determination for Group Hospitalization and Medical Services, Inc.

Order No. 14-MIE-012

---

**BRIEF FOR D.C. APPLESEED BEFORE THE DEPARTMENT OF  
INSURANCE, SECURITIES AND BANKING ON REMAND FROM THE  
AUGUST 29, 2019 DECISION OF THE DISTRICT OF COLUMBIA  
COURT OF APPEALS**

---

## Table of Contents

<b>INTRODUCTION</b> .....	1
<b>BACKGROUND</b> .....	2
A.    GHMSI’s Ever-Growing Excessive Surplus .....	3
B.    The District’s Critical Health Needs .....	5
C.    Past Delays in DISB Proceedings .....	5
<b>DISCUSSION</b> .....	7
A.    The Commissioner Should Immediately Order GHMSI to Spend the \$51 Million Affirmed by the Court of Appeals, and Promptly Resolve the Issues Remanded by the Court of Appeals to Determine GHMSI’s Additional Excess Surplus .....	7
1.    The Effect of Equity Portfolio Risk on GHMSI’s Need For Surplus .....	8
2.    Percentage of GHMSI’s Excessive Surplus to be Attributed to the District.....	12
3.    Prejudgment Interest on Excess Surplus That GHMSI Owed to the District as of End of 2011 .....	14
4.    Reimbursement of Appleseed’s Actuarial Fees .....	16
5.    Determination of an Appropriate Plan for Community Health Reinvestment of GHMSI’s Excess Surplus .....	18
B.    Other Issues for a DISB Final Order.....	20
C.    Further Proceedings by the Commissioner .....	20
<b>CONCLUSION</b> .....	21

## INTRODUCTION

More than eleven years ago – in January 2009 – the D.C. Council passed the Medical Insurance Empowerment Amendment Act (“MIEAA” or “the Act”). The Act requires the Department of Insurance, Securities, and Banking (“DISB”) to hold Group Hospitalization and Medical Services, Inc. (“GHMSI”) accountable to its nonprofit mission and federal charter by ordering GHMSI to spend the maximum feasible amount of its surplus attributable to the District of Columbia to address health needs in the District. MIEAA codified DISB’s recognition of GHMSI’s federal charter obligation to engage in charitable activity for community benefit.<sup>1</sup>

To this date – eleven years after the statute was enacted – *GHMSI has not yet been required to comply with the statute*, and *GHMSI has not yet spent a single dollar from its excessive, ever-increasing surplus on healthcare needs in the District*. The adverse effects on health care in the District due to GHMSI’s failure to adhere to the requirements of its charter have been compounded by the facts that (1) the District currently faces a public health emergency due to COVID-19 in which the healthcare needs of District residents are staggering; (2) the District government’s ability to meet those needs has been greatly reduced by the revenue shortfall the emergency has caused; and (3) GHMSI’s surplus has risen even more, to an all-time high.

On April 21, 2020, CareFirst announced that it had “earmarked an initial investment of \$2 million to aid the immediate health, social and economic needs of our communities.” *CareFirst COVID-19 Response and Relief Request For Proposal*, CAREFIRST (Apr. 24, 2020), <https://www.carefirst.com/community/rfp/coronavirus-response-and-relief.page>. CareFirst is to be commended for doing so and for recognizing the “unprecedented strain on resources and capacity as a result of COVID-19” and the acute impact of COVID-19 on “disproportionately disadvantaged populations.” *Id.* D.C. Appleseed (“Appleseed”) agrees with CareFirst’s observation that “[t]he COVID-19 pandemic has highlighted the need for enhanced public health and social needs programming to support communities most impacted by the crisis.”<sup>2</sup> *Id.*

During that earmarking process, CareFirst “engaged more than 60 organizations to understand the most critical needs arising from COVID-19.” *Id.* CareFirst indicates that it is, therefore, well positioned to direct funding to address community health needs by supporting

---

<sup>1</sup> Lawrence H. Mirel, Report of the District of Columbia Department of Insurance, Securities, and Banking In the Matter of: Inquiry into the Charitable Obligations of GHMSI/CareFirst in the District of Columbia (May 15, 2005). One purpose of the Act was to make clear that GHMSI’s obligation to engage in community benefit spending extends beyond its basic operations. The then-Attorney General of the District, Robert J. Spagnoletti reported to the City Administrator that GHMSI has a “legal obligation to *devote its entire operation* to serving, directly or indirectly, the charitable, public health purposes” created by its federal charter. Letter from Robert J. Spagnoletti, Attorney General, to Robert Bobb, City Administrator, at 1 (Aug. 4, 2005) (emphasis added).

<sup>2</sup> The latest data, as of this filing, show that the COVID-19 pandemic has claimed the lives of 323 District residents. *Coronavirus Data*, GOV’T OF D.C., <https://coronavirus.dc.gov> (last updated May 9, 2020).



“nonprofit 501(c)(3) organizations or public health entities working to provide relief to communities’ health, social, and economic needs that continue to arise during the COVID-19 pandemic.”<sup>3</sup> *Id.* CareFirst is indeed well positioned to direct public funds toward health needs in the District – as the company’s own actuarial expert has indicated, as a result of the pandemic, CareFirst’s excess surplus has likely increased.<sup>4</sup>

In these pressing circumstances, Appleseed respectfully urges the Commissioner to proceed on two simultaneous paths in order to (1) ensure the immediate expenditure of the funds definitively upheld by the Court of Appeals toward addressing needs created by the pandemic, which would now best serve MIEAA’s statutory purpose, while (2) allowing for a prompt resolution of the remaining issues related to additional funds. As set forth in the accompanying motion, Appleseed specifically asks that the Commissioner: (1) immediately order GHMSI to spend down the \$51 million of excess surplus attributable to the District as determined by the DISB in December 2014 and affirmed by the D.C. Court of Appeals in August 2019; and (2) promptly address the five issues the Court remanded to the DISB in its August 2019 decision, in coordination with Maryland and Virginia to the extent required by the Court of Appeals.

## BACKGROUND

The long history of this case has been set forth in opinions by both the Commissioner and the Court of Appeals, and Appleseed does not repeat all of that history here. Instead, this brief focuses on the two urgent aspects of the current situation: (1) the \$51 million in excess surplus that has been upheld by the Court of Appeals, which should be spent immediately on community health needs created by the pandemic, and (2) the five issues remanded by the Court to the DISB that should be promptly resolved. They are not unduly complicated and their resolution would make available at least an additional \$250 million to address pressing community health needs.

---

<sup>3</sup> This process raises two important questions that Appleseed urges DISB and CareFirst to consider. First, CareFirst has not stated *when* it will disburse the funds to those organizations – as CareFirst points out, the funds are desperately needed now. CareFirst has proposed a “request for proposal” (RFP) process that could be excessively burdensome and too prolonged to meet the organizations’ immediate need for resources. Although the RFP process could help ensure that the funds are directed to the greatest need, Appleseed urges CareFirst to expedite it. Second, and more importantly, as demonstrated below, \$2 million is a small fraction of the sum that MIEAA obligates CareFirst to commit to community health needs. Appropriate calculations indicate that CareFirst is obligated to additionally devote more than \$300 million of excess GHMSI surplus to address the pandemic and other health needs in the District, including the \$51 million already affirmed by the D.C. Court of Appeals.

<sup>4</sup> See HAYLEY ROGERS, CHARLIE MILLS & MATTHEW J. KRAMER, MILLIMAN, INC., ESTIMATING THE IMPACT OF COVID-19 ON HEALTHCARE COSTS IN 2020 (Apr. 2020), <https://milliman-cdn.azureedge.net/-/media/milliman/pdfs/articles/estimating-the-financial-impact-covid19.ashx>; see also Amol S. Navathe and Ezekiel J. Emanuel, *How Health Insurers Can Be Heroes. Really.*, N.Y. TIMES (May 6, 2020), <https://www.nytimes.com/2020/05/06/opinion/coronavirus-insurance.html>.

The case for prompt action by the Commissioner on both the \$51 million and on the five issues remanded by the Court is particularly compelling because GHMSI continues to refuse to acknowledge that its surplus is excessive; refuses to comply with the Commissioner's determinations of statutory limits on that surplus; and has allowed its surplus to rise dramatically so that, at the end of 2019, it was at an all-time high. MIEAA requires GHMSI to "engage in community health reinvestment to the maximum feasible extent consistent with financial soundness and efficiency." D.C. Code § 31-3505.01. Moreover, there are critical health needs in the District that the DISB should address by ordering GHMSI to spend down excess surplus. In the current public health emergency, those needs have become even more urgent. And past delays in the DISB proceedings themselves have contributed significantly to the long overdue enforcement of GHMSI's community health obligations, further supporting immediate action to require disbursement of the amount resolved and to resolve as soon as possible the five remaining issues that will determine the remaining amount to be disbursed.

### **A. GHMSI's Ever-Growing Excessive Surplus**

Despite the D.C. Council's passage of MIEAA eleven years ago, GHMSI has spent down *none* of its excess surplus to address the community health needs of the District as required by that statute. To the contrary, GHMSI has continued to *increase* its surplus to an all-time high – well above the "efficient" level that MIEAA requires be maintained, as determined by the Commissioner in his December 2014 decision, and subsequently affirmed by the Court of Appeals.

In that December 2014 decision, the Commissioner calculated that GHMSI had excessive surplus of \$268 million based on GHMSI's own statistical model and concluded that 721% was the maximum risk-based capital (RBC) ratio that GHMSI was permitted. At that time, GHMSI's RBC ratio was 998%, significantly in excess of that maximum, and its surplus was \$963.5 million. Decision and Order at 1, *In re Surplus Review and Determination for Group Hospitalization and Medical Services, Inc.*, No. 14-MIE-26 (Dep't of Ins., Sec. & Banking, Dec. 30, 2014) [hereinafter 2014 Decision].

Several developments subsequent to the Commissioner's December 2014 decision highlight GHMSI's persistent failure to comply with MIEAA. First, as the Court of Appeals acknowledged, DISB's regulations require GHMSI "to file an annual financial report with DISB detailing 'the company's surplus and examin[ing] *whether the company's surplus is considered excessive under the [MIEAA].*'" *D.C. Appleseed Center for Law and Justice, Inc. v. D.C. Department of Insurance, Securities and Banking*, 214 A.3d 978, 984 (D.C. 2019) (quoting D.C. Mun. Regs. tit. 26 § 4601.1 (2017)) (emphasis added). GHMSI's surplus has risen further following the Commissioner's 2014 decision: 883% in 2015, 851% in 2016, 1011% in 2017, 923% in 2018, and 1088% in 2019.<sup>5</sup>

GHMSI thus grew its surplus during those years pursuant to calculations that ensured that the surplus was excessive under MIEAA. GHMSI's agent, Milliman, Inc. continued to use its

---

<sup>5</sup> The annual CareFirst reports from 2015 through 2018 of GHMSI's surplus are available at: <https://disb.dc.gov/node/315992>.

own – and not MIEAA’s – method for assessing surplus, so GHMSI continued to conclude that its ever-increasing surplus was permissible. For example, Milliman continued to apply its own 98% confidence level in assessing GHMSI’s requisite surplus. But the Commissioner had determined that MIEAA requires a 95% confidence level, which determination the Court of Appeals affirmed. *D.C. Appleseed*, 214 A.3d at 990–92. The 95% confidence level is now final.

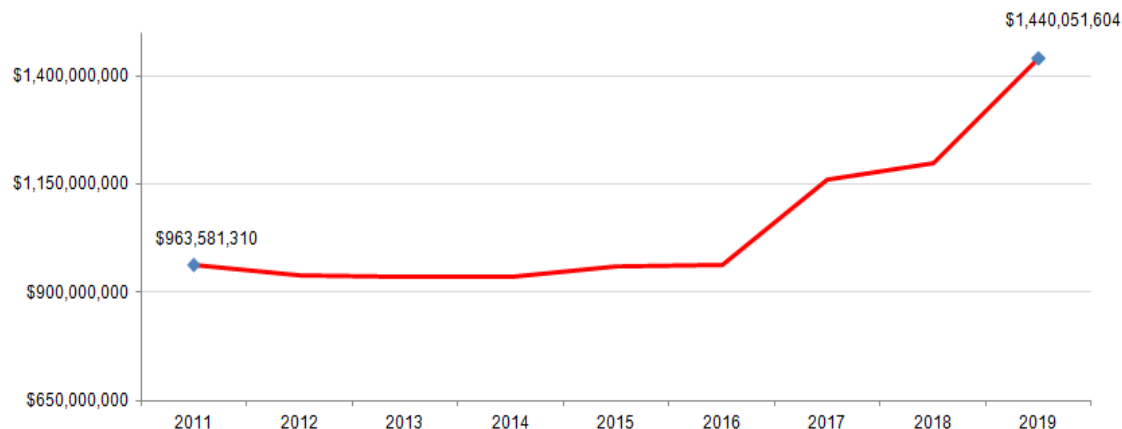
Second, in his 2017 proposed settlement and consent order on GHMSI’s surplus, the Commissioner made clear that he considered the 721% RBC ratio established in the December 2014 decision *to be controlling*. See Decision and Order on GHMSI Motion to Approved Proposed Consent Order at 9, *In re Surplus Review and Determination for Group Hospitalization and Medical Services, Inc.*, No. 14-MIE-26 (Dep’t of Ins., Sec. & Banking, Aug. 3, 2017). The Commissioner provided that if GHMSI’s RBC ratio fell below 721%, its obligation to spend down surplus would be suspended. Order and Terms of Consent at 3, *In re Surplus Review and Determination for Group Hospitalization and Medical Services, Inc.*, No. 14-MIE-26 (Dep’t of Ins., Sec. & Banking, Aug. 3, 2017). But GHMSI has since increased its RBC ratio to 1088%.

Third, the Court of Appeals **rejected all** of GHMSI’s arguments challenging the appropriateness of the Commissioner’s 721% RBC ratio. As a result, while resolution of the issues now on remand before the Commissioner could reduce the permissible RBC ratio under MIEAA, that ratio cannot increase. Furthermore, because the Court rejected all of GHMSI’s arguments that could reduce the Commissioner’s determination that the company has an excess surplus of \$51 million, it is now clear under the Court’s decision that GHMSI must spend down, at a minimum, that \$51 million amount.

But GHMSI has not taken action to spend down the \$51 million. Instead, as shown in the chart below, GHMSI has steadily increased its surplus from 2011 through the end of 2019. At year-end 2019, GHMSI’s surplus reached an all-time high of \$1.44 billion, and its RBC ratio reached 1088%.

**GHMSI’s total adjusted capital (surplus) and risk-based capital (RBC) ratio, 2011-2019**

	2011	2012	2013	2014	2015	2016	2017	2018	2019
Total adjusted capital (TAC)	\$963,581,310	\$941,070,954	\$934,751,475	\$934,408,634	\$960,214,523	\$963,238,051	\$1,161,213,975	\$1,200,102,655	\$1,440,051,604
Risk based capital (RBC) ratio	998.3%	921.3%	932.3%	877.6%	881.5%	850.6%	1010.7%	922.9%	1088.3%



In short, to date neither MIEAA, nor the DISB's rulings, nor the Court of Appeals' decisions, has caused GHMSI to reduce its surplus to address community health needs of the District. Absent action by the Commissioner, MIEAA will be rendered a dead letter and GHMSI will continue largely to disregard its federal charter, with its nonprofit mission and charitable and benevolent purpose, to the great detriment of the District's residents.

## **B. The District's Critical Health Needs**

The D.C. Council's purpose in enacting MIEAA was to require that GHMSI direct its excess surplus to its charitable purpose, i.e., to invest excess surplus in community health needs of the District. The Council determined in 2009 that District residents were facing a "wide variety" of "healthcare issues" and stated that the "primary motivation" for MIEAA was to have GHMSI use excess surplus to address those issues. Council of D.C. Comm. on Pub. Servs. & Consumer Affairs, B. 17-934, at 9 (2008); *D.C. Appleseed Center for Law and Justice, Inc. v. D.C. Department of Insurance, Securities and Banking*, 54 A.3d 1188, 1214 (D.C. 2012).

That purpose remains unfulfilled: GHMSI has steadily *increased*, not decreased, its excess surplus. Moreover, since MIEAA's enactment, the District's critical health needs have increased. As the Commissioner is aware, the COVID-19 pandemic has created a public health emergency. GHMSI can and should now use its excess surplus to address the health needs caused by this pandemic.

Indeed, as the Commissioner expressly noted in the December 30, 2014 decision, GHMSI's own statistical model – which the Commissioner adopted to assess GHMSI's permissible surplus – included a "catastrophic events risk factor" recognizing "the potential effect of events that are infrequent, severe, and unpredictable natural disasters (for example, pandemics . . . ). 2014 Decision at 43.

GHMSI's extraordinary, historically high excess surplus ensures that it can do much more than meet its obligations to subscribers during this pandemic. At long last, GHMSI should be brought into compliance with MIEAA and should be required to invest its significant excess surplus to help address the dire health care needs of the District community.

## **C. Past Delays in DISB Proceedings**

DISB's eleven-year delay in fulfilling MIEAA's mandates is due primarily to its failure to adjudicate GHMSI's surplus promptly, and then its failure to comply with MIEAA when action was belatedly taken, including as follows:

- Following enactment of MIEAA in January 2009, the Commissioner held a hearing in September 2009 concerning compliance with the statute;
- It was more than a year later, in October 2010, before the Commissioner issued a decision determining that GHMSI held no excess surplus;

- Appleseed promptly appealed that decision, sought expedited review, and argued the appeal in June 2011. DISB did not participate in the argument, but simply asked that the Court summarily affirm the decision.
- In a lengthy September 2012 opinion, the Court reversed the Commissioner on two grounds: failure to apply MIEAA's requirement that GHMSI commit the maximum feasible amount of its surplus to community health reinvestment, and failure to adequately explain the determination that GHMSI had no excess surplus. The Court also indicated that to comply with MIEAA's timing requirement for surplus reviews, the Commissioner should act on that remand no later than October 2013.
- DISB did not comply with that three-year deadline (which began to run at the time of the initial surplus review in 2010). Instead, in December 2013, the Commissioner's expert, Rector & Associates (Rector), issued a report concluding – as it had in the first proceeding – that GHMSI had no excess surplus.
- Appleseed then sought information from the Commissioner explaining Rector's conclusion. In June 2014, the Commissioner held a hearing on that conclusion and received supporting analysis from GHMSI and its actuarial expert, as well as contrary analysis from Appleseed and its actuarial expert.
- In December 2014, the Commissioner issued a final opinion agreeing with Appleseed that GHMSI held excess surplus (\$268 million) and finding that 21% of that excess (\$56 million, later reduced to \$51 million) should be committed to health reinvestment in the District. Appleseed, however, contended that both GHMSI's excess surplus and the portion attributable to the District were much larger.
- The Commissioner ordered GHMSI to file a plan by March 2015 to spend down the excess surplus the Commissioner found attributable to the District. When GHMSI did not comply with this order, the Commissioner then took more than a year – until August 2016 – to issue a plan of his own, which required GHMSI to rebate the \$51 million to its current subscribers.
- GHMSI then filed a motion for reconsideration of the August 2016 order. The Commissioner denied that motion, but not until February 2018. During that year-and-a-half delay, DISB staff and GHMSI – without Appleseed's knowledge – agreed on a possible settlement that GHMSI had submitted to the Commissioner. When Appleseed demonstrated that the proposed settlement contained several terms out of compliance with MIEAA, the Commissioner submitted a revised settlement for GHMSI's review; GHMSI rejected the revised settlement in September 2017. When DISB took no further action, Appleseed asked the D.C. Court of Appeals to issue a mandamus order requiring the Commissioner to end further delay by ruling on GHMSI's long-pending motion for reconsideration. The Court issued a mandamus order in January 2018 requiring the

Commissioner to act in February 2018, which he did – repeating the Commissioner’s earlier requirement that GHMSI rebate \$51 million to subscribers as of August 2016.

- Appleseed appealed the Commissioner’s February 2018 order. The appeal was argued in April 2019, and the Court, working under an expedited schedule, issued an opinion just four months later, on August 29, 2019. The Court upheld the determination that GHMSI has a minimum excess surplus of \$51 million, and it also identified five issues that remain to be addressed adequately by the Commissioner, which are necessary to determine the full amount of the excess surplus beyond the affirmed \$51 million.
- On November 13, 2019, after the DISB failed to take action on the remand from the Court’s August 29 opinion, Appleseed filed a request with DISB, urging the Commissioner to act promptly in response to the Court’s decision and to issue a final order.
- On April 6, 2020, Appleseed and Councilmember Mary Cheh wrote a letter to the current DISB Commissioner, who was appointed on January 21, 2020, urging her to order the spend down by GHMSI of the \$51 million and to address the five issues remanded by the Court.
- DISB has not yet taken action in response to the Court’s August 29, 2019 decision, but on February 27, 2020, the new Commissioner issued an order indicating that the case was before her on remand from the Court of Appeals. On April 6, 2020, she indicated that she would be responding to the Councilmember Cheh/Appleseed letter in the coming weeks.<sup>6</sup>

## **DISCUSSION**

### **A. The Commissioner Should Immediately Order GHMSI to Spend the \$51 Million Affirmed by the Court of Appeals, and Promptly Resolve the Issues Remanded by the Court of Appeals to Determine GHMSI’s Additional Excess Surplus**

Given the past delay, and the health crisis created by the coronavirus pandemic, it is urgent that the Commissioner act in two ways, as Appleseed indicated in its April 6 letter.

First, the Commissioner should immediately order the spending of \$51 million in excess surplus, as determined by the Commissioner in December 2014. Because the Court of Appeals rejected all of GHMSI’s challenges to that determination, the \$51 million determination is GHMSI’s minimum obligation and should be disbursed. The Commissioner should require that these funds prioritize spending on needs arising from the pandemic – potentially including forgiving or reducing premiums for all individual members or, as feasible, those at risk of losing coverage, and supporting frontline healthcare workers in their fight against the pandemic.

---

<sup>6</sup> Email from Karima Woods, Comm’r., Dep’t of Ins., Sec. and Banking, to Walter Smith, Exec. Dir., D.C. Appleseed Ctr. for Law & Justice (Apr. 6, 2020).

Second, the Commissioner should move promptly to resolve the five issues remanded by the Court of Appeals. These issues are relatively narrow. They entail the possibility of an additional \$262.44 million or more (for a total of \$313.44 million or more, based on interest running through June 2020) to be spent to address community health needs in the District. The Commissioner should resolve them as expeditiously as possible.

The Court of Appeals has directed the Commissioner to address: (1) the effect on GHMSI's need for surplus of the risk posed by its portfolio investment; (2) the percentage of GHMSI's excess surplus to be attributed to the District; (3) the request for prejudgment interest from GHMSI on the excess surplus owed to the District as of the end of 2011; (4) reimbursement of Appleseed's actuarial fees; and (5) determination of an appropriate plan for "community health reinvestment" of GHMSI's excess surplus.

Taken together, resolution of these issues consistent with MIEAA requires GHMSI to spend \$313.44 million from its current \$1.44 billion surplus. Spending down this amount will leave GHMSI with a surplus of \$1.13 billion and an RBC ratio of 851%.

After addressing below the merits of the five remand issues, Appleseed then sets forth a proposed procedure for resolving the issues, taking into account the need to coordinate with Virginia and Maryland.

## **1. The Effect of Equity Portfolio Risk on GHMSI's Need For Surplus**

### **a. The Court of Appeals' Directive on Remand**

As the Court stated, in determining GHMSI's permissible surplus as of December 31, 2011, "the actuaries attempted to predict the range of possible future gains and losses" on GHMSI's equity investments. *D.C. Appleseed*, 214 A.3d at 992. The purpose of the prediction was to assess the impact of such gains and losses on GHMSI's projected revenues and thus on the level of surplus it needed to maintain to protect against potential losses to the portfolio, *i.e.*, before the surplus reached an excessive level that required additional surplus to be reinvested for community health. 2014 Decision at 31.

During the administrative proceedings, Appleseed objected that GHMSI's expert "exaggerat[ed] the effect of potential equity portfolio losses," thereby significantly overstating GHMSI's need for surplus to cover such losses. *D.C. Appleseed*, 214 A.3d at 992. Nonetheless, DISB's expert and the Commissioner "adopted [GHMSI's] approach . . . without mentioning Appleseed's objection." The Court of Appeals has "remand[ed] this issue for the Commissioner to specifically address Appleseed's objection." *Id.*

Appleseed's objection to GHMSI's prediction is twofold. First, it contains significant errors in calculation, which the District's Attorney General's Office ("OAG") and GHMSI have attempted to walk back or downplay. Second, those significant miscalculations produce a result that is inconsistent with the Commissioner's own determination that MIEAA requires the use of "middle of the fairway" projections in assessing GHMSI's surplus.

## **b. Correcting the Commissioner's Calculation Error**

The reason the Commissioner “exaggerat[ed] the effect of potential equity portfolio losses” was that he measured the risk of those losses not against GHMSI’s equity portfolio but against GHMSI’s projected nonFEP premium revenue of \$3.038 billion. A129, A1588. The equity portfolio is only 16% of the size of GHMSI’s nonFEP premium revenue, as Milliman acknowledged. Group Hospitalization and Medical Services, Inc. Post-Hearing Brief, *In re Surplus Review & Determination for Group Hospitalization and Medical Services., Inc.* (Dep’t of Ins., Sec. & Banking, Nov. 7, 2014), Exhibit 12, at 16 (A1589) [hereinafter Milliman Rebuttal]. Thus, multiplying the percentage impact on the equity portfolio by the size of the nonFEP premium revenue—as Milliman did—grossly overstates the impact of that factor by a factor of more than 6 to 1. A1733. As a result, the Milliman model on which the Commissioner relied overstated the need for surplus to cover that risk to the same extent.

GHMSI initially denied that there was any mistake and then later argued that any mistake was insignificant.<sup>7</sup> GHMSI’s counsel argued to the Court of Appeals that the expression of the shortfall as a percentage of nonFEP revenue was no more significant than expressing the amount of a recipe ingredient in cups versus teaspoons.<sup>8</sup> That is colorful language, but as the calculations show, flatly wrong. Measuring in cups or in teaspoons would be consequential indeed if the recipe did not account for the large difference between the two, and it was not accounted for here.

To correct the error, Appleseed’s actuarial expert adopted Milliman’s probability distribution for equities as closely as possible, but adjusted its percentage deviations to account for the 6-to-1 mismatch between the value of equities and the size of nonFEP premium revenue. D.C. Appleseed’s Motion for Reconsideration, *In re Surplus Review & Determination for Group Hospitalization and Medical Services., Inc.* (Dep’t of Ins., Sec. & Banking, Jan. 9, 2015) app. Mark Shaw Statement at 10 [hereinafter Shaw Statement]. Re-running the model to account for downside risk to the projected equity return, which was calculated to be 7% per year, produces a much smaller need for additional surplus and in turn reduces the needed RBC ratio from the

---

<sup>7</sup> OAG likewise defended the error on behalf of DISB by arguing to the Court that the negative 3% deviation relied on by Milliman as the most likely downside risk to GHMSI’s nonFEP premium revenue was applied as a percentage of the projected 7%, meaning the most likely expected return was only .21% less than 7% (3% times 7% is .21%), leaving an expected return of 6.79% (7% minus .21%). But as further discussed below, that is flatly contradicted by the language of the probability distribution itself, which expressly states that the percentages in the probability distribution represent three-year “Surplus Change as % of nonFEP Insured Premium.” Milliman Rebuttal at 16 (A1588) (emphasis added). All of GHMSI’s probability distributions – including the equity portfolio factor – expressed surplus impacts in the same way, i.e., as a percentage of nonFEP revenue. *Id.* As a matter of math, 3% of nonFEP revenue is \$91.4 million, not the much smaller \$4.3 million that results from the OAG reading.

<sup>8</sup> Brief for Intervenor Group Hospitalization and Medical Services, Inc., *D.C. Appleseed Center for Law and Justice, Inc. v. D.C. Department of Insurance, Securities and Banking*, 214 A.3d 978 (D.C. 2019) (No. 18-AA-178), <http://www.dcappleseed.com/wp-content/uploads/2018/11/2018-10-31-GHMSI-Intervenor-Brief.pdf>.



Commissioner's 721% figure to 615% RBC. Shaw Statement at 12. This reduction in surplus need in turn increases GHMSI's *excess* surplus by a further \$102.3 million. Adding this to the excess surplus found by the Commissioner increases the excess surplus from \$267.6 million to \$369.9 million.

**c. The Further Adjustment Needed to Correct for the Understated Projected Return to Equities**

In addition to overstating the projected loss to the equities comprising a portion of GHMSI's holdings, Milliman understated the projected return to the entire investment portfolio. One further adjustment needs to be made to correct this error. Milliman projected that the total return to GHMSI's investment portfolio for the 2012-2014 period would be 3.75%, and then used its model to estimate the downside risk to this projected return. But the record shows that Milliman understated the projected return to the portfolio – and to that same extent, therefore, overstated the needed surplus.

Milliman based its expected return to the investment portfolio by assuming that equities would return an average of 7% annually for the three-year period from 2012 to 2014 and that GHMSI's remaining assets would return 3.5%, for a blended total rate of 3.75%. Milliman also assumed that equities represented 16% of the portfolio; accordingly, other assets represented 84%. Milliman Rebuttal at 17 (A1589).

But Milliman's projected return calculation across the whole portfolio is incorrect: Milliman's own figures demonstrate that the projected return to the investment portfolio was 4.06%, not 3.75%. A portfolio that is composed of 16% equities earning 7%, along with 84% other assets earning 3.5%, is earning an expected return of 4.06% (that is,  $(0.16 \times 7\%) + (0.84 \times 3.5\%) = 4.06\%$ ). Shaw Statement at 10. Applied to a portfolio of \$1.23 billion at year-end 2011, earning 4.16% rather than 3.75% means that GHMSI would earn \$3.8 million per year more than Milliman assumed – resulting in “a total investment return understatement of \$11.4 million due only to Milliman's own arithmetic error.” *Id.*

Thus, permissible surplus at the end of 2011 was a further \$11.4 million lower than the Commissioner projected, and GHMSI's excess surplus was accordingly higher by that same \$11.4 million. This \$11.4 million error, when added to the more significant error produced by the overstatement of equity risk due to the misuse of the probability distribution in the statistical model, increases GHMSI's total excess surplus from \$369.9 million to \$381.3 million.

**d. The Foundational Error in the Commissioner's Approach**

The calculation errors described above compound a foundational error in the Milliman analysis on which the Commissioner relied. Put simply, the methodology employed by the Commissioner did not follow his own regulatory standards for assessing the equity portfolio risk and GHMSI's need for surplus. As a result, the Commissioner's methodology significantly overstated the downside risk to GHMSI's projected gains on its investment portfolio, and overstated GHMSI's need for surplus.

*The legal standard under MIEAA.* In the December 30, 2014 Decision, the Commissioner appropriately determined that MIEAA requires review of GHMSI's permissible surplus based on "reasonable 'middle-of-the-fairway' projections," not "highly attenuated risks," 2014 Decision at 21. Further, the Commissioner decided that the projections should be "based on relevant historical experience and reasonable projections for how future experience may deviate from historical experience." *Id.* at 30. The analysis that the Commissioner relied on to assess the risk to GHMSI's equity portfolio, however, did not follow these requirements.

*Milliman's projected rate of return.* At the outset, GHMSI's expert, Milliman, considered historical returns of Standard and Poor's (S&P) 500 Index from 1950 to 2011 to project that GHMSI's equity portfolio would return an average of 7% per year for the three-year period 2012-2014. A1587. If each year's growth was at this average, GHMSI's portfolio would have increased by \$97,537,508 (annual growth at 7% for three years would produce compounded growth of 22.5%).

As further explained below, Milliman used a probability distribution that concluded, in the face of this historical data, that the most likely return on equities for the 2012-2014 period would be only \$6.1 million, or \$91.4 million less than the \$97 million return Milliman had projected for this time period.

*Milliman's probability distribution.* Milliman reached this result by employing in its statistical model a probability distribution reflecting "the potential impact of a deviation from the assumed 7.0 % [annual] underlying rate of return on equities, due to fluctuation in market values during the projection period [2012-2014]." A1587. In that probability distribution, the deviation with the largest probability was a 29% shortfall totaling \$91.4 million; in other words, the most likely deviation from the \$97 million expected gain on the equity portfolio was a shortfall equivalent to -3% "of NonFEP Insured Premium." A1588. Owing again to the 6-1 mismatch between the size of GHMSI's equity portfolio and the projected size of its nonFEP premium revenue, Milliman's statistical model in effect concluded that the most likely equity portfolio gain on an average annual basis would be barely more than 1% – even though, as the Commissioner noted, the average annual gain over the previous 50 years had been 7.3%, and even though Milliman projected that the actual gain would be 7%.

The Commissioner's expert, Rector & Associates, Inc., agreed with this approach, as did the Commissioner. They adopted Milliman's probability distribution, finding that "while equity values have increased at an average rate of 7.3% over the last 50 years, there has been significant volatility around this average." 2014 Decision at 37 (citing Rector Third Scheduling Order at 5-6). Rector found, and the Commissioner agreed, that Milliman's probability distribution reasonably reflected the "potential for deviation and variation" from the 7% annual return assumed in Milliman's pro forma projection for equity return during 2012-2014. *Id.*

*Inconsistency with MIEAA.* The Commissioner's adoption of this probability distribution not only involves a substantial mathematical miscalculation, but it is also inconsistent with the statutory standard articulated by the Commissioner. Under MIEAA, the probability distribution must reflect "middle-of-the-fairway" projections of how "future experience may deviate from historical experience." As Appleseed showed in its motion for reconsideration of the Commissioner's December 2014 Decision, the probability distribution used in the Milliman

model did not reasonably reflect potential deviations from the 7% equity projection. D.C. Appleaseed's Motion for Reconsideration at 4–8, *In re Surplus Review & Determination for Group Hospitalization and Medical Services., Inc.* (Dep't of Ins., Sec. & Banking, Jan. 9, 2015). Nowhere did Milliman, Rector, or the Commissioner offer any explanation of how or why the most likely future experience might deviate so drastically from historical experience.

In sum, the probability distribution on which the Commissioner relied assumed that GHMSI would most likely fall short by \$91 million from its projected equity return and needed at least that amount of additional surplus to make up for the loss. Nothing in the record or the Commissioner's stated standards justifies such an assumption. A correct evaluation of the equity portfolio factor alone increases GHMSI's total excess surplus from \$268 million to \$381.3 million.

## **2. Percentage of GHMSI's Excessive Surplus to be Attributed to the District**

### **a. The Court of Appeals' Directive on Remand**

As Appleaseed explained before the Court of Appeals, the Commissioner did not follow his own principles when determining that just 21% of GHMSI's excess surplus was attributable to the District of Columbia.

The Commissioner's December 2014 Decision announced two principles for attributing excess surplus among the jurisdictions: (1) attribute premium revenue to the jurisdiction that was the situs of the contract giving rise to the revenue; and (2) assess the profitability of that revenue per jurisdiction in order to determine how much each jurisdiction contributed to excess surplus. 2014 Decision 52–53, 55–56.

The Court of Appeals agreed with Appleaseed that the Commissioner did not explain adequately how he applied those principles in determining the amount of excess surplus to be attributed to the District as MIEAA requires. The Court held that “the Commissioner in this case has in a number of important aspects not adequately explained the approach the Commissioner took to apportioning surplus.” *D.C. Appleaseed*, 214 A.3d at 995.

The Court identified three ways in which the Commissioner's explanation for his decision to attribute just 21% of GHMSI's excess surplus to the District was inadequate: (1) the Commissioner limited his analysis of the jurisdictions' relative contributions to surplus based solely “on a snapshot of 2011 rather than an effort to analyze GHMSI's surplus history and to determine the District's contributions to that surplus over time”; (2) the Commissioner “addressed only to a very limited degree alleged differences among the District, Virginia, and Maryland with respect to the riskiness and profitability of GHMSI's activities”; and (3) the Commissioner “took as dispositive” GHMSI's attribution by jurisdiction of FEP premium revenue, even though that treatment “has varied over time” (shifting from situs to residence) and even though relying on GHMSI's treatment “led the Commissioner to treat FEP policies differently from nonFEP policies without providing a sufficient rationale for such differential treatment.” *Id.* The Court therefore “remand[ed] for further consideration of these issues.” *Id.*

**b. The Three Errors Underlying the Commission's Flawed Application of its Attribution Principles**

The Court identified essentially the same problems with the Commissioner's decision that Appleseed raised both in its reconsideration motion before the Commissioner and in its briefs before the Court of Appeals.

First, Appleseed demonstrated that basing the attribution determination solely on contributions to surplus in 2011, as the Commissioner did, would not fairly measure how much of the excess surplus as of the end of 2011 was attributable to each of the three jurisdictions. Rather, given that GHMSI's maximum permissible surplus was 721% RBC, it was necessary to assess contributions to surplus beginning with the year when GHMSI's surplus was last below 721% RBC in order to measure the source of the excess that led the surplus to rise to its impermissible level at the end of 2011 – i.e., to 998% RBC from 721% RBC. As Appleseed stated, “the last time that GHMSI's year-end surplus was below a 721% RBC ratio was at 12/31/2002. It follows then that all of the excess surplus above 721% RBC was generated in the 9-year period from 2003 to 2011.” Shaw Statement at 4.

Second, while the Commissioner properly adjusted gross FEP and nonFEP revenue separately to account for the higher profitability of nonFEP revenue, he failed to adjust for differences in the profitability of nonFEP revenue among the three jurisdictions. Because the District's nonFEP revenue was significantly more profitable than that in the other jurisdictions, this failure led to a significant understatement of excess surplus attributable to the District. Indeed, GHMSI's financial statements make clear that while only about 30% of GHMSI nonFEP gross revenue was earned in the District during 2003-2011, more than 65% of GHMSI's nonFEP *profit* derived from the District during that period. *Id.*, Shaw Statement at 3. *See also* A1727-28. Failure to adjust for the difference in profitability resulted in an incorrect answer to the Commissioner's own overriding attribution question: “where did the money come from?” 2014 Decision at 53 (quoting *Benedik v. Commissioner*, 429 F.2d 41, 43 (2d Cir. 1970)). Surplus comes from profits, but the Commissioner failed to account for how much profit came from the District.

Finally, Appleseed explained that during nearly the whole of the period 2003-2011, GHMSI reported FEP revenue consistent with the Commissioner's principle that revenues be attributed among the jurisdictions based on the situs of the contract leading to the revenue. However, in 2010 and 2011, for the first time and without explanation, GHMSI began attributing FEP revenue based on the residence of subscribers. This caused GHMSI to attribute a portion of FEP revenue to Maryland that had previously been attributed to the situs of the FEP contract, the District of Columbia. And to that same extent, this change caused an understatement of premium revenue attributable to the District. Notwithstanding that this change contradicted the Commissioner's explicit rejection of residence as the appropriate method for attributing premium revenue, 2014 Decision at 52–53, the Commissioner approved it on the ground that GHMSI “should be bound” by how it reported the revenue. *Id.* at 54 n.30. Appleseed argued that this view had it backward: GHMSI's regulatory filings must comply with MIEAA; MIEAA is not subordinate to GHMSI's choices in its regulatory filings, particularly when those choices reverse its longstanding prior practice. The Court of Appeals determined that the Commissioner's acceptance of GHMSI's regulatory filing is not a “sufficient rationale” for this inconsistent

treatment of situs versus residence as between FEP and nonFEP. *D.C. Appleseed*, 214 A.3d at 995. Rather, GHMSI should be bound by the Commissioner’s assessment of MIEAA, i.e., that situs of the contract controls.

**c. Correcting the Commissioner’s Attribution to Account for the Three Identified Errors**

To correct for the prior Commissioner’s three attribution errors, the Commissioner should now: (1) take into account contributions to excess surplus from the years 2003 through 2011, not just from 2011; (2) measure profitability of nonFEP revenue during those years by jurisdiction to determine how much nonFEP revenues in each jurisdiction actually contributed to GHMSI’s surplus; and (3) attribute FEP revenue during those years among jurisdictions according to the situs of the contract. As *Appleseed* showed, these three changes – all consistent with the Commissioner’s announced principles and with the Court of Appeals’ analysis – result in an appropriate attribution of excess surplus to the District at the end of 2011 of 58.3%. A1732.<sup>9</sup>

As previously explained, correcting the Commissioner’s errors on GHMSI’s equity portfolio increases GHMSI’s excess surplus at the end of 2011 to \$381.3 million. Multiplying this total GHMSI excess surplus by the 58.3% attributable to the District means that the amount owed for community reinvestment for public health in the District (before interest) is \$222.3 million.

When appropriate interest is added to this amount, *see infra* Section 3, the total amount is \$313.44 million (based on interest running through June 2020).

**3. Prejudgment Interest on Excess Surplus That GHMSI Owed to the District as of End of 2011**

**a. The Court of Appeals’ Directive to Address the Request for Prejudgment Interest**

In a July 19, 2017 letter to the Commissioner, *Appleseed* requested that the Commissioner order that interest be paid by GHMSI beginning at the end of 2011 on the amount of excess surplus finally determined to be owed at that date. *Appleseed* explained that, among other things, “there has been considerable delay in protecting the public’s interest in GHMSI’s excess surplus,” “GHMSI should not profit from this delay,” “interest earned on the excess surplus belongs to the public, not the company,” and the Commissioner has authority to award interest based on his broad discretion under MIEAA to “issue such orders as are necessary to enforce the purposes of the statute.” Letter from Walter Smith, Exec. Dir., D.C. *Appleseed* Ctr. for Law & Justice, to Hon. Stephen Taylor, Comm’r, Dep’t of Ins., Sec. & Banking (July 19, 2017) (citing D.C. Code Section 31-3506(i)).

---

<sup>9</sup> This attribution would have been higher (63.5%) had the excess surplus calculation been limited to GHMSI’s profit. However, given that the Commissioner determined that the attribution should include GHMSI’s interest in BlueChoice, 2014 Decision at 54 n.28, that interest is included in this calculation, resulting in a lower attribution (58.3%). A1732.

The Court of Appeals noted that the Commissioner did not address this request. Nor had GHMSI or DISB disputed that the request was made or that the Commissioner had failed to address it. *D.C. Appleseed*, 214 A.3d at 995–96. The Court therefore directed the Commissioner to address the request on remand. *Id.*

### **b. Prejudgment Interest Is Appropriate**

As Appleseed explained in its appellate brief, relevant local precedent supports imposing prejudgment interest. The Court of Appeals made clear in *Riggs Nat'l Bank v. District of Columbia*, that where, as here, money was owed at an earlier date but not paid, denying interest “would deny full compensation to [those entitled to the payment] while allowing the recalcitrant party to take advantage of his own wrong and become the richer for it.” 581 A.2d 1229, 1252 (D.C. 1990). Similarly, *D.C. Pub. Sch. v. D.C. Dep't of Emp't Servs*, 123 A.3d 947, 952 (D.C. 2015), upheld an agency determination to award prejudgment interest notwithstanding the lack of explicit statutory authority to do so.

In addition, Councilmember Cheh, the author of MIEAA, stated before the Court that “[a]s a matter of sound public policy, the Court should add interest to the award, as argued by [Appleseed].” Amicus Curiae Brief of D.C. Councilmember Mary M. Cheh at 8.

DISB did not respond to these contentions. GHMSI argued that “in absence of unequivocal prohibition of interest on statutory obligation,” the Court should look to the statutory “purpose in imposing the obligation.” GHMSI Intervenor Brief at 28 (citing *Rodgers v. United States*, 332 U.S. 371, 373–74 (1947)). Appleseed agrees. Three principles support imposing prejudgment interest here: (1) there is no prohibition against interest in MIEAA; (2) the Commissioner has broad authority to issue orders effectuating MIEAA’s purpose,<sup>10</sup> which was to promptly commit GHMSI’s excess surplus to community health reinvestment; and (3) the interest that the company has earned on its excess surplus during the past eight years’ delay in implementation (2012-2019) should be used to serve community health needs of the District, not retained by GHMSI.

### **c. Calculating Prejudgment Interest**

The interest on GHMSI’s excess surplus is properly determined with reference to its actual total returns earned on that excess during 2012-2019, including its return on equities (dividends plus net appreciation in the value) and interest on bonds. Computing the amount earned on the excess surplus during those years is consistent with the Court’s determination in *Riggs Bank* that the party improperly withholding an amount of money from those to whom it was owed should not retain the interest earned on that amount, but should transfer that earned interest to those improperly denied the money.

Based upon GHMSI’s publicly available annual statements detailing the company’s investment income and capital gains during 2012-2019 (including its 50% share of Blue Choice), GHMSI earned an average annual rate of return of 4.06% on its excess surplus during those years, for a cumulative gain of 41%. When that gain is added to the \$222.3 million of excess

---

<sup>10</sup> D.C. Code Section 31-3506(i).

surplus due the District at the end of 2011 based on the amount attributed to it, the total due the District is \$313.44 million. This is the amount GHMSI should commit to community health reinvestment in the District.

#### **4. Reimbursement of Appleseed's Actuarial Fees**

##### **a. The Court of Appeals' Directive to Address the Request for Actuarial Fees**

As with prejudgment interest, Appleseed requested recovery of its actuarial fees before the Commissioner. Again, the Commissioner did not address the issue; nor did DISB or GHMSI dispute that the request for recovery of fees was made or that the Commissioner did not address it. Accordingly, the Court of Appeals directed the Commissioner to address the issue on remand. *D.C. Appleseed*, 214 A.3d at 995–96.

##### **b. The Commissioner Should Grant Appleseed's Request for Its Out-of-Pocket Actuarial Fees as a Payment Separate from Spend-Down Of Excess Surplus for Community Health Benefit**

In its July 19, 2017 Letter to the Commissioner, Appleseed recognized that participants in litigation generally are responsible for their costs unless otherwise provided by statute, and that MIEAA does not expressly provide for a participant to recover fees. But MIEAA does authorize the Commissioner to award fees in appropriate circumstances, and the circumstances in this drawn-out administrative proceeding and parallel litigation justify recovery of Appleseed's actuarial fees, which have benefited both the Commissioner's review of GHMSI's surplus and the public interest. Reimbursement of actuarial fees would be in addition to GHMSI's spend-down of its excess surplus.

In this case, the Court of Appeals recognized the value and contribution of Appleseed's role in enforcing MIEAA,<sup>11</sup> and in multiple instances, the Commissioner has recognized the importance of Appleseed's advocacy to implement MIEAA.<sup>12</sup> In addition to this recognition of

---

<sup>11</sup> As the Court of Appeals laid out in some detail in its first opinion, when Appleseed appealed DISB's erroneous October 2010 determination that GHMSI has no excess surplus, that appeal came "at the end of Appleseed's protracted pursuit of greater investment by GHMSI in accessible health care for D.C. residents." *D.C. Appleseed Ctr. for Law & Justice, Inc. v. D.C. Dep't of Ins., Secs., & Banking*, 54 A.3d 1188, 1210 (D.C. 2012). As the Court said, Appleseed has not "merely [sought] to enforce the requirements of the MIEAA, but has been a catalyst for and helped to create those requirements." *Id.* As the Court also said, Appleseed has engaged in "dogged and concrete work . . . over a number of years to establish and enforce the legal structure created by the MIEAA so as to enhance the availability of affordable health care and promote public health in the District of Columbia." *Id.* at 1208.

<sup>12</sup> As the Commissioner said in his December 2014 decision finding \$268 million in excess surplus, "[t]he Commissioner acknowledges and appreciates Appleseed's efforts in enhancing the record and contributing its analyses of GHMSI's surplus." 2014 Decision at 7 n.2. The Commissioner also explained that the permitted extensive involvement by Appleseed in the

Appleseed’s peculiarly important third-party contribution, MIEAA contemplates GHMSI paying for independent expertise used by the Commissioner in reaching a determination.<sup>13</sup>

Appleseed was able to sustain its longstanding involvement in developing and implementing MIEAA due in part to the significant pro bono contributions from two law firms—Covington & Burling and Harkins Cunningham—and from health economist Deborah Chollet at Mathematica Policy Research. However, it became clear early in the DISB proceedings that retaining an independent actuarial expert was critical to address the complexities of the statistical model central to the arguments of both GHMSI’s expert, Milliman, and the Commissioner’s expert, Rector.

Appleseed’s independent actuarial expert disagreed with many elements in Milliman’s and Rector’s use of the model, including their use of the confidence level and the premium growth estimates. And it was the Commissioner’s disagreement with Milliman and Rector on those two elements that caused him to conclude, contrary to GHMSI’s position, that GHMSI has \$268 million of excess surplus. Although the Commissioner did not formally engage Appleseed’s expert, MIEAA expressly acknowledges that actuarial expertise independent of GHMSI may aid the Commissioner, and where it does, the Commissioner should have the discretion to impose the costs of that expertise on GHMSI.

The Commissioner should exercise that discretion here. The expertise of Appleseed’s independent actuarial expert has directly aided the Commissioner in resolving this case, and it will continue to do so in these remand proceedings. Indeed, key information needed to resolve both the equity portfolio and attribution issues now before the Commissioner comes solely from Appleseed’s expert. Although Milliman and Rector both determined that those issues were properly addressed, the Court of Appeals rejected those determinations.

It is important to the implementation of MIEAA to make it possible for a small nonprofit to pursue this matter before the Commission and in the Court in service to the public. Allowing recovery of at least part of its Appleseed’s out-of-pocket costs (which are not covered by pro bono) for that long-term effort is key to that role.

---

remand proceedings “in light of Appleseed’s longstanding involvement with and special interest in the MIEAA.” *Id.* at 7 n.2.

<sup>13</sup> MIEAA provides that “[w]hen determining what surplus is attributable to the District and whether surplus is excessive, the Commissioner may retain . . . independent actuaries . . . the cost of which shall be borne by the corporation.” D.C. Code § 31-3506(h) (emphasis added). DISB regulations further clarify that “the Commissioner shall make a final determination regarding the corporation’s surplus . . . with the assistance of experts, if necessary,” and that “[t]he cost of any experts used by the Commissioner shall be borne by the corporation.” D.C. Mun. Regs. tit. 26A, § 4602.5 (emphasis added). MIEAA also allows the commissioner to “issue such orders as are necessary to enforce the purposes of” the act. D.C. Code § 31-3506(i). As the Commissioner has recognized, “MIEAA was enacted ‘to ensure that nonprofit hospital and medical service corporations pursue their public health mission.’” Decision and Order at 15, *In re Surplus Review & Determination for Grp. Hospitalization & Med. Servs., Inc.*, No. 14-MIE-19 (D.C. Dep’t of Ins., Sec. & Banking, Aug. 30, 2016).



In addition to Appleseed’s prior showing that reimbursement of our actuarial fees is justified, the author of the statute, Councilmember Cheh, confirmed the importance of such compensation in her amicus brief to the Court of Appeals:

[I]t is important that GHMSI be required to compensate DC Appleseed for its out-of-pocket actuarial fees – something that the DISB Commissioner failed to address. DC Appleseed is a small nonprofit that works to improve the lives of District residents. Its work is invaluable to the D.C. Council working toward this common goal. In this David versus Goliath matter, DC Appleseed’s resources are far outmatched by GHMSI, and it has incurred out-of-pocket actuarial fees [of \$432,000] which, for DC Appleseed, represent a significant amount of its relatively small budget.<sup>14</sup>

We must encourage our public organizations to do this kind of work. Here, this means that apart from the exact dollar outcome of the GHMSI excess surplus issue, DC Appleseed should be reimbursed for the fees paid to the actuarial experts, who have provided vitally important input at every stage of years of the DISB proceedings. DISB had the discretion to award these fees but failed even to consider them, which was clear error on DISB’s part.

Cheh Amicus Brief at 8.

Viewed as a whole, the Commissioner should award reimbursement of the requested out-of-pocket fees. The requested amount is small relative to the large amount of excess surplus at issue. Because it is an amount separate from and in addition to GHMSI’s excess surplus, it will not diminish the amount reinvested in community health in the District, and it will help Appleseed to continue to monitor GHMSI’s activities in this proceeding as the company spends down its excess surplus.

## **5. Determination of an Appropriate Plan for Community Health Reinvestment of GHMSI’s Excess Surplus**

With respect to the ultimate use of GHMSI’s excess surplus, the Court of Appeals noted that the parties “extensively debated the Commissioner’s decision to order a rebate rather than some other type of community-health reinvestment.” *D.C. Appleseed*, 214 A.3d at 996. Because the Court was otherwise remanding the case for further proceedings, it left this debate for the Commissioner to address. *Id.*

MIEAA distinguishes between expenditures of excess surplus “that promote and safeguard the public health” and expenditures “that benefit current or future subscribers.” *See* D.C. Code §31-3501(1A). Both are within the definition of “community health reinvestment,” but each is distinct from the other. The real-life differences between the two are, of course, significant.

---

<sup>14</sup> If the Commissioner approves reimbursing Appleseed for its out-of-pocket actuarial fees, Appleseed will submit invoices documenting these fees.

Appleseed explained to the Court of Appeals that the Commissioner's rebate order failed to give sufficient consideration to the possibility of requiring that at least part of GHMSI's excess surplus be directed to addressing community health needs in the District, rather than exclusively as rebates to current subscribers (Opening Brief at 40-44). In the present posture of the case – including GHMSI's decade-long delay in spending down its excess surplus – rebating all or most of the excess to subscribers is simply not reasonable.

Several strong reasons support this view. First, the D.C. Council's principal purpose in passing the Act was to use GHMSI's excess surplus to address the "wide variety" of "healthcare issues" that cause District residents to "fight[] an uphill battle in elevating the quality and expectancy of their lives." Committee on Public Serv. & Consumer Affairs, Report on Bill 17-934, MIEAA, at 9 (Oct. 17, 2008). The Commissioner adopted as his remedial standard that the remedy must "best serve []" this purpose of the Act (along with its "fair and equitable" requirement). A4139. Across-the-board rebates to individual current subscribers do not effectively serve this purpose, let alone (to quote the Commissioner's standard) "best-serve" it.

Second, more than eight years after the surplus year at issue (2011), rebates to individual current subscribers would be unreasonable as a practical matter. MIEAA envisioned annual filings and prompt determinations of whether GHMSI surplus was excessive, so that, when the remedial choice was rebates to subscribers rather than to "support and promote the public health," such rebates would be promptly returned to the subscribers that had funded the excess surplus. That is now impossible. Refunding rebates to current subscribers would inevitably provide windfalls to some subscribers that did not fund any of the excess surplus, and deny refunds to many that funded the excess but are no longer subscribers. Thus, rebates would be both impermissibly under-inclusive and impermissibly over-inclusive. They would constitute an economic transfer from past subscribers to current subscribers, and they would flout the statutory standard that the spend-down of excess surplus be "fair and equitable." D.C. Code § 31-356(g).<sup>15</sup>

In short, rebates to subscribers do not further the principal purpose of the Act, would contravene expectations with respect to the timetable for completing a surplus review, and would violate the "fair and equitable" standard. Rebates of 2011 excess surplus cannot possibly "best-serve" the purposes of the Act when the Act expressly provides an alternative remedy that squarely furthers the purposes of the Act and that does not entail the arbitrary, inequitable outcomes that would result from individual current subscriber rebates.

In its recent report entitled "CareFirst's Investment in Public Health," GHMSI focused on three priorities for public health investment in the District: improving maternal and child health; empowering the region's safety net clinics and promoting the patient-centered medical home concept; and behavioral health. Appleseed supports these initiatives and would welcome a

---

<sup>15</sup> Further, it was not only the Council's intention to use GHMSI's excess surplus to address pressing community health needs, but to address the needs of *District residents*. Because the vast majority of GHMSI subscribers are not District residents, this means that returning the whole of the excess surplus exclusively as rebates to individual current GHMSI subscribers will not serve the Council's purpose.

spend-down plan that considered them. At the same time, however, the spend-down plan approved by the Commissioner should also take into account the community health needs posed by the current coronavirus pandemic.

## **B. Other Issues for a DISB Final Order**

In addition to ordering immediate payment of the \$51 million portion of excess surplus affirmed by the Court of Appeals, and resolving the five remand issues, the Commissioner should address several other matters in a final order. Appleseed addressed those issues in its earlier comments objecting to GHMSI's proposed consent order. D.C. Appleseed's Comments on GHMSI's Proposed Consent Order for Resolving Proceedings Under the Medical Insurance Empowerment Amendment Act, *In re Surplus Review and Determination for Group Hospitalization and Medical Services, Inc.*, No. 14-MIE-26 (Dep't of Ins., Sec. & Banking, May 9, 2017).

Appleseed explained that any Final Order requiring community health reinvestment of GHMSI's excess surplus should make clear: (1) the types of programs or initiatives that qualify as community health reinvestment; (2) who will make the determinations regarding how and when the excess surplus will be dedicated to those community health reinvestments; (3) the standards that will be followed in making those determinations; (4) the standards and measures for ensuring that GHMSI meets its obligations under MIEAA both to reinvest excess surplus and also to expend the maximum feasible amount each year for community health reinvestment; (5) a mechanism that ensures the company meets those obligations and (6) that DISB will have a role in systematically reviewing and certifying GHMSI's compliance with the Order and with MIEAA.

These are important provisions that should be addressed in the Commissioner's final order.

## **C. Further Proceedings by the Commissioner**

The above discussion presents Appleseed's views concerning how the five remand issues should be resolved, and how a final spend-down order should be structured. Appleseed understands, of course, that GHMSI and representatives of Virginia or Maryland may have different perspectives. As noted in the Motion accompanying this brief, for the Commissioner to hear from these stakeholders and to appropriately coordinate with them, and, to implement the decision of the Court of Appeals, Appleseed proposes that the Commission enter an order directing the following steps:

- The Commissioner should immediately order GHMSI to spend down the \$51 million of excess surplus.
- The Commissioner should permit GHMSI to respond to Appleseed's Motion and accompanying brief no later than 20 days after the filing of this Motion and brief.
- The Commissioner should permit the Virginia and Maryland state insurance regulators and any other interested party to submit a pre-hearing public statement to DISB no later

than 14 days after filing of this Motion and brief or GHMSI's response, whichever is later. Any pre-hearing public statement should be limited to 20 pages.

- If GHMSI and/or Virginia and Maryland insurance regulators submit a response to Appleseed's Motion and brief, the Commissioner should permit Appleseed to file a reply, no later than 14 days after the filing of the response.
- At the close of the parties' opportunity to respond to this Motion and the accompanying brief and Appleseed's opportunity to submit a reply, the Commissioner, in consultation with Virginia and Maryland state insurance regulators on the public record, should issue a notice for a joint public hearing (by teleconference, if need be) regarding the issues that remain to be addressed on remand in light of the Court of Appeals' decision and the existing factual record. The Commissioner should schedule the joint public hearing to be no more than 14 days after the close of the parties' opportunity to respond to this Motion and Appleseed's opportunity to submit a reply.
- The Commissioner should jointly preside over the public hearing with the relevant Virginia and Maryland state insurance regulators, during which any interested party may make a public statement and respond to regulator questions, and address the positions expressed in any pre-hearing submissions.
- Appleseed, GHMSI, the Virginia and Maryland state insurance regulators, and any other interested party should be afforded the opportunity to submit a responsive public statement no later than 14 days after the joint hearing. Any post-hearing public statement may include the party's proposed findings and conclusions regarding the remand issues and their effect on GHMSI's permissible year-end 2011 surplus, and should be limited to 30 pages.
- The Commissioner should issue a final decision on remand within 30 days after receiving any post-hearing statements.

This schedule is proposed as a means to provide a timely and orderly remand proceeding that comports with MIEAA and the Court of Appeals' decision.

## **CONCLUSION**

For the reasons stated, and pursuant to the Commissioner's interpretation of MIEAA, we urge the Commissioner to enter an order that requires GHMSI to spend \$51 million immediately from its excess surplus for community health reinvestment, and then order that GHMSI spend down, from its current surplus of \$1.44 billion, the remaining \$262.44 million of the \$313.44 million in excess surplus attributable to the District to address community health needs in the District of Columbia. GHMSI should also be required, separately from its spend-down of excess surplus, to reimburse Appleseed for its out-of-pocket actuarial fees, given the significant contribution that Appleseed has made to these proceedings through that actuarial expert.

Respectfully submitted,



---

\*Walter Smith  
(D.C. Bar No. 238949)  
D.C. Appleseed Center for Law & Justice, Inc.  
1111 Fourteenth Street, NW,  
Suite 510  
Washington, D.C. 20005  
Tel: (202) 289-8007  
Fax: (202) 289-8009  
wsmith@dcappleseed.org

Richard B. Herzog  
(D.C. Bar No. 17731)  
Harkins Cunningham LLP  
1700 K Street, NW, Suite 400,  
Washington, D.C. 20006  
Tel: (202) 973-7602  
Fax: (202) 973-7610  
rbh@harkinscunningham.com

Marialuisa Gallozzi  
(D.C. Bar No. 413874)  
Beth Brinkmann  
(D.C. Bar No. 477771)  
Bradley K. Ervin  
(D.C. Bar No. 982559)  
Covington & Burling LLP  
One CityCenter, 850 Tenth Street, NW  
Washington, D.C. 20001  
Tel: (202) 662-6000  
Fax: (202) 662-6291  
mgallozzi@cov.com

*Counsel for Appleseed*

## CERTIFICATE OF SERVICE

I certify that on this 14th day of May, 2020, I caused one copy of the foregoing to be sent by electronic mail to the following:

Adam Levi, Assistant General Counsel  
D.C. Department of Insurance and Securities  
Regulation  
810 First Street, NE, Suite 701  
Washington, D.C. 20002  
Phone: 202-442-7759  
adam.levi@dc.gov

Loren AliKhan  
James McKay  
Office of the Solicitor General  
Office of the Attorney General for the  
District of Columbia  
441 4th Street, N.W., Suite 630  
Washington, D.C. 20001  
loren.alikhan@dc.gov  
james.mckay@dc.gov

Lisa Hertzler Schertler  
SCHERTLER & ONORATO, LLP  
1101 Pennsylvania Ave., N.W.  
Suite 1150  
Washington, D.C. 20004  
lschertler@schertlerlaw.com

Michelle S. Kallen  
Office of the Attorney General of Virginia  
202 North Ninth Street  
Richmond, VA 23219  
mkallen@oag.state.va.us

I also caused one copy of the foregoing to be sent by U.S. mail to the following:

Virginia Bureau of Insurance  
P.O. Box 1157  
Richmond, Virginia 23218-1157

Maryland Office of the Attorney General  
200 St. Paul Place  
Baltimore, MD 21202

Maryland Insurance Administration  
200 St. Paul Place, Suite 2700  
Baltimore, MD 21202



---

Marialuisa Gallozzi

# **Exhibit 2**

**GOVERNMENT OF THE DISTRICT OF COLUMBIA  
DEPARTMENT OF INSURANCE, SECURITIES AND BANKING**

	)	
IN THE MATTER OF	)	
	)	
Surplus Review and Determination	)	Order No.: 14-MIE-012
for Group Hospitalization and Medical	)	
Services, Inc.	)	
	)	

**DECISION AND ORDER**

This Decision and Order sets forth the factual findings and legal conclusions of the Acting Commissioner of the District of Columbia Department of Insurance, Securities and Banking (“Commissioner”) regarding whether the 2011 surplus of Group Hospitalization and Medical Services, Inc. (“GHMSI”) attributable to the District of Columbia is “excessive,” as defined by applicable law.

Throughout these proceedings, the Commissioner has stressed that this surplus review requires thoughtful analysis of complex facts and laws. The opinion below reflects the factual findings and legal conclusions reached after hearing testimony from over a dozen witnesses and reviewing hundreds of pages of submissions by GHMSI, various experts, other regulators, and other interested persons. As detailed further below, the Commissioner concludes:

- GHMSI’s surplus as of December 31, 2011 was 998% RBC-ACL (approximately \$963.5 million);
- the appropriate level for GHMSI’s surplus was 721% RBC-ACL (approximately \$695.9 million) and because GHMSI’s surplus exceeded 721% RBC-ACL, it was excessive;
- 21% of GHMSI’s surplus is attributable to the District of Columbia; and
- GHMSI must submit a plan to the Commissioner for dedication of its excess 2011 surplus attributable to the District of Columbia to community health reinvestment in a fair and equitable manner.



## TABLE OF CONTENTS

I.	JURISDICTION .....	2
II.	PROCEDURAL HISTORY.....	3
	A. Brief Description of GHMSI and Surplus Review .....	3
	B. Review of GHMSI 2008 Surplus.....	4
	C. Review of GHMSI 2011 Surplus.....	6
	D. The Record.....	10
III.	FACTUAL BACKGROUND.....	10
IV.	ANALYSIS OF GHMSI SURPLUS .....	12
	A. Applicable Law .....	12
	1. District of Columbia Statutes and Regulations .....	12
	2. Court of Appeals Framework.....	14
	B. GHMSI Surplus is Greater than the Appropriate RBC Standards.....	16
	C. GHMSI's Surplus is Unreasonably Large and Inconsistent with its Community Health Reinvestment Obligations .....	18
	1. Defining Financial Soundness and Efficiency .....	18
	2. Estimating Surplus Needs .....	21
	3. Model Assumptions and Operation.....	23
	4. 2011 Surplus Level Conclusions.....	49
	D. Allocation of Surplus to the District of Columbia.....	50
	E. GHMSI's Community Health Reinvestment.....	58
	F. Coordination with Other Jurisdictions .....	62
	G. Requirements for GHMSI Plan.....	65
V.	ORDER.....	66

### I. JURISDICTION

The Commissioner has the authority to decide whether GHMSI's surplus attributable to the District of Columbia is excessive pursuant to D.C. Official Code § 31-3506(e) (2012 Repl.), which codifies Section 7(e) of the Hospital and Medical Services Corporation Regulatory Act of 1996, effective April 9, 1997 (D.C. Law 11-245; D.C. Official Code § 31- 3501 *et seq.*), as amended by the Medical Insurance Empowerment Amendment Act of 2008, effective March 25,

2009 (D.C. Law 17-369) (the “MIEAA”) (in this Decision and Order, “the Act” refers to the Hospital and Medical Services Corporation Regulatory Act of 1996 as amended by the MIEAA). The Commissioner’s determination also is governed by the regulations implementing the Act, 26A DCMR §§ 4600.1 to 4699.4.

## **II. PROCEDURAL HISTORY**

### **A. Brief Description of GHMSI and Surplus Review**

GHMSI is a nonprofit hospital and medical services corporation domiciled in the District of Columbia (the “District”) and regulated by the Commissioner under the Act. *See* D.C. Official Code § 31-3501 (2012 Repl.).<sup>1</sup> As a nonprofit hospital and medical services corporation, GHMSI is required by the Act to “engage in community health reinvestment to the maximum feasible extent consistent with financial soundness and efficiency.” *Id.* at § 31-3505.01. The Act further provides that the Commissioner must review GHMSI’s surplus at least once every three years and may issue a determination regarding whether the surplus is excessive. *Id.* at § 31-3506(e). GHMSI’s surplus may be considered excessive only if it exceeds certain risk-based capital standards and is determined by the Commissioner to be unreasonably large and inconsistent with GHMSI’s obligation under the Act to engage in community health reinvestment. *Id.* All of these provisions of the Act were added by the MIEAA, which became effective March 25, 2009. Under regulations implementing the MIEAA, GHMSI must file an annual report with the Commissioner detailing its surplus and examining whether it is excessive. 26A DCMR § 4601.1.

---

<sup>1</sup> GHMSI was organized and operates under a federal charter as a “charitable and benevolent institution.” An Act providing for the incorporation of certain persons as Group Hospitalization and Medical Services, Inc., approved Aug. 11, 1939 (Pub. L. No. 76-395, § 8; 53 Stat. 1412, 1414), as amended (the “Charter”). The Charter requires that GHMSI be operated as a nonprofit entity for the benefit of its certificate holders and further provides that it is to be legally domiciled in the District of Columbia and licensed and regulated by the District in accordance with the District’s laws and regulations. Charter at §§ 1, 3, 5.

**B. Review of GHMSI 2008 Surplus**

Following the MIEAA's enactment and applying its new standards, during 2009-2010 the Department of Insurance, Securities and Banking ("DISB" or the "Department") performed a comprehensive review of GHMSI's surplus as of December 31, 2008. In a Final Decision and Order issued on October 29, 2010, then-Commissioner Gennet Purcell determined that GHMSI's 2008 surplus of 845% RBC-ACL (approximately \$687 million) was not excessive. DISB, Final Decision and Order, *In the Matter of: Surplus Review and Determination Regarding Group Hospitalization and Medical Services, Inc.*, Order No. 09-MIE-007 (Oct. 29, 2010) (the "2010 Order"). (See Section IV.B., below, for an explanation of RBC-ACL.)

In the 2010 Order, Commissioner Purcell noted that by the end of 2009 GHMSI's surplus had increased to 902% RBC-ACL (approximately \$761 million), and that this amount would be considered excessive "if all of the assumptions underlying this review were to remain the same." *Id.* at 12. Commissioner Purcell did not deem the 2009 surplus to be excessive, however. *Id.* Instead, she concluded that it would be necessary to conduct a *de novo* review of GHMSI's surplus for any year after 2008 because changes in GHMSI's regulatory and financial environment – particularly those brought by implementation of the Patient Protection and Affordable Care Act (the "ACA") and related health care reform legislation – could affect the company's surplus needs. *Id.* at 12-13. Accordingly, consistent with the Act's requirement that GHMSI's surplus be reviewed at least once every three years, Commissioner Purcell ordered a subsequent review to occur by July 31, 2012. *Id.* at 14.

On November 24, 2010, the D.C. Appleseed Center for Law and Justice, Inc. ("Appleseed") filed a petition with the District Columbia Court of Appeals challenging the 2010 Order on the grounds that Commissioner Purcell had: (1) incorrectly interpreted the Act, (2)

failed to provide adequate reasons to support her determination that GHMSI's 2008 surplus was not excessive, and (3) abused her discretion in failing to order an immediate review of GHMSI's 2009 and 2010 surpluses. *D.C. Appleseed Center for Law and Justice, Inc. v. District of Columbia Department of Insurance, Securities and Banking*, 54 A.3d 1188, 1192, 1198 (D.C. App. 2012) (“*Appleseed Appeal*”).

On September 13, 2012, the D.C. Court of Appeals issued a decision affirming in part and reversing in part the 2010 Order. *Appleseed Appeal*, 54 A.3d at 1220. The Court affirmed Commissioner Purcell's decision to not order an immediate review of GHMSI's 2009 and 2010 surpluses, holding that “in light of the changing conditions identified in the order[,]” she had not abused her discretion by deferring further review until July 31, 2012. *Id.* at 1220. The Court reversed Commissioner Purcell's decision on the 2008 surplus, ruling that she had not correctly interpreted the Act in determining whether GHMSI's surplus was excessive and had not provided sufficient explanation for her determination. *Id.* at 1219.

Based on these holdings, the Court remanded the matter to DISB for further proceedings consistent with its opinion, including (1) a more complete explanation of the reasoning in support of the surplus determination and (2) an interpretation of the Act, “as guided by the Department's discretion and expertise, that follows the framework we have set out in this opinion....” *Id.* at 1220-21. As discussed in Section IV.A.2., below, the Court's “framework” consists of guidance on how the Act should be construed in light of GHMSI's statutory obligation to engage in community health reinvestment to the “maximum feasible extent consistent with financial soundness and efficiency.” *See id.* at 1218-20.

**C. Review of GHMSI 2011 Surplus**

Before the D.C. Court of Appeals issued its decision, DISB already had begun to solicit input from interested persons regarding the appropriate standards for, and scope of, the next surplus review. On June 1, 2012, GHMSI filed the report required by 26A DCMR § 4601.1 for its surplus as of December 31, 2011. *See* CareFirst BlueCross BlueShield, Report on GHMSI Surplus [for 2011], 1 (June 1, 2012) (“2011 Surplus Report”).

When the Court remanded the 2008 surplus review to DISB in September 2012, then-Commissioner William P. White determined that further review of the 2008 surplus would be moot. Commissioner White concluded that the review instead should focus on GHMSI’s surplus as of December 31, 2011, which was the surplus for which the most recent information was available at the time. Commissioner White further concluded that a review of the 2011 surplus would satisfy the statutory mandate to review GHMSI’s surplus review at least once every three years. *See* D.C. Official Code § 31-3506(e) (2012 Repl.).

DISB retained Rector & Associates, Inc. (“Rector”), an insurance regulatory and financial analysis firm, and NovaRest, Inc., an actuarial firm, to assist in the surplus review. *See* D.C. Official Code § 31-3506(h) (2012 Repl.) (authorizing retention of consultants to assist with a surplus review). Rector in turn retained FTI Consulting, Inc., to assist it with actuarial analysis. (“Rector,” in this Decision and Order, refers to Rector and FTI Consulting together.)

At the outset of its engagement, Rector met at least twice with key staff from GHMSI and its consulting expert, Milliman, Inc., as well as with Appleseed and its consultant, United Health Actuarial Services, Inc. (“UHAS”), to discuss the structure of Rector’s work, the actuarial model used by Milliman to assist GHMSI in determining its surplus needs (the “Milliman Model”), and the standards to be used by DISB in the analysis of GHMSI’s surplus. Transcript, Group

Hospitalization and Medical Services, Inc. Surplus Review Hearing, 26 (June 25, 2014) (“Tr.”). During those meetings, GHMSI, Milliman, Appleseed, and UHAS all provided input into the appropriate structure and standards to be used for the examination. *Id.* Following the meetings, Rector requested and received additional information from Milliman and GHMSI regarding GHMSI’s surplus and the Milliman Model. *Id.*

On December 9, 2013, Rector issued a report with its findings and recommendations concerning GHMSI’s 2011 surplus. Rector & Associates, Inc., Report to the D.C. Department of Insurance, Securities and Banking – Group Hospitalization and Medical Services, Inc. (Dec. 9, 2013) (the “Rector Report”). In brief, the Rector Report concluded that GHMSI should strive for a target of 958% RBC and that GHMSI’s surplus should be measured against a benchmark range of 875% to 1040% RBC. Rector Report at 13. (Sections IV.C. and IV.E., below, discuss the Rector Report in greater detail.)

Following release of the Rector Report, DISB hosted a series of conference calls among DISB staff, Rector, GHMSI, Appleseed, and their consultants to discuss Appleseed’s comments and questions on the report’s findings, methodologies, and underlying data. During this time, Appleseed submitted four lengthy sets of questions and data requests to DISB. DISB replied to each of these requests with detailed written responses and disclosures of data which were added to the Record. *See* Section II.D., below, and the attached Exhibit 1 for a complete description of materials in the Record and where they may be located.<sup>2</sup>

---

<sup>2</sup> The Commissioner acknowledges and appreciates Appleseed’s efforts in enhancing the record and contributing its analyses of GHMSI’s surplus. Although the Commissioner denied Appleseed’s request for formal party status, the Commissioner granted Appleseed expansive rights of participation. *See* DISB, Order on DC Appleseed Participation, *In the Matter of: Surplus Review and Determination Regarding Group Hospitalization and Medical Services, Inc.*, Order No. 14-MIE-004 (June 10, 2014) (“Participation Order”). These rights included extensive engagement with DISB, its consultants and GHMSI; more than tripling the applicable page limit for a pre-hearing brief; and permitting Appleseed to make a lengthy oral presentation as well as a closing statement at the

(continued on next page)

The Commissioner initially scheduled a hearing for the surplus review to take place in March 2014 but ultimately rescheduled the hearing for June 25, 2014, to ensure that Appleseed and any other interested persons would have sufficient time to review and respond to information provided by DISB in response to Appleseed's questions and data requests.<sup>3</sup> The Commissioner sent hearing notices directly to Maryland and Virginia Insurance Commissioners.

Prior to the hearing, GHMSI and Appleseed submitted pre-hearing briefs for the Commissioner's consideration. Appleseed also submitted an extensive analysis of GHMSI's surplus prepared by Mark Shaw of UHAS. In addition, the Commissioner received written statements from numerous other persons, including the Maryland Insurance Commissioner, the Blue Cross Blue Shield Association ("BCBSA"), and recipients of GHMSI's charitable giving.

At the hearing on June 25, 2014, the Commissioner heard testimony from Rector, GHMSI, Appleseed, Milliman, and UHAS, each followed by lengthy question and answer sessions with the Commissioner and Associate Commissioner for Insurance Philip Barlow. The Commissioner also heard testimony from a number of other interested persons. The hearing concluded with closing statements by Appleseed and GHMSI and final remarks by the Commissioner.

After the hearing, the Commissioner issued a series of orders (1) requesting additional information from Rector, GHMSI, and Appleseed; (2) establishing a schedule for the submission of responses to these requests; and (3) setting a deadline of November 7, 2014, for the filing of

---

(continued from prior page)

hearing. *See id.* The Commissioner granted these enhanced rights in light of Appleseed's longstanding involvement with and special interest in the MIEAA. *See id.*

<sup>3</sup> The final hearing notice is available on DISB's website and is part of the hearing record, as described in Section II.D., below. *See also* D.C. Register, Vol. 61-No. 19 at 4385-4386 (May 2, 2014). Prior hearing notices are available in D.C. Register, Vol. 61- No. 3 at 384 (Jan. 17, 2014) and D.C. Register, Vol. 61-No. 11 at 2093-2094 (Mar. 14, 2014).

final rebuttal statements. *See, e.g.,* DISB, Third Scheduling Order, *In the Matter of: Surplus Review and Determination Regarding Group Hospitalization and Medical Services, Inc.*, Order No. 14-MIE-005 (Aug. 7, 2014); Order with Supplemental Information Requests, Order No. 14-MIE-008 (Oct. 3, 2014). The Commissioner received submissions from Rector, GHMSI and Appleseed in September and October 2014, in response to his requests. After the hearing, the Commissioner also received a Statement of the Virginia State Corporation Commission's Bureau of Insurance, and a Statement from Therese M. Goldsmith, the Maryland Insurance Commissioner, addressing surplus allocation. *See* Section II.D.; Exhibit 1. *See also* Section IV.F., below, for a discussion of communications with Maryland and Virginia.

In the post-hearing period, the Commissioner denied, on two grounds, a request from Appleseed for certain confidential and proprietary information submitted to DISB by GHMSI. First, the Commissioner determined that much of the information requested by Appleseed was not relevant to the review of GHMSI's surplus, would not be relied upon by the Commissioner in reaching a final determination, and therefore was not needed by Appleseed. Second, the Commissioner concluded that Appleseed already had received extensive information concerning GHMSI's operations and the analysis performed by Rector, as evidenced by the fact that it had provided the Commissioner with detailed analyses of GHMSI's surplus, and therefore did not need additional confidential and proprietary information to contribute to the Commissioner's final determination. Order on DC Appleseed Request for Disclosure of Confidential and Proprietary Information, Order No. 14-MIE-010 (Oct. 24, 2014).

GHMSI and Appleseed submitted final rebuttal statements on November 7, 2014. On November 24, 2014, Appleseed submitted a letter acknowledging that the rebuttal period had closed, but requesting leave to respond to information in GHMSI's rebuttal statement. Because



the rebuttal period had closed, the Commissioner denied this request and confirmed the closing of the record in this proceeding. Order Closing Record, Order No. 14-MIE-011 (Nov. 26, 2014).

**D. The Record**

At the June 25, 2014 hearing, the Commissioner gave notice that “the surplus-related material posted on DISB’s website will be the official record for this proceeding.” Tr.11:9-11. All non-confidential materials related to the review of GHMSI’s surplus are publicly available on various webpages on DISB’s website at [www.disb.dc.gov](http://www.disb.dc.gov). *See also* Exhibit 1 –Hearing Record Index for 2011 Surplus Review. The Record materials include the reports by GHMSI pursuant to 26A DCMR § 4601.1; GHMSI annual statements; the Rector Report; Appleseed’s information requests and responses to those requests; pre-hearing briefs; written testimony and other statements prepared for the hearing; the hearing transcript; DISB requests for supplemental information and responses to those requests; and the final rebuttal statements. Excluding GHMSI’s regulatory filings, there are over 2,000 pages of surplus-related materials on DISB’s website which the Commissioner considered in reaching this Decision. *See id.*

**III. FACTUAL BACKGROUND**

GHMSI is a wholly owned subsidiary of CareFirst, Inc., a nonprofit holding company. It is affiliated with CareFirst of Maryland, Inc. (“CFMI”), which is also a wholly owned subsidiary of CareFirst, Inc. *See* Health Annual Statement for the year ended December 31, 2011 of the condition and affairs of Group Hospitalization and Medical Services, Inc., 25.9 (“2011 Annual Statement”). CFMI and GHMSI share ownership of CareFirst Holdings, LLC. (“CFH”), which in turn owns 100% of CareFirst BlueChoice, a health maintenance organization operating in the District, Maryland and certain counties in Virginia. *See id.* GHMSI owns approximately 50% of

CFH, the vast majority of which consists of CareFirst BlueChoice.<sup>4</sup> *See id.* For purposes of this review, “GHMSI” means the combination of 100% of the business of GHMSI itself and GHMSI’s approximately 50% ownership of CFH.

GHMSI does business in the District as CareFirst BlueCross BlueShield. It uses the BlueCross and BlueShield names and logos subject to certain requirements established under licensing agreements it maintains with the BCBSA. *See* Group Hospitalization and Medical Services, Inc.’s Responses to Questions in the Third Scheduling Order, 7 (Sep. 5, 2014) (“GHMSI Resp. Third Sched. Order”).

GHMSI plays a significant role in providing health insurance in the District. CareFirst’s CEO, Chet Burrell, testified that, in the District, CareFirst provides 76% of commercial health insurance coverage for individuals under age 65; provides 72% of small group coverage; and covers 80% of the U.S. Congress. Tr.90:16-20. CareFirst also serves many larger employer groups. *Id.* at 89:25, 90:1. As of December 31, 2011, GHMSI had nearly 288,000 policies<sup>5</sup> in force and contracted with over 59,000 network providers throughout the District, Maryland and Virginia. Response of Group Hospitalization and Medical Services, Inc. to Supplemental Information Request 1(d) in DISB Order No. 14-MIE-08 (October 3, 2014) (Oct. 31, 2014) (“GHMSI 1(d) Resp.”). During 2011, GHMSI wrote approximately \$4.4 billion in premiums and paid nearly \$3.7 billion in claims. *Id.*

As of year-end 2011, GHMSI’s surplus stood at 998% RBC-ACL, or \$963,581,310. 2011 Surplus Report at 1; 2011 Annual Statement at 28, line 4. GHMSI describes the 2011

---

<sup>4</sup> CFH also owns certain other subsidiaries that are much smaller than BlueChoice and which do not significantly affect the analysis here.

<sup>5</sup> This figure includes policies issued to individuals and to employers/groups. Thus, the number of individuals covered by GHMSI policies is significantly higher.

surplus as equivalent to “just under three months of claim expense.” Group Hospitalization and Medical Services, Inc., Pre Hearing Brief – DISB Review of GHMSI Surplus Pursuant to the Medical Insurance Empowerment Act of 2008, D.C. Code § 31-3501 *et seq.*, 6 (June 10, 2014) (“GHMSI Pre-Hearing Brief”). More factual findings about GHMSI’s surplus appear in the discussion in Section IV, below.

## **IV. ANALYSIS OF GHMSI SURPLUS**

### **A. Applicable Law**

#### **1. District of Columbia Statutes and Regulations**

Two separate but interrelated provisions of the Act<sup>6</sup> define the scope of the Commissioner’s surplus review: (1) under section 31-3505.01, GHMSI must “engage in community health reinvestment to the maximum feasible extent consistent with financial soundness and efficiency,” and (2) under section 31-3506(e), the Commissioner must periodically review the portion of GHMSI’s surplus attributable to the District to determine whether it is “excessive.” D.C. Official Code §§ 31-3505.01, 31-3506(e) (2012 Repl.). Section 31-3506(e) further provides that GHMSI’s surplus may be considered excessive only if:

- (1) The surplus is greater than the appropriate risk-based capital requirements as determined by the Commissioner for the immediately preceding calendar year; and
- (2) After a hearing, the Commissioner determines that the surplus is unreasonably large and inconsistent with the corporation's obligation [to engage in community health reinvestment] under § 31-3505.01.

---

<sup>6</sup> As noted in Section I, above, the “Act” refers to the Hospital and Medical Services Corporation Regulatory Act of 1996, effective April 9, 1997 (D.C. Law 11-245; D.C. Official Code § 31- 3501 *et seq.*), as amended by the Medical Insurance Empowerment Amendment Act of 2008, effective March 25, 2009 (D.C. Law 17-369) (the “MIEAA”).

*Id.* at §31-3506(e). The Act defines community health reinvestment as “expenditures that promote and safeguard public health or that benefit current or future subscribers, including premium rate reductions.” *Id.* at § 31-3501(1A).

DISB regulations clarify that if the Commissioner makes a preliminary determination that GHMSI’s surplus is excessive because it exceeds applicable risk-based capital requirements, then the Commissioner must schedule a public hearing to make a final determination regarding whether the surplus is “excessive and unreasonably large.” 26A DCMR § 4601.5.<sup>7</sup>

In determining whether GHMSI’s surplus is excessive, the Commissioner must “take into account all of the corporation’s financial obligations arising in connection with the conduct of the corporation’s insurance business, including premium tax paid and the corporation’s contribution to the open enrollment program required by § 31-3514 and payments and expenditures pursuant to a public-private partnership.” D.C. Official Code § 31-3506(f) (2012 Repl.). Also, “the Commissioner shall consider the interests and needs of the jurisdictions in the corporation’s service area.” *Id.* at § 31-3506.01(b).<sup>8</sup>

To facilitate the surplus review, DISB regulations require GHMSI to file an annual report with the Commissioner concerning the company’s surplus and whether it is excessive under the Act. 26A DCMR § 4601.1. Under the Act, the Commissioner must review the portion of

---

<sup>7</sup> The regulations define an “unreasonably large surplus” as a surplus that is greater than the sum of “(a) The appropriate NAIC [National Association of Insurance Commissioners] risk-based capital level requirements determined by the Commissioner and the Blue Cross/Blue Shield Association capital requirements based on the company’s surplus from the immediately preceding year” and “(b) The amount of surplus needed by the corporation to meet its expected and unanticipated contingencies.” 26A DCMR § 4699.4.

<sup>8</sup> DISB regulations provide further guidance for assessing whether the surplus is excessive. The regulations mandate consideration of (1) the risk-based capital requirements for health insurers developed by the NAIC as implemented by District law in D.C. Official Code § 31-3851.01 *et seq.* (2012 Repl.) and (2) the capital requirements established by the BlueCross BlueShield Association. 26A DCMR § 4601.4. The regulations permit consideration of (a) “actuarially determined risk exposures as well as the expected and unanticipated contingencies of the company” and (b) “the anticipated cost of the corporation’s contribution to the open enrollment program required by section 15 of the Act.” *Id.* at § 4601.8.

GHMSI's surplus that is attributable to the District no less often than once every three years and may issue a determination as to whether the surplus is excessive. D.C. Official Code § 31-3506(e) (2012 Repl.). The surplus review required by the Act must be "undertaken in coordination with the other jurisdictions in which the corporation conducts business." *Id.* DISB therefore must coordinate with both Maryland and Virginia, where GHMSI also conducts business. Maryland itself reviews GHMSI's surplus in separate proceedings. *See, e.g.*, Statement of Therese M. Goldsmith, Maryland Insurance Commissioner (June 25, 2014) ("Maryland Pre-Hearing Statement"); Maryland Insurance Administration, Consent Order, *In re Targeted Surplus Ranges for CareFirst of Maryland Inc. and Group Hospitalization and Medical Services, Inc.*, Case No. MIA-2012-09-006 (Sept. 14, 2012) ("Maryland Consent Order").

The Act further states:

- (1) If the Commissioner determines that the surplus of the corporation is excessive, the Commissioner shall order the corporation to submit a plan for dedication of the excess to community health reinvestment in a fair and equitable manner.
- (2) A plan submitted pursuant to paragraph (1) . . . may consist entirely of expenditures for the benefit of current subscribers of the corporation.

D.C. Official Code § 31-3506(g) (2012 Repl.)

In reviewing the Commissioner's 2010 Order, the D.C. Court of Appeals provided guidance as to how the Act should be interpreted and applied, as discussed below.

## **2. Court of Appeals Framework**

In its 2012 decision, the D.C. Court of Appeals reviewed the standards for evaluating GHMSI's surplus in light of the Act's structure and legislative history. *Appleseed Appeal*, 54 A.3d at 1213-15. The Court noted the interrelationship between section 31-3505.01, which mandates that GHMSI engage in community health reinvestment to the maximum feasible extent

consistent with financial soundness and efficiency, and section 31-3506(e)(2), which requires the Commissioner to determine whether GHMSI's surplus is unreasonably large and inconsistent with GHMSI's community reinvestment obligation under section 31-3505.01. *Appleseed Appeal*, 54 A.3d at 1213-14. Both sections, the Court noted, were added to the Act by the MIEAA. *Id.* at 1214. Reviewing the MIEAA's legislative history, the Court took note of "the Council's twin objectives in amending the statute: (1) obligating GHMSI to reinvest in community health 'to the maximum feasible extent,' (2) without undermining GHMSI's 'financial soundness and efficiency.'" *Id.* at 1214. In the Court's judgment, "A harmonious interpretation of the statute's language, viewed in its entirety, requires that a surplus determination . . . keep both these objectives in mind." *Id.*

Accordingly, the Court held that "the two determinations required by § 31-3506(e)(2)—whether GHMSI's surplus is 'unreasonably large' and whether the surplus is inconsistent with GHMSI's community health reinvestment obligations under §31-3505.1—must be made in tandem, not *seriatim*, to give full effect to the statute." *Appleseed Appeal*, 54 A.3d at 1215. Having reached this conclusion, the Court acknowledged that "there remain details as to how such a determination is to be made. As to the specification of how surplus and community reinvestment are to be calculated and balanced, we defer to the agency's reasonable discretion in light of its expertise in this subject matter." *Id.*

Applying the D.C. Court of Appeal's guidance, the Commissioner interprets section 31-3506(e)(2) as requiring him to determine the level of surplus that maximizes GHMSI's community health reinvestment without undermining GHMSI's financial soundness and efficiency. Stated differently, the Act requires the Commissioner to determine the amount of surplus that is large enough to be consistent with financial soundness and efficiency, but no

larger. A surplus in excess of this amount would be unreasonably large and inconsistent with GHMSI's community reinvestment obligations. The Commissioner concludes that this approach fully encompasses the objectives of the Act and provides the tandem analysis envisioned by the Court.

**B. GHMSI Surplus is Greater than the Appropriate RBC Standards**

As noted above, the Act has a two-step process for determining whether GHMSI's surplus is excessive: (1) determining whether the surplus is greater than "the appropriate risk-based capital standards" established by the Commissioner, and (2) deciding, after a hearing, whether the surplus is unreasonably large and inconsistent with GHMSI's community health reinvestment obligations. D.C. Official Code § 31-3506(e) (2012 Repl.).

For the first step, DISB regulations state that, in determining the appropriate risk-based capital standards, the Commissioner must consider the NAIC risk-based capital standards for health insurers adopted under District law and the capital requirements established by the BCBSA for its licensees. 26A DCMR § 4601.4.

Risk-based capital ("RBC") is a method developed by the NAIC to determine the minimum amount of capital an insurer should hold to support its business operations in consideration of its size and risk profile. NAIC, *Risk-Based Capital* (Nov. 25, 2014) (available at [www.naic.org/cipr\\_topics/topic\\_risk\\_based\\_capital.htm](http://www.naic.org/cipr_topics/topic_risk_based_capital.htm)) ("RBC Website"). *See also* NAIC, *Risk-Based Capital Forecasting & Instructions - Health* (2013), available through [www.naic.org](http://www.naic.org) ("NAIC RBC Instructions"). The RBC standards require an insurer with greater risk to hold a higher amount of capital to protect against insolvency. *See* RBC Website. RBC focuses on the material risks typically faced by insurers but does not necessarily encompass every risk an insurer may encounter. *Id.* RBC is intended as an early warning system for U.S. insurance regulators to identify insurers at risk of insolvency and take appropriate action to address

financial problems with a company. *Id.* The RBC framework thus “operates as a tripwire system that gives regulators clear legal authority to intervene in the business affairs of an insurer that triggers one of the action levels specified in the RBC law. . . . [and] alerts regulators to undercapitalized companies while there is still time for the regulators to react quickly and effectively to minimize the overall costs associated with insolvency.” *Id.*

Insurers calculate their RBC using a mathematical formula developed by the NAIC that incorporates various standards for quantifying risks. *Id.* District law requires every domestic insurer, including GHMSI, to file an annual “RBC report” that discloses its RBC ratio, as calculated using instructions published by the NAIC. D.C. Official Code § 31-3851.02 (2012 Repl.).

District law identifies various RBC action levels at which company or regulatory action is required to address an insurer’s financial deficiencies. *See* D.C. Official Code §§ 31-3851.03 to 31-3851.06 (2012 Repl.). Each action level is a multiple of a reference level of RBC known as the insurer’s RBC Authorized Control Level (“RBC-ACL”). *Id.* If a health insurer’s surplus falls below 200% RBC-ACL, it must submit a plan to the Commissioner for corrective action to bring its surplus up to a safer level. *Id.* at § 31-3851.03. District law authorizes and requires additional actions if an insurer’s surplus drops to lower RBC-ACL levels. *See id.* at §§ 31-3851.04 – 31.3851.06.

In addition to the RBC standards established under District law, GHMSI is subject to certain capital standards established by the BCBSA for its licensees. GHMSI Resp. Third Sched. Order at 7. As discussed in greater detail below, these standards include a requirement that a licensee take corrective action to improve its financial position if its surplus falls below 375% RBC-ACL. GHMSI Resp. Third Sched. Order at 8; *see also* Section IV.C.3.a., below.



Under D.C. Official Code § 31-3506(e)(1), the Commissioner must determine the “appropriate risk-based capital standards” and whether GHMSI’s surplus exceeds those standards as a first step in his review. Prior to the surplus review hearing, the Commissioner determined that the appropriate RBC standards for purpose of section 31-3506(e)(1) are 200% RBC-ACL and 375% RBC-ACL, which are the thresholds at which GHMSI must take corrective action to improve its financial position under, respectively, the NAIC RBC standards for health insurers adopted under District law and the BCBSA’s capital standards. The Commissioner further concluded that GHMSI’s surplus was greater than the appropriate RBC standards under section 31-3506(e)(1) because its 2011 surplus of 998% RBC-ACL exceeded both the 200% RBC-ACL and the 375% RBC-ACL thresholds.<sup>9</sup>

**C. GHMSI’s Surplus is Unreasonably Large and Inconsistent with its Community Health Reinvestment Obligations**

**1. Defining Financial Soundness and Efficiency**

The second step of the review requires that the Commissioner determine whether GHMSI’s surplus is unreasonably large and inconsistent with its statutory obligation to engage in community health reinvestment to the maximum feasible extent consistent with financial soundness and efficiency. D.C. Official Code § 31-3506(e)(2) (2012 Repl.). In accordance with *Appleseed Appeal*, this step of the analysis requires the Commissioner to determine the level of surplus that will maximize GHMSI’s community health reinvestment (*i.e.*, ensure the greatest quantity or highest degree attainable for community health reinvestment that the company is

---

<sup>9</sup> This finding also triggered the public hearing requirement under D.C. Official Code § 31-3506(e)(2) and 26A DCMR §§ 4601.4 and 4061.5.

capable of making) without undermining its financial soundness and efficiency.<sup>10</sup> To make this determination, the Commissioner must consider (1) what constitutes “surplus,” (2) what it means for surplus to be consistent with financial soundness, and (3) what it means for surplus to be consistent with efficiency. *See* D.C. Official Code § 31-3506(e)(2) (2012 Repl.); *Appleseed Appeal*, 54 A.3d 1188.

The Act defines “surplus” as “the amount by which all admitted assets of the corporation exceeds its liabilities, inclusive of reserves” that the corporation is required to establish by District law. D.C. Official Code §§ 31-3501(11), 31-3509 (2012 Repl.). In other words, an insurer’s surplus is the value of its admitted assets<sup>11</sup> above and beyond its reserves. Reserves, in turn, are amounts an insurer sets aside to pay claims, cover the cost of administering claims and cover other liabilities reported in its statutory financial statement. *Id.* at § 31-3509. Reserves alone, however, are not enough to ensure an insurer’s financial stability. As the Act implicitly recognizes, an insurer needs assets above and beyond reserves—*i.e.*, surplus—to protect against a variety of risks and provide for various contingencies to ensure that its operations are financially sound and efficient. *See id.* at § 31-3501(11). *See also* GHMSI Pre-Hearing Brief at

---

<sup>10</sup> The Commissioner has broad discretion in interpreting the phrase, “maximum feasible extent.” *see Younger v. Turnage*, 677 F. Supp. 16 (D.D.C. 1988) (“*Younger*”) (In the absence of specific statutory standards, court deferred to agency discretion in fulfilling obligation to provide services “to the maximum feasible extent” or “to the maximum extent possible.”); *Vietnam Veterans of America v. Principi*, No. 04-0103, 2005 WL 901133, \*6-7 (D.D.C. Mar. 11, 2005) (relying on *Younger*, interpreting “‘to the maximum extent possible’ as hortatory and not as a legally binding standard by which to review the Secretary’s judgment.”). At least one court, in a non-binding decision, concluded that “maximum” means the “greatest in quantity or highest degree attainable.” *Burke v. Experion Information Solutions, Inc.*, No. 1:10-cv-1064, 2011 WL 1085874, \*4 (E.D. Va. Mar. 18, 2011) (citing *Webster’s Third New International Dictionary* 1396 (1993)). The U.S. Supreme Court itself has affirmed the plain meaning of “feasible” as “capable of being done, executed, or effected.” *Amer. Textile Mfg. Inst., Inc. v. Donovan*, 452 U.S. 490, 508-509 (1981).

<sup>11</sup> “Admitted assets” are defined as “assets having economic value which can be used to fulfill policy obligations and are permitted, as allowed in the . . . [NAIC] Accounting Practices and Procedures Manual, to be reported as admitted assets on the statutory financial statement of the insurer . . . , but excluding assets of separate accounts . . . .” D.C. Official Code § 31-1371.02(5) (2012 Repl.).

3 (“An insurance company must retain surplus in order to protect against future risks and contingencies that could impair the company’s ability to service its policyholders.”).

The Act does not define what it means for surplus to be consistent with financial soundness. Based on the Act’s purpose, the Commissioner concludes that a surplus is consistent with financial soundness if it is sufficient to address all reasonable risks and contingencies faced by the insurer in excess of the risks for which reserves are established. (These risks and contingencies are discussed in detail in Section IV.C.3.c., below.)

The Act also does not define what it means for surplus to be consistent with efficiency. The dictionary definition of “efficient” is “capable of producing desired results without wasting materials, time, or energy.” Merriam-Webster Online Dictionary at <http://www.merriam-webster.com>. Based on this common understanding of “efficiency,” the Commissioner concludes that a surplus is consistent with efficiency only if it is no greater than—and no less than—the level required to meet the reasonable risks and contingencies for which surplus is required.<sup>12</sup> In other words, the surplus must be neither so high as to be wasteful of the

---

<sup>12</sup> The Commissioner does not agree with Appleseed’s argument that the surplus calculus should be adjusted for alleged “administrative inefficiency.” See D.C. Appleseed Report to the D.C. Department of Insurance, Securities and Banking: Surplus Review of Group Hospitalization and Medical Services, Inc. (“GHMSI”), 41-42 (June 10, 2014) (“Appleseed Pre-Hearing Brief”). Although the Commissioner expects GHMSI to be efficient in its operations, he does not agree that the company’s administrative expenses are relevant to determining whether, under the Act, its surplus is excessive. GHMSI correctly points out that it would make no sense for the Act to refer to operating efficiencies because GHMSI’s administrative expenses are recovered in annual rate filings and neither contribute to nor draw from surplus. Group Hospitalization and Medical Services, Inc., Post-Hearing Brief – DISB Review of GHMSI Surplus Pursuant to the Medical Insurance Empowerment Act of 2008, D.C. Code § 31-3501, *et seq.*, 23 (Nov. 7, 2014) (“GHMSI Post-Hearing Brief”); see also Testimony of Phyllis Doran, F.S.A., M.A.A.A., District of Columbia Department of Insurance, Securities and Banking Public Hearing to Review the Surplus and Community Health Re-Investment of GHMSI, 8 (June 25, 2014) (“Doran Testimony”). Moreover, even if the Act could be interpreted as Appleseed suggests, Appleseed has presented no clear evidence that GHMSI’s operations are inefficient. Appleseed’s analysis relies upon a comparison of GHMSI with a limited selection of “peer” plans without any explanation as to how the comparison plans were selected or why they were deemed to be peers (other than the fact that they all make use of the BlueCross or BlueShield trademarks) and fails to give any consideration to operational differences among the selected plans. See Mark E. Shaw, United Health Actuarial Services, Inc., Report to the D.C. Department of Insurance, Securities and Banking Group Hospitalization and Medical Services, Inc. MIEAA Surplus Review, 33-38 (June 10, 2014) (“Shaw Pre-Hearing Report”).

company's resources nor so low as to render GHMSI unable to respond efficiently to reasonable risks and contingencies if they occur. For example, one of the risks for which surplus is necessary is the risk that the insurer will underestimate future increases in health care costs when setting premium rates, making rates inadequate to cover claims and the cost of adjusting claims. A surplus level would be inefficient if it were so low that a reasonable risk of rating inadequacy, if realized, would require GHMSI to request a large, "catch-up" rate increase, which would be disruptive to subscribers and harmful to the company.

To determine whether GHMSI's surplus is excessive, the Commissioner evaluates GHMSI's surplus needs to determine an appropriate level of surplus and then compares the company's actual surplus to this target level. In conducting this analysis, the Commissioner ensures that the target surplus level is consistent with the Act's standards, including financial soundness, efficiency, and maximizing community reinvestment, by considering only reasonable risks and contingencies faced by GHMSI. In other words, the analysis does not consider highly attenuated risks.<sup>13</sup> Rather, it applies reasonable, "middle-of-the-fairway" projections of surplus needs to arrive at a target surplus that is large enough to be consistent with financial soundness and efficiency, but no larger.

## **2. Estimating Surplus Needs**

Having defined the applicable standards, the next step is to apply those standards to determine a target surplus level that maximizes GHMSI's community health reinvestment without undermining its financial soundness and efficiency. To assist with this determination, the Commissioner retained Rector to conduct an analysis of the various risks and contingencies

---

<sup>13</sup> As discussed in greater detail below, the analysis of risks involves evaluating both the probability and severity of the risk. In other words, a risk such as a catastrophic event might have a low probability but may be considered in the analysis if it also has a high severity.

for which GHMSI must maintain surplus. To understand how the Commissioner reached his determination, it is helpful to understand how Rector conducted its analysis.

Rector's analysis relied in part on the Milliman Model, which is an actuarial model developed by Milliman and used by GHMSI to forecast its long-term surplus needs over a three-year projection period. Rector Report at 9. Rector did not rely upon the Milliman Model as originally presented. Rather, after an extensive review,<sup>14</sup> Rector modified numerous aspects of the Milliman Model to bring it in line with the Act's standards. (This Decision and Order refers to the Milliman Model, as modified by Rector, as the "Modified Milliman Model.")

The purpose of Rector's review and modifications was to ensure that the conceptual approach taken by Milliman was reasonable and that each individual assumption underlying the model was a reasonable, "middle-of-the-fairway" assumption. Tr. 74:14-75:16; *see* Rector Report at 18 *et seq.* To this end, Rector performed validation testing of the assumptions in both a bottom-up fashion (validating the selections made relative to each assumption against company, industry or other relevant experience) and a top-down fashion (comparing the assumptions selected, as a group, to GHMSI's historical operating results). Rector Report at 34; Tr.20-22; Rector & Associates, Inc., Questions for/ Information Requested from Rector [in Response to Third Scheduling Order], 10-11 (Aug. 27, 2014) ("Rector Resp. Third. Sched. Order"). In addition, Rector evaluated each conceptual approach adopted by Milliman and made certain modifications where appropriate. Rector Report at 11, 18-20. The modifications made by Rector to the Milliman Model and how Rector arrived at those modifications are discussed in detail below.

---

<sup>14</sup> Rector's review included analysis of a Milliman report prepared for GHMSI on the development of an optimal surplus target range; evaluation of supplemental materials provided by Milliman and GHMSI; consideration of related materials provided by Appleseed and UHAS; and discussions, both in person and by telephone conference, with Milliman, Appleseed, and UHAS. Rector Report at 10.

The Commissioner has reviewed Rector's work and concludes that Rector's modifications are reasonable and appropriate and, except for the assumptions adopted by Rector regarding premium growth, produced reasonable, "middle-of-the-fairway" assumptions for the analysis of GHMSI surplus needs. With respect to premium growth, after further review and in consultation with NovaRest, the Commissioner concluded that the assumptions for this factor should reflect a lower projected level of premium growth than was assumed by Rector.

The Commissioner concludes that the Modified Milliman Model, with the modifications made by Rector and the additional revisions he requested, is an appropriate tool to use in determining a target surplus level for GHMSI under the Act. The Commissioner concurs with Rector's conclusion that, in using the Milliman Model (as modified), neither he nor Rector

were being deferential to Milliman or to GHMSI or that GHMSI was being advantaged. Projection models [like the Milliman Model] are essentially calculators and should produce similar results if similar assumptions are used. If a given model is properly constructed, it ultimately isn't all that important whose model you use. Rather, the important decisions pertain to the numbers put into the calculator. In other words, the assumptions selected for the model to run.

Tr. 20:15-24.

### **3. Model Assumptions and Operation**

The discussion below reviews each step of the modeling process. It includes a discussion of the analysis conducted by Rector to evaluate the assumptions and conceptual approaches used in the modeling, the modifications made by Rector to arrive at the Modified Milliman Model, and the further revisions made by the Commissioner. Unless otherwise stated, the Commissioner concurs with Rector's analysis and conclusions.

#### ***a) Benchmark RBC Levels and Corresponding Confidence Levels***

The modeling used to determine whether GHMSI surplus is excessive is a multi-step process. It begins by selecting two benchmark levels of RBC against which to measure

GHMSI's surplus. The selected benchmarks—200% and 375% RBC-ACL—are the same as those adopted for determining whether the surplus is greater than appropriate risk-based capital requirements under D.C. Official Code § 31-3506(e)(1) (2012 Repl.). *See* Section IV.B., above. The Commissioner concludes that these benchmark levels are similarly appropriate for use in the modeling process.<sup>15</sup>

Next, confidence levels are selected to determine an amount of surplus that will provide an appropriate level of confidence that GHMSI's surplus will not fall below the benchmark RBC thresholds during a three-year review period. As with other aspects of this review, in selecting appropriate confidence levels the Commissioner seeks to calibrate the selection so as to maximize community health reinvestment without undermining financial soundness and efficiency.

(1) 95% Confidence Level for 200% RBC-ACL Benchmark

Given the potentially severe consequences to GHMSI and the District's health insurance market if GHMSI's surplus were to fall below 200% RBC-ACL and the difficulty GHMSI would have rebuilding surplus from such a low level, the Commissioner concludes that a confidence level of 95% with respect to the 200% RBC-ACL benchmark is appropriate.

As discussed in Section IV.B. above, 200% RBC-ACL is the level at which an insurer's surplus is considered to be deficient, requiring the insurer to submit a plan for corrective action to the Commissioner. U.S. insurance regulators, including DISB, consider a 200% RBC-ACL level to be a significant indicator of very real problems with an insurer's financial and operational strength. Rector Report at 15.

---

<sup>15</sup> They also are the same benchmarks the Commissioner used to evaluate GHMSI's 2008 surplus. *See* 2010 Order at 10. The D.C. Court of Appeals found no error in the Commissioner's use of these standards in the previous review. *Appleseed Appeal*, 54 F.3d at 1217-18.

Moreover, the consequences to GHMSI under its licensing agreement with BCBSA if its surplus falls below 200% RBC-ACL are potentially severe. If this occurred, the BCBSA could revoke GHMSI's licenses to use the Blue Cross and Blue Shield names and trademarks.

GHMSI Resp. Third Sched. Order at 9. Loss of the licenses would mean that BCBSA could appoint another BCBSA licensee to do business in GHMSI's Blue service area. *Id.* BCBSA also would assign GHMSI's approximately 365,000 Federal Employee Program ("FEP") members – representing 33% of GHMSI's total enrollment – to another BCBSA licensee. *Id.* at 9-10. In addition, most of GHMSI's National Account business – approximately 290,000 members, representing 29% of its total enrollment – would be transferred to the other BCBSA licensees. *Id.* at 10. Finally, if the BCBSA were to revoke GHMSI's licenses, all of GHMSI's members would lose full access to providers participating in the Blue Cross and Blue Shield networks. *Id.*

Having a surplus near or below 200% RBC-ACL also would likely cause significant concern among GHMSI's policyholders and other customers, possibly leading them to seek another, more stable insurer or administrator, which would further weaken the company.

Tr.128:5-18. The Commissioner concurs with Rector's estimation that having GHMSI's surplus drop to 200% RBC-ACL would cause "extreme distress" in the District's health insurance market, and given GHMSI's dominance in the District market, be far more troubling and disruptive than if such a loss were sustained by a similarly sized health insurer with a more modest share of the market. Tr.39:20 - 40:3.

The adverse consequences of having GHMSI's surplus fall below 200% RBC-ACL are compounded by the company's status as a nonprofit insurer, which makes it difficult for the company to rebuild surplus. Unlike for-profit insurance companies, GHMSI does not have the ability obtain funds from the capital markets if needed. Tr.40:5-8. Nor does GHMSI have a



parent company that might have cash available to contribute if GHMSI were under financial stress. Tr.40:8-10.

The ACA's medical loss ratio ("MLR") also limits GHMSI's ability to rebuild surplus. The MLR rules, which were first implemented in 2011, limit how quickly a health insurer may build surplus by raising rates. Under the MLR rules, an insurer must pay rebates to its policyholders if its non-medical costs exceed 15% of premiums in the large group market or 20% in the small group or individual markets. *See* D.C. Official Code § 31-3311.02 (2012 Repl.); 45 C.F.R. § 158.210. This requirement limits the amount of surplus an insurer can generate in any one year because any funds that would go to surplus must come out of the 15% to 20% of premiums allocated for non-medical costs, which include employee salaries, broker commissions, equipment, and administrative costs and other such expenses. 45 C.F.R. § 158.221(b).<sup>16</sup>

In light of the adverse consequences and challenges outlined above, the Commissioner concludes a 95% confidence level is appropriate for the 200% RBC-ACL benchmark and that it is the confidence level most consistent with the requirements of the Act. This level provides a very high degree of confidence that GHMSI's surplus will not fall below 200% RBC-ACL and therefore is consistent with financial soundness and efficiency. At the same time, a 95% confidence level maximizes GHMSI's community reinvestment by not allowing GHMSI to accumulate surplus at a level that is inefficient or unnecessary for financial soundness.

---

<sup>16</sup> Federal regulations implementing the ACA permit the Secretary of Health and Human Services to defer the payment of rebates if the payment would cause an insurer's surplus to fall below 200% RBC-ACL. 45 C.F.R. § 158.270. There is no guarantee, however, that the Secretary would grant such relief or would grant it in a timely manner. Moreover, because a deferral can be granted only if the payment of rebates would cause the insurer's surplus to fall below 200% RBC-ACL, the availability of this relief appears to be limited to circumstances where surplus already may be dangerously low.

(2) Alternate Confidence Levels for 200% RBC-ACL Benchmark

In reaching the conclusion that the 95% confidence level for the 200% RBC-ACL threshold is appropriate here, the Commissioner carefully considered – but ultimately rejected – the alternate levels proposed by Appleseed, GHMSI, and Rector.

The Commissioner disagrees with Appleseed’s proposed 90% confidence level for the 200% RBC-ACL benchmark. The Commissioner concludes that this level of confidence—a one-in-ten chance of surplus falling below 200% RBC-ACL—would pose too great a risk to the solvency of GHMSI given the potential for severe adverse consequences if the company’s surplus drops to this level. The Commissioner agrees with Appleseed that the confidence level chosen for this review must be calibrated to the Act’s standards. But under the Act any such calibration must be made only to a point consistent with financial soundness and efficiency. A 90% confidence level goes beyond what is efficient and could jeopardize the company’s financial soundness.

Nor does the Commissioner agree with GHMSI’s proposal to adopt a 98% confidence level. In support of its position, GHMSI points to confidence levels in the range of 98% and above used by GHMSI’s consultants at various times, the A.M. Best rating agency, and the European Union under its Solvency II standards. GHMSI Post-Hearing Brief at 14-15. None of the standards cited by GHMSI are appropriate for this review. There is no evidence that GHMSI’s consultants took into account the requirements of the Act in the selection of their confidence levels. Moreover, the Commissioner notes that one GHMSI consultant—Lewin—employed a 95% confidence level with respect to the 200% RBC-ACL benchmark. *See, e.g.,* The Lewin Group, Recommended Surplus Range for GHMSI: Approach and Considerations for Determining the Appropriate Range of Surplus in 2011, 19-20 (May 20, 2011) (the “Lewin Report”). The confidence levels cited by GHMSI that are used by A.M. Best and by the

European Union are designed for different purposes than those that apply to this review and do not take into account the requirements of the Act.

Finally, although Rector also recommended a 98% confidence level for the 200% RBC-ACL benchmark, Rector took pains to state that the selection of an appropriate confidence level is a matter of judgment. Tr.40:25-41:1. As the D.C. Court of Appeals emphasized, in selecting a confidence level, consideration must be given to calibrating the level in accordance with the requirements of the Act. *Appleseed Appeal*, 54 A.3d at 1218-1219. This determination ultimately is entrusted to the Commissioner's reasonable discretion. *Id.* at 1215.

After consideration of all the facts in the record, the Commissioner concludes that a confidence level of 95% for the 200% RBC-ACL benchmark is most consistent with the Act's standards.

### (3) 85% Confidence Level for 375% RBC-ACL Benchmark

The Commissioner concludes that an 85% confidence level is appropriate for the 375% RBC-ACL benchmark. The adverse consequences of falling to 375% RBC-ACL are real and justify establishing a reasonably high level of confidence that GHMSI's surplus will not fall below that benchmark. But because the consequences are less severe than those at the 200% RBC-ACL benchmark level, the confidence level in turn may be lower.

There are good reasons to avoid a surplus level below 375% RBC-ACL. As stated above, 375% RBC-ACL is the BCBSA "Early Warning" threshold. GHMSI Resp. Third Sched. Order at 8; *see also* Section IV.B., above. If GHMSI's RBC falls below 375% RBC-ACL, it must submit a recovery action plan to the BCBSA outlining the steps it will take to increase its RBC. GHMSI Resp. Third Sched. Order at 8. The BCBSA also would subject GHMSI to certain enhanced reporting and monitoring requirements and require it to disclose its financial condition to all health care providers and group and individual policyholders before entering into

contracts with them. *Id.* at 9. The BCBSA thus clearly regards a surplus below 375% RBC-ACL to be an indication of financial weakness requiring enhanced oversight of its licensee and development of a plan by the licensee to bring its surplus up to a safer level. It is reasonable to conclude that GHMSI's policyholders and administrative services customers would view a surplus below 375% RBC-ACL in the same light, which could cause GHMSI to lose business and weaken the company. In addition, Milliman expressed concern that at 375% RBC-ACL, GHMSI would likely need to curtail long-term investments important to GHMSI's viability, limit or suspend social mission initiatives, and limit or cease innovation in markets and products while the company focused on rebuilding its surplus. Milliman, Inc., *CareFirst Inc. – Group Hospitalization and Medical Services, Inc. – Development of Optimal Surplus Target Range*, 12 (May 31, 2011) (“Milliman Report”).

The potential adverse consequences of a 375% RBC-ACL level are substantial, but are not so dire and immediate as those at the 200% RBC-ACL level. The Commissioner therefore concludes that the confidence level for the 375% RBC-ACL threshold should remain reasonably high but be lower than that for the 200% RBC-ACL threshold. The 10 percentage point difference between the confidence levels for the two benchmarks (95% vs. 85%) is justified by the fact that the negative consequences of falling to 375% RBC-ACL, though significant, are not nearly as severe as those associated with a surplus below 200% RBC-ACL. The Commissioner concludes that a confidence level of 85% for the 375% RBC-ACL benchmark is appropriately calibrated to the standards of the Act.

***b) Modeling Risks and Contingencies***

The next portion of the analysis involves identifying the various risks and contingencies to which GHMSI is subject and estimating their potential impact on surplus. The purpose of this step is to determine how much surplus GHMSI should maintain to achieve a 95% confidence

level that its surplus will not fall below 200% RBC-ACL and an 85% confidence level that its surplus will would not fall below 375% RBC-ACL during the projection period.

The modeling of risks and contingencies involves several stages. First, the relevant risks and contingencies are identified and grouped into discrete “risk factors.”<sup>17</sup> Sarah Schroeder, Memorandum re: Overview of Milliman Modeling Methodology, 1 (May 12, 2014) (“Rector Modeling Memo”). Next, for each risk an estimate is made of the probability that the risk will occur and how severe an effect it would have on GHMSI’s surplus if it occurred. *See id.* at 2. In this step, each risk is assigned an array of estimated probabilities and associated severities. For example, it might be estimated that a particular risk has a 50% chance of having no impact on GHMSI’s surplus, a 25% chance of having a positive impact of a certain magnitude and a 25% chance of having a negative impact of a certain magnitude. The estimated probabilities and severities for each risk are based on relevant historical experience and reasonable projections for how future experience may deviate from historical experience. *See id.*

The next step is to feed the probability/severity arrays, or “probability distributions,” into an automated projection calculator that produces numerous gain and loss outcomes, each of which is then ranked from worst loss outcome to best gain outcome. Rector Modeling Memo at 2. Rector used an automated calculator developed by Milliman for this purpose but built its own calculator to validate Milliman’s approach. Tr. 20:3-9. Next, a loss outcome is selected based on the desired confidence level that surplus will not decline below a threshold level. If, for

---

<sup>17</sup> Rector used the following risk factors: (1) premium growth rate, (2) equity portfolio asset values, (3) rating adequacy and fluctuation, (4) unpaid claim liabilities and other estimates, (5) change in interest/discount rate, (6) bond portfolio impairment, (7) overhead expense recovery and fee income risks-commercial business, (8) overhead expense recovery and fee income risks-FEP indemnity business, (9) overhead expense recovery and fee income risks-FEP operations center business, (10) overhead expense recovery and fee income risks-BlueCard, (11) other business risks, (12) catastrophic events, and (13) unidentified development and growth. *See* Rector Report; Milliman Report; Rector Modeling Memo. These factors are discussed in detail in the next section below.

example, a confidence level of 95% is desired, the loss outcome in the 95<sup>th</sup> percentile of the ranked outcomes is selected.

Finally, the selected loss outcome is incorporated into a three-year *pro forma* financial statement to determine what effect it would have on GHMSI's surplus if it were to occur. In this way, the modeling produces an estimate of how much surplus GHMSI would need to be able to sustain the loss outcome and still remain above a specific RBC threshold at the selected level of confidence. Rector's analysis of the Milliman Model included an analysis of all of the assumptions used in the *pro forma* income statement and a comparison of GHMSI's historic financial results to those generated using the *pro forma* income state to validate the financial projections. Jim Toole, FTI Consulting, Memorandum re: Milliman Pro Forma Financial Projection Model Methodology Validation (Feb. 7, 2014) ("Pro Forma Memo"); Rector Resp. Third. Sched. Order at 11-15. In validating these assumptions, Rector found them to be reasonable and did not believe it was necessary or appropriate to make any adjustments to Milliman's baseline assumptions. Rector Resp. Third. Sched. Order at 12.<sup>18</sup>

**c) Risk Factors**

A key aspect of modeling is the choice of assumptions underlying each risk factor. In light of the D.C. Court of Appeals' admonition that the Commissioner should provide a complete explanation of the reasoning supporting his determination, *see Appleseed Appeal*, 54 F.3d at 1219, the following discussion reviews in detail the approach Rector took to evaluate the reasonableness of the assumptions underlying each risk factor and the revisions Rector made to

---

<sup>18</sup> As discussed in detail below, Rector did make adjustments to some of the assumptions used by Milliman to develop the probability/severity distributions used in the Milliman Model. Some of these adjustments flowed through to the *pro forma* financial statement because certain assumptions used to build the financial statement—for example investment earnings and pricing margins—also are captured in the 13 risk factors used for the risk modeling. *Id.*

ensure that each factor reflects reasonable, “middle-of-the-fairway” assumptions. Of the 13 risk factors used in the modeling, three—Premium Growth Rate, Equity Portfolio Asset Values, and Rating Adequacy and Fluctuation—had the most significant effect on the results of the modeling. The discussion therefore focuses most heavily on these three factors. Except as stated with respect to the premium growth factor, the Commissioner concurs with Rector’s analysis as to each of the risk factors described below.

(1) Premium Growth Rate

Premium growth rate is a key factor because the amount and type of premium projected to be written by a health insurer are important determinants of the insurer’s future surplus needs. Rector Report at 27.

Milliman had considered the effect of premium growth in the Milliman Model but did so in a way that Rector believed gave undue weight to the worst possible outcome for this factor. Rector Report at 20. Instead of following Milliman’s approach, Rector created a separate risk factor for premium growth to obtain a more reasonable projection of the effect it would have on surplus. *Id.* The Commissioner concurs with this approach.

The Commissioner also concurs with much of Rector’s analysis of how to develop appropriate assumptions for premium growth. Specifically, Rector and the Commissioner generally agree that this factor should take into account: (1) historical premium experience; (2) changes that might cause deviation from this historical experience, particularly due to ACA implementation, and (3) different treatment of FEP and non-FEP business. The Commissioner, like Rector, therefore first considered GHMSI’s historical premium growth rate. Rector

calculated an average annual premium growth rate of 8.4%.<sup>19</sup> Rector Resp. Third Sched. Order at 15; Jim Toole, FTI Consulting, Memorandum re: Premium Growth Assumption, 2 (May 16, 2013) (“Rector Premium Growth Memo”).

The Commissioner also carefully evaluated Rector’s analysis of the likely effect of factors that might change GHMSI’s future premium growth, causing it to deviate from historical growth levels. *See* Rector Resp. Third Sched. Order at 16-17; Rector Report at 28; Rector Premium Growth Memo at 3. The factors considered by Rector were: (a) changes in future enrollment, including changes in enrollment due to ACA implementation; (b) rising health care costs, and (c) policyholder cost-sharing decisions. Rector Resp. Third Sched. Order at 16-17; Rector Report at 28-29; Rector Premium Growth Memo at 3.

Regarding changes in enrollees, Rector noted that the number of GHMSI’s enrollees had fluctuated up and down during the historical review period, but had declined more recently, with significant declines in 2009 and 2010. Rector believed it was reasonable to assume that this decline would not continue and that if GHMSI could maintain its market share, a slow but steady increase in enrollees could be assumed due to natural population growth in GHMSI’s service area. Rector Report at 28-29; Rector Premium Growth Memo at 3.

Regarding increases in health care costs, Rector assumed a baseline health care cost trend of 8% based on projections developed by PwC and the Health Cost Index database developed and maintained by Milliman. Rector Premium Growth Memo at 4; *see also* Rector Resp. Third Sched. Order at 17; Rector Report at 29. Based on projections developed by the Society of Actuaries, Rector also believed that the implementation of ACA reforms—namely, the individual mandate and health care exchanges—would cause GHMSI’s premiums to increase

---

<sup>19</sup> Rector excluded the growth rate for 2008, which was unusually low due to a one-time change in the insured population caused by a reinsurance transaction. *Id.* at 2-3.



more quickly than historical averages. Rector Resp. Third Sched. Order at 17; Rector Report at 28-29; Rector Premium Growth Memo at 4.

Regarding benefit reductions and employee cost shifting, Rector noted that in recent years many insureds have opted for less coverage in exchange for reduced premiums and many employers have altered their plan design to offer fewer benefits and greater cost sharing, all of which have put downward pressure on premium growth. Rector Report at 29; Rector Premium Growth Memo at 4. Rector's projections for premium growth assumed that insureds have reached a point of diminishing returns with respect to these strategies, which would relieve the downward pressure on premiums. Rector Resp. Third Sched. Order at 17; Rector Report at 29; Rector Premium Growth Memo at 4.

The Commissioner agrees with Rector that, in developing projections for premium growth, GHMSI's Federal Employee Program ("FEP") and non-FEP business should be examined separately, for several reasons.<sup>20</sup> See Rector Resp. Third Sched. Order at 17; Rector Report at 29; Rector Premium Growth Memo at 5. First, although the FEP is an insured program, it is constructed in a manner that significantly reduces GHMSI's short-term underwriting risk with respect to the program. Rector Resp. Third Sched. Order at 17; Rector Report at 29; *see also* Rector Premium Growth Memo at 5. Second, the NAIC RBC formula that assigns risk charges to various types of health businesses applies a significantly lower risk charge to FEP business. Rector Resp. Third Sched. Order at 17; Rector Report at 29. Finally, Rector anticipated that the increase in enrollment likely to result from the ACA would affect GHMSI's

---

<sup>20</sup> GHMSI supports 620,000 federal employees in this region and also supports an operations center for 5 million federal employees nationwide. Tr.139:16-20. Rector therefore recognized that "the FEP constitutes a relatively large portion of GHMSI's business." Rector Report at 29.

non-FEP business more significantly than its FEP business. Rector Resp. Third Sched. Order at 17; Rector Report at 29; Rector Premium Growth Memo at 5.

Based on this approach, Rector developed a probability distribution for projected FEP and non-FEP premium growth rates reflecting estimated high, mid- and low ranges of premium growth. *See* Rector Report at 30; Rector Premium Growth Memo at 8. Rector's mid-points for annual premium growth with respect to FEP and non-FEP business were, respectively, 7.5% and 12.4%. Rector Report at 30; Rector Premium Growth Memo at 8.

The Commissioner concluded that Rector's probability distribution for projected FEP premium growth rates is reasonable.

However, after reviewing GHMSI's historical rates of premium growth and the anticipated effect of the ACA, the Commissioner, in consultation with NovaRest, concluded that Rector's projections for non-FEP premium growth, based on a 12.4% probability distribution midpoint, were too high. The Commissioner concluded that Rector overestimated the non-FEP premium growth rate because they gave too much weight to the impact of the ACA and not enough weight to slower rates of premium growth experienced by GHMSI in 2009 through 2011. Therefore, the Commissioner, through his staff and consultants, projected lower levels of premium growth due to the ACA. Specifically, they revised the projection to reflect a lower "take up" rate, i.e., they assumed a decreased number of previously uninsured individuals would purchase insurance under the ACA. The Commissioner deemed the decrease appropriate given the levels of uninsured individuals and the problems with take-up in the first year of any new program. Accordingly, the Commissioner developed the following modified probability distribution for non-FEP premium growth with a mid-point of 8.0% annual premium growth based on historic growth and ACA growth combined:

**Table 1. Commissioner’s Requested Premium Growth Probability Distributions**

Non-FEP Business		FEP Business	
<u>Growth Rate</u>	<u>Probability</u>	<u>Growth Rate</u>	<u>Probability</u>
4.5%	25%	6.5%	25%
8.0%	50%	7.5%	50%
12.2%	25%	8.4%	25%

Based on the advice of NovaRest and DISB’s own analysis, the Commissioner concludes that the modified probability distribution shown in Table 1 is a more reasonable assumption for premium growth than those proposed by Rector, GHMSI, or Appleseed, and therefore is more consistent with the requirements of the Act.

(2) Equity Portfolio Asset Values

The Equity Portfolio Asset Values factor assesses risks associated with GHMSI’s investment portfolio and their implications for reported surplus levels. Milliman Report at 16. Specifically, it pertains to variations in anticipated earnings from equity investments as expressed in a probability distribution. Rector Resp. Third Sched. Order at 5. The *pro forma* financial projections used in the Milliman Model start with an average annual investment earnings rate of 3.75% as a baseline assumption. Rector Resp. Third Sched. Order at 5. This baseline assumption reflects the anticipated return on GHMSI’s investment portfolio, which consists of a blend of equity and fixed income investments. *Id.* Thus, anticipated earnings from equity investments are just one part of GHMSI’s total anticipated investment earnings. *Id.*

The Commissioner concurs with Rector’s analysis of the reasonableness of the model’s treatment of the equity portfolio factor. In the Modified Milliman Model, Rector used the same baseline assumption for average annual investment earnings—3.75%—and the same probability distribution for equity portfolio asset values as were used in the Milliman Model. Rector Resp. Third Sched. Order at 5; Rector Report at 21. To evaluate the reasonableness of the baseline

assumption and potential deviations from the baseline, Rector reviewed Standard & Poor's index data starting in 1957. Rector Resp. Third Sched. Order at 5. Rector found that while equity values have increased at an average rate of 7.3% over the last 50 years, there has been significant volatility around this average. *Id.* at 5-6. By comparing the deviations in the S&P 500 over a 50-year period, Rector was able to validate the assumptions relating to the equity portfolio asset values used in the stochastic portion of the Milliman Model and the reasonableness of the potential for deviation and variation from the equity portion of the average annual investment earnings rate assumption under the *pro forma* portion of the Milliman Model. *Id.* at 6.

### (3) Rating Adequacy and Fluctuation

The rating adequacy and fluctuation factor reflects the risk that actual claims and expenses will differ from the amounts anticipated when premium rates are set, focusing on the effect of trend on the adequacy of premium rates. Milliman Report at 15; Rector Resp. Third Sched. Order at 6.

The Commissioner concurs with Rector's analysis and treatment of the rating adequacy and fluctuation factor. Rector reviewed the various components of the standard trend deviation that Milliman used in its modeling. *Id.* For the secular trend component—*i.e.*, the component that represents the trend variation based on changes in health care costs—Rector took into account the annual change in the Healthcare Cost Index for the period 1986-2010. *Id.* For other components of the standard trend deviation, Rector reviewed GHMSI's historical experience and industry data to confirm the appropriateness of the assumptions used for this risk factor. *Id.*

Rector made several changes to the way Milliman modeled the rating adequacy and fluctuation risk factor. Milliman had applied two different trend miss<sup>21</sup> periods (a two-year and a three-year miss period) as inputs to the modeling process. Rector Report at 22. Because Rector believed this approach overstated the likely effect of trend miss, it instead incorporated the effects of trend miss into a revised rating adequacy and fluctuation factor as variables with their own probability distribution. *Id.* Rector also found that the way Milliman had determined historical variability of the secular components of trend assumed that trends were independent from one year to the next. *Id.* Rector's analysis demonstrated that trends occurring between time intervals are correlated to trends from prior periods. *Id.* In keeping with this analysis, Rector made appropriate changes to the trend variability assumptions and the manner in which trend is incorporated into the rating adequacy and fluctuation risk factor. *Id.*

Rector questioned several of Milliman's assumptions concerning rating adequacy and fluctuation. First, Milliman had assumed that the ACA's MLR rebate requirements would have an effect on rating adequacy and fluctuation. *Id.* Although the effect assumed by Milliman was minimal, Rector demonstrated that the rebate requirement would be very unlikely to affect rating adequacy and fluctuation and therefore excluded this effect. *Id.* at 22-23; *see also* Jim Toole, FTI Consulting, Memorandum re: ACA Reform and Surplus Requirements, 2-3 (Sept. 12, 2013) ("ACA Reform Memo").

Second, Milliman also had assumed that, as a result of the ACA, the time between rate filings and their effective date would increase and, in addition, regulators would restrict future

---

<sup>21</sup> "Trend" or "health care cost trend" refers to the annual change in an insurer's health care costs resulting from factors such as price inflation, advances in technology, changes in utilization of health care services and cost shifting by health care providers to compensate for low reimbursement rates from governmental plans. Rector Report at 19 n. 28. "Trend miss" is the projected period of time that GHMSI's actual trend differs from its anticipated trend before GHMSI makes adjustments to its trend assumptions. *Id.* at 19.

requested premium rate increases. *See* Rector Report at 23. After discussions with regulators and Milliman, Rector agreed with Milliman that health care reform would slow the implementation of rate changes, but disagreed that regulators were likely to disapprove requested rate increases, especially in cases where GHMSI was in a financially difficult position. *See id.* at 23; ACA Reform Memo at 4. Therefore, Rector removed the effect of restricted premium rate increases from the rating adequacy and fluctuation risk factor. *Id.*

Third, Milliman originally included estimated effects on trend miss for coverage changes required by the ACA, including unlimited benefits, coverage for dependents to age 26, and the removal of pre-existing condition exclusions for children. ACA Reform Memo at 4. Because these requirements had been in effect since 2010, Rector determined that they had become a normal part of the pricing landscape and therefore no longer should have an effect on trend miss. ACA Reform Memo at 4. Therefore, Rector removed any risk components for these changes. *Id.*

Fourth, the Milliman Model only took into account the requirements of the ACA that were in effect at the time Milliman conducted its analysis, but Milliman increased its recommended surplus range for GHMSI based on a rough estimate of the effects of ACA requirements that would go into effect in the future. Rector determined that a more accurate way to estimate the impact of future ACA requirements would be to incorporate them directly into the modeling process. Rector Report at 23. Accordingly, Rector included in the rating adequacy and fluctuation risk factor appropriate estimated effects of the ACA arising from underwriting restrictions, policyholder behavioral changes, and the individual coverage mandate. Rector Report at 23. Regarding underwriting restrictions, Rector noted that the ACA would restrict the ability of GHMSI to rate policies based on an individual's prior medical history or behavioral

factors or to rate group policies based on age or gender of group members. ACA Reform Memo at 5. These changes would force GHMSI to change its pricing structure and could cause it to face anti-selection,<sup>22</sup> both of which could cause it to misprice its coverage. *Id.* With respect to behavioral changes, Rector noted that there was considerable uncertainty regarding how consumers would respond to upcoming changes in the marketplace due the ACA. *Id.* For example, it was unclear how newly insured policyholders would utilize healthcare and whether policyholders would seek to change coverage as premiums changed. *Id.* Rector also noted that the ACA underwriting restrictions and the potential for policyholder behavioral changes were interrelated. *Id.* In this regard, the greater the changes made to the underwriting process, the greater the uncertainty regarding changes to policyholder behavior. *Id.* In order to reflect the increased variability, Rector assumed the standard deviation of trends for those currently insured in the individual and small group markets would increase by 20%. *Id.*

Rector also took into account the likely effect of the ACA's individual coverage mandate, which would likely introduce a new population of insureds in the individual market who would not have a history of insured experience and therefore be difficult to price. *Id.* at 5-6. Rector estimated that the variability of these new insured risks would be double the variability of risks in the current insured population and included an appropriate effect on the rating adequacy and fluctuation risk factor. *Id.* at 6.

---

<sup>22</sup> Anti-selection, also known as adverse selection, occurs whenever persons make insurance purchasing decisions based on their knowledge of their insurability or likelihood of making a claim. *See* NAIC, Adverse Selection Issues and Health Insurance Exchanges Under the Affordable Care Act (2011). For example, persons in better health may defer purchasing insurance or purchase insurance with fewer benefits and more cost-sharing while persons in worse health may purchase insurance sooner and purchase plans with greater benefits and less cost-sharing. If an insurer underestimates the amount of anti-selection it will encounter, its pricing will be inadequate.

(4) Unpaid Claims Liabilities and Other Estimates

The unpaid claims liability factor takes into account risks associated with nonpayment of claims and other liabilities due to reserving errors. Rector Resp. Third Sched. Order at 6. The probability distributions for this risk factor correlate with those for the rating adequacy and fluctuation factor. *Id.* at 6-7. In other words, the probability that rates will be inadequate correlates with the probability that reserves will be inadequate. *Id.* at 6-7. Therefore, Rector's analysis and the data relied upon with respect to this risk factor were the same as those used for the rating adequacy and fluctuation risk factor. *Id.* The Commissioner concurs with Rector's analysis of this factor.

(5) Change in Interest/Discount Rate

As stated above, the *pro forma* projections used in the model start with a baseline assumption of an average 3.75% annual investment earnings rate. This baseline assumption is based on the anticipated return for GHMSI's investment portfolio, which consists of a blend of equity and fixed income investments. Rector Resp. Third Sched. Order at 6. The change in interest/discount risk factor relates to the potential deviation and variation from the portion of the baseline assumption relating to interest and discount rates. *Id.*

The Commissioner concurs with Rector's evaluation of the change in interest/ discount rate factor. To evaluate the probability distribution for this risk factor, Rector assessed various characteristics and components of the bond market that could affect changes in interest and discount rates, including the interest rate environment, degree of volatility in the bond market, the outlook for inflation, and the characteristics of GHMSI's bond portfolio (term of maturity, market yield, and unrealized gains and losses). *Id.* Based on this analysis, Rector used a probability distribution for this risk factor reflecting a 45% chance that interest rates would stay



relatively the same or decrease and a 55% chance that they would increase by a material amount. *Id.* at 8.

(6) Bond Portfolio Impairment

The bond portfolio impairment risk factor reflects the potential deviation and variation from the portion of the baseline assumed return on GHMSI's investment portfolio that relates to bond investments. Rector Resp. Third Sched. Order at 8.

The Commissioner concurs with Rector's validation of the bond portfolio impairment factor. To validate the probability distribution for this factor, Rector analyzed various components and characteristics of the bond market that could affect bond portfolio impairments, including the portfolio rating mix, bond market conditions, the economic environment, and characteristics of GHMSI's bond portfolio. *Id.* In the course of its analysis, Rector also noted that there was an 83% chance that this risk factor would have little or no impact on surplus at all. *Id.*

(7) Overhead Expense Recovery and Other Business Risks

There are five risk factors associated with overhead expense recovery and other business risks. Rector Resp. Third Sched. Order at 9.<sup>23</sup> These risk factors are intended to capture the risk that GHMSI could not recover all of its overhead expenses if it were to lose business. *Id.* In other words, if GHMSI were to lose business, it could cut some expenses but would likely not be able to cut all expenses proportionately to the loss of business, thereby increasing its expenses relative to the amount of business it wrote. *Id.*

---

<sup>23</sup> The risk factors included in this category are (1) overhead expense recovery and fee income risks-commercial business, (2) overhead expense recovery and fee income risks-FEP indemnity business, (3) overhead expense recovery and fee income risks-FEP operations center business, (4) overhead expense recovery and fee income risks-BlueCard, and (5) other business risks. See Rector Report; Milliman Report; Rector Modeling Memo.

The Commissioner concurs with Rector's evaluation of these business risk factors. To evaluate the appropriateness of these factors' probability distributions, Rector analyzed various components of GHMSI's overhead, including general and administrative expenses for each of its business segments, the correction period that would be required to eliminate the overhead expenses involved, and the likelihood that GHMSI could lose certain business segments. *Id.* In the course of its analysis, Rector noted that, depending on the risk factor, there was 75% to 90% probability that a risk factor in this category would have little or no effect on GHMSI's surplus. *Id.*

#### (8) Catastrophic Events

The catastrophic events risk factor reflects the potential effect of events that are infrequent, severe, and unpredictable natural disasters (for example, pandemics, earthquakes, or hurricanes) and human activity (for example, terrorism, major litigation including large data security breach litigation, and nuclear accidents). *See* Rector Report at 24.

The Commissioner agrees with Rector's analysis of, and revisions to, Milliman's catastrophic risk factor modeling. In this regard, Milliman's assumptions for catastrophic events included a base charge to surplus of 2.5% of non-FEP premiums in all of its modeling simulation outcomes. *Id.* Because catastrophic events are, by their nature, infrequent events, Rector did not believe it was appropriate to include such a charge in this risk factor and therefore removed it. *Id.* Milliman's assumptions for the catastrophic event risk factor also include contingent provisions for some of its modeling outcomes. *Id.* Based on its analysis, Rector concluded that it was appropriate to include such contingent provisions. *Id.* The probability distribution employed by Rector in the Modified Milliman Model assumed a 90% chance that catastrophic events would have no impact on GHMSI's surplus, a 7.5% chance that such events would result

in a decrease in surplus equal to 2.5% of non-FEP premium, and a 2.5% chance that such events would decrease surplus by 7.5% of non-FEP premium. *Id.* at 24-25. Rector found that the changes it made in the assumptions underlying the catastrophic events risk factor reduced the anticipated surplus needs produced by the modeling by a fairly significant amount. Rector Report at 25.

(9) Unidentified Growth and Development

The unidentified growth and development factor captures the risk that GHMSI would need to make extraordinary expenditures resulting from unanticipated growth or investment needs, including technology and infrastructure investments, new product development, and responses to legislative changes. Rector Report at 25. This risk factor encompasses the impact of capital investments that produce non-admitted assets, which cannot be included in surplus and therefore constitute a direct charge to surplus, as well as growth and development expenditures that exceed budgeted amounts included in GHMSI's premium rate structure. *Id.* at 25, n. 32; 26. GHMSI's growth in such non-admitted assets is a way to capture its investment in electronic data and processing equipment.

The Commissioner concurs with Rector's evaluation of the unidentified growth and development risk factor. To evaluate the appropriateness of this risk factor's probability distributions, Rector analyzed the average annual change in GHMSI's non-admitted assets, excluding non-admitted assets relating to investments, taxes, and pension plan expenditures, which could obscure more general trends. Rector Resp. Third Sched. Order at 10; *see also* Rector Report at 27. In addition, Rector took into account the recent experience of the health insurance industry as a whole with respect to the growth of non-admitted assets, which Milliman did not do. Rector Report at 27; Rector Resp. Third Sched. Order at 10. Rector found that the

changes it made to the assumptions relating to unidentified growth and development had a fairly significant impact on the modeling results by bringing down projected surplus needs, similar to the effect of the changes Rector made to the assumptions used for the catastrophic events risk factor. Rector Report at 27.

***d) Rector Conclusions Based on Modified Milliman Model***

The modifications made by Rector to the Milliman Model resulted in a significant decrease in the projected surplus needs of GHMSI from the surplus recommended by Milliman. Based on its analysis, Milliman had concluded that an appropriate target for GHMSI's surplus fell in the range of 1050% to 1300% RBC-ACL, taking into account the impact of federal health care reforms that were in effect at the time of the initial analysis. Milliman Report at 5.<sup>24</sup> After making the modifications discussed above, Rector ran the Modified Milliman Model at a 98% confidence level with respect to the 200% RBC-ACL benchmark and an 85% confidence level with respect to 375% RBC-ACL. Based on these results, Rector estimated that, as of December 31, 2011, GHMSI would need a surplus of 958% RBC-ACL to meet the first test (200% RBC-ACL at a 98% confidence level) and a surplus of 746% RBC-ACL to meet the second test (375% RBC-ACL at an 85% confidence level. Rector Report at 12, 30. Because GHMSI should meet both tests to comply with the Act's standards, Rector concluded that in determining whether GHMSI's surplus is excessive, the appropriate target surplus is 958% RBC-ACL. *Id.* at 12, 32.

Rector then examined GHMSI's historical RBC levels since 1999 and found that year-to-year changes in surplus had become less volatile in the period 2004 to 2012, averaging 82.5 RBC

---

<sup>24</sup> In addition, Milliman estimated that its recommended surplus range could increase by 100% to 150%—*i.e.*, to a range of 1150% to 1450% RBC-ACL—due to the impact of federal health care reforms that were not yet in effect at the time of the analysis. *Id.* Milliman characterized its estimate as an indication of the directional nature of the impact of health care exchanges, rather than a precise quantification of their potential financial consequences. Rector Report at 20; *see* Milliman Report at 5, 8.

percentage points. *Id.* at 13. Based on this data, Rector recommended a “safe harbor” range for GHMSI’s surplus of 958% RBC-ACL plus or minus approximately 82.5%—*i.e.*, Rector recommended that the Commissioner find GHMSI’s surplus was not “excessive” if it was within the range of 875% to 1040% RBC-ACL. *Id.*

*e) Post-Hearing Modeling*

As discussed above, the Commissioner concluded that revisions should be made to the confidence level and the assumptions used by Rector for the premium growth rate risk factor. Milliman ran the modifications to the premium growth assumptions adopted by the Commissioner at various confidence levels requested by the Commissioner. Rector then validated the calculations. *See* Milliman, Inc., Letter re: Response to DISB October 3, 2014 Order with Supplemental Information Requests (Oct. 15, 2014) (“Milliman Resp. Supp. Info Req.”); Rector & Associates, Inc., Letter re: R&A Review of GHMSI and Milliman 10/15/14 Response To DISB Supplemental Information Request Order No. 14-MIE-08 (Oct. 24, 2014). The modeling requested by the Commissioner estimated that GHMSI would need a surplus of 721% RBC-ACL to ensure that its surplus would not fall below 200% RBC-ACL at a 95% confidence level and a surplus of 672% RBC-ACL to ensure that its surplus would not fall below 375% RBC-ACL at an 85% confidence level. Milliman Resp. Supp. Info Req. at 3. Because GHMSI must meet both tests to ensure that its surplus is consistent with financial soundness and efficiency, the Commissioner concludes that in determining whether GHMSI’s surplus is excessive, the appropriate target surplus is 721% RBC-ACL.

The Commissioner further concludes that a single target point, rather than a range, complies with the purpose and intent of the Act. The purpose of the surplus review required by the Act is to determine a target surplus that maximizes GHMSI’s community reinvestment

without undermining the company's financial soundness or efficiency. The Commissioner is concerned that, by establishing a range, the upper boundary of the range would effectively become the target point for surplus, which would encourage GHMSI to hold levels of surplus in excess of a level that maximizes community reinvestment and is efficient. Thus, the Commissioner concludes that a target point more effectively accomplishes the Act's purposes.

*f) Assessing Appleseed's Recommended Surplus Level*

The Commissioner carefully considered, but ultimately rejected, Appleseed's recommendation for a target level of surplus radically lower than 721% RBC-ACL. Appleseed recommended adoption of a surplus level between 400% and 500% RBC, or approximately \$400 to \$500 million. *See* Appleseed Pre-Hearing Brief at 45; DC Appleseed Center for Law & Justice, Rebuttal Statement – D.C. Department of Insurance, Securities & Banking: Surplus Review of Group Hospitalization and Medical Services, Inc. ("GHMSI"), 3 (Nov. 7, 2014) ("Appleseed Rebuttal Brief").

According to Appleseed, the adjustments to the Modified Milliman Model made by its actuarial consultant, Mr. Shaw of UHAS, "show that a surplus *below* \$400 million would be appropriate looking solely to the Modified Milliman Model and applying a properly calibrated confidence level." Appleseed Rebuttal Brief at 3 (emphasis added). This is a remarkable assertion given that if GHMSI were to maintain a surplus level of less than \$400 million, as Appleseed suggests, the company could very easily slip below 375% RBC-ACL.<sup>25</sup>

---

<sup>25</sup> The credibility and reasonableness of Mr. Shaw's analysis are further called into question when one considers their full effect. If the Commissioner were to accept all of his recommended assumptions, GHMSI would have a surplus target of 205% RBC-ACL. Shaw Pre-Hearing Report at 58, Chart 25. In addition, if the adjustments recommended by Mr. Shaw due to alleged inefficiencies in GHMSI's administrative expenses are considered, the target surplus for GHMSI would be approximately 55% RBC-ACL. *See id.* & 37. These levels of surplus are clearly unreasonably low, financially unsound, and therefore inconsistent with the standards of the Act. Appleseed itself did not endorse them, and instead advocated for a higher target between 400% to 500% RBC-ACL.

Ultimately, Appleseed recommends a higher surplus target—\$400 to \$500 million—than that suggested by its consultant’s report. Appleseed Rebuttal Brief at 3. In doing so, however, it does not identify which portions of UHAS’s analysis the Commissioner should adopt and which portions should be modified or discarded. Instead, Appleseed’s recommended surplus range is based on an impressionistic analysis relying on several considerations.

First, Appleseed argues that Mr. Shaw’s analysis demonstrates that \$400 to \$500 million is more than enough surplus to protect GHMSI from all reasonably probable contingencies. Appleseed Rebuttal Brief at 3. As discussed above, however, Mr. Shaw’s analysis does not lead to a reasonable projection of surplus needs and therefore is not a suitable benchmark for determining an appropriate level of surplus.

Second, Appleseed argues that intervention by GHMSI’s management, DISB, and the BCBSA would prevent GHMSI from becoming insolvent. According to Appleseed, there is “every reason to believe” that such intervention would be successful given GHMSI’s dominant market position, uniquely powerful brand, territorial exclusivity with respect to its brand, and breadth of its provider networks. *Id.* The Commissioner agrees that timely intervention and the other factors mentioned by Appleseed would have an important effect on the ability of GHMSI to maintain a financially sound position. Nevertheless, these considerations already are reflected in the selection of confidence levels and assumptions underlying the Commissioner’s analysis.

Appleseed also argues that historical experience—namely, the fact that GHMSI’s surplus increased during the Great Recession of 2008-2009—shows that a surplus of \$400 to \$500 million “is more than adequate to protect the company from significant economic risk.” *Id.* As with the likely effect of intervention and related factors, historical experience already is heavily

factored into the Commissioner's analysis. Moreover, historical experience is not the only consideration here. The analysis necessarily considers reasonable projections for future experience as it may deviate from historical experience. Moreover, as discussed in detail above, the analysis encompasses much more than just economic risk.

Appleseed further argues that its surplus recommendation is consistent with the surplus level recommended by Rector for GHMSI's 2008 surplus and the level recommended by Commissioner Mirel in 2005. *Id.* at 54. As Commissioner Purcell found in the 2010 Decision and the D.C. Court of Appeals recognized, the underlying assumptions and projections that go into an analysis of GHMSI's surplus needs may vary greatly from year to year depending on changes in the regulatory and financial environment in which GHMSI operates. 2010 Order at 12-13; *see Appleseed Appeal* at 1220 ("in light of the changing conditions identified in the [2010 Order]," the Commissioner did not abuse her discretion by deferring further review of GHMSI's surplus until 2012). Appleseed's position on this score fails to give adequate consideration to the significant changes that have occurred since the time of those earlier reviews, not least of which is the implementation of the ACA's market reforms.<sup>26</sup>

#### **4. 2011 Surplus Level Conclusions**

Based on the foregoing analysis, the Commissioner concludes that the appropriate level for GHMSI's surplus as of December 11, 2011 is 721% RBC-ACL (approximately \$695.9 million).

---

<sup>26</sup> Although it is not possible to quantify precisely each factor that lead to a different conclusion regarding the appropriate level for GHMSI's 2011 surplus as compared to its 2008 surplus, the most important factor is the uncertainty concerning the impact implementation of the ACA will have on GHMSI's ability to forecast accurate premium rates in a volatile market. *See* Jim Toole, FTI Consulting, Memorandum re: GHMSI Benchmark Surplus Range Reconciliation, 3 (March 6, 2014) ("Benchmark Memo"). The full effect of the ACA was not considered in the analysis of GHMSI's 2008 surplus. *Id.* Appleseed does not dispute that the ACA has some impact, but argues that the impact will be far less than what GHMSI, Milliman or Rector suggest. *See, e.g.,* Appleseed Pre-Hearing Brief at 31, Shaw Pre-Hearing Report at 3; Appleseed Rebuttal Brief at 16.



To reach this determination, the Commissioner solicited, received and analyzed voluminous amounts of information from GHMSI, Maryland and Virginia insurance regulators, Appleseed, and other interested persons. The Commissioner and his advisors carefully and extensively analyzed the many technical considerations and underlying assumptions that went into the actuarial modeling used to estimate GHMSI's surplus needs. The Commissioner acknowledges that any modeling of this sort requires numerous judgments concerning appropriate historical benchmarks and reasonable projections of future experience. Within a reasonable range, experts can, and often do, disagree about the appropriate assumptions to be employed in any such analysis. For this reason, the Commissioner not only looked at the individual components of the analysis, but also at the "big picture" impact of his final determination on GHMSI. Based on both a granular analysis and a consideration of the larger picture, the Commissioner concludes that 721% RBC-ACL is the appropriate target for GHMSI's 2011 surplus. The Commissioner also concludes that any target below that level would not be financially sound or efficient for GHMSI and its subscribers. Conversely, establishing a target above 721% RBC-ACL would be inefficient and inconsistent with GHMSI's statutory obligation to maximize its community health reinvestment.

**D. Allocation of Surplus to the District of Columbia**

To this point, the Commissioner has addressed the surplus as a whole. All participants in this proceeding implicitly have recognized that as a practical matter, in the first instance the surplus must be examined in its totality. GHMSI even urged the Commissioner to "not address the attribution of GHMSI's surplus at this time." Group Hospitalization and Medical Services, Inc.'s Further Response to Questions in the Third Scheduling Order and Statement Regarding Attribution, at 1 (Oct. 10, 2014) ("GHMSI Attribution Resp.").

Surplus allocation is a difficult concept. The Maryland Insurance Commissioner, for example, argues that “the concept of attributing by geography the surplus of an active nonprofit health service plan whose service area spans multiple jurisdictions is fundamentally flawed.” Statement of Therese M. Goldsmith, Maryland Insurance Commissioner, at 2 (Oct. 10, 2014) (“Maryland Post-Hearing Statement”). Maryland’s expert similarly contends: “Apportionment of surplus attributable to a particular jurisdiction . . . is a concept that has no financial meaning, applicability, or relevance and should be reconsidered. This is because surplus is non-divisible and exists for the protection of the entire enterprise and all of its policyholders.” Invotex Group, Report on: Surplus Evaluation Consulting Services For the Maryland Insurance Administration Project #D80R92000007, at 3 (Oct. 30, 2009) (“Invotex Report”), attached as exhibit to Maryland Post-Hearing Statement.<sup>27</sup>

Nevertheless, the Act requires the Commissioner to determine whether “*the portion of the surplus of the corporation that is attributable to the District*” is excessive. D.C. Official Code § 31-3506(e) (2012 Repl.) (emphasis added).

The Act does not specify how the attribution of surplus to the District is to be performed. DISB’s regulations, however, state that “attributable to the District”:

shall mean the process used by the Commissioner to allocate the portion of the surplus of a hospital and medical services corporation that is derived from the company’s operations in the District of Columbia based on the following factors:

(a) The number of policies by geographic area;

---

<sup>27</sup> GHMSI similarly argues that “[a]ttribution of reserves by jurisdiction is inconsistent with sound actuarial practice no matter what approach is used. Surplus simply cannot be subdivided by jurisdiction. . . . Outside of these proceedings, there is no accounting standard or requirement in the industry that would justify such separate accountings, let alone require them.” GHMSI Attribution Resp. at 1. Whether and how these criticisms and concerns should be addressed is a question for the D.C. Council, not DISB. As currently formulated, the Act’s plain terms require an allocation.

(b) The number of health care providers under contract with the company by geographic area; and

(c) Any other factor that the Commissioner deems to be relevant based on the record of a public hearing held pursuant to section 4602.

26A DCMR 4699.2. By permitting the consideration of “[a]ny other factor that the Commissioner deems to be relevant,” the regulations give the Commissioner considerable latitude in determining how to allocate the surplus.

GHMSI and Appleseed disagree on how the Commissioner should exercise his discretion in allocating the surplus attributable to the District. GHMSI contends that GHMSI’s surplus should be attributed based on GHMSI subscribers’ residence, reasoning that (1) its “Congressional Charter instructs GHMSI that it must conduct business on behalf of its subscribers, (2) GHMSI’s surplus was built from premiums paid by or on behalf of its subscribers, and (3) GHMSI’s surplus exists solely for the benefit of its subscribers.” GHMSI Attribution Resp. at 2. In contrast, Appleseed maintains that the Commissioner should allocate surplus based on the proportion of premiums that originate in each jurisdiction, arguing that (1) “the surplus is produced by the premiums paid by individuals and small-group and medium-group employers and their employees,” (2) because the individuals and employers who produced the surplus through their premium payments are supported in their activities by the resources and services of the jurisdiction where they are located, the attribution method should reflect the contribution to surplus made by those employers and individuals,” and (3) allocating surplus on the basis of the situs of the contracts that produced the surplus is also consistent with insurance practices both here and in other jurisdictions.” Appleseed Rebuttal Brief at 55.

After reviewing all submissions, the Commissioner concludes that the location or “situs” of the contract – as measured by the premiums reported and number of policies issued in each

jurisdiction – is the most relevant consideration and will accord it the most weight in allocating surplus. Focusing on policy situs – rather than on individual subscriber residency – is consistent with standard regulatory practice and authority. In this regard, the Commissioner has express statutory authority to regulate insurers “doing insurance business in the District.” D.C. Official Code § 31-202(a) (2012 Repl.). “Doing insurance business” encompasses both assuming risks and issuing insurance policies. *See id.* at § 31-202(b). Insurers themselves quantify the business done in the District by filing annual statements “setting forth specifically the net amount of its premium receipts, the amount of losses paid, [and] the amount of expenses incurred . . . .” *Id.* at § 31-205(a).

Focusing on reported premiums, in particular, is appropriate given the statutory language here. GHMSI observed that the Act requires allocation of the surplus “attributable” to the District, and that “attribute” means “due to, caused by, or generated by.” GHMSI Attribution Resp. Exh. 1 at 33 (quoting *Electrolux Holdings, Inc. v. United States*, 491 F.3d 1327, 1330-31 (Fed. Cir. 2007)). In other words, “[t]he question to be answered is ‘where did the money come from? The answer will ordinarily be the source to which the gain is ‘attributable.’” *Id.* (quoting *Benedek v. Commissioner*, 429 F.3d 41, 43 (2d Cir. 1970)). Both GHMSI and Appleseed agree that “GHMSI’s surplus was built from premiums paid by or on behalf of its subscribers.” GHMSI Attribution Resp. at 2; *see also* Appleseed Rebuttal Brief at 55 (“the surplus is produced by the premiums paid by individuals and small-group and medium-group employers and their employees.”).

The Commissioner has reviewed the data from the 2011 Annual Statement filed by GHMSI, as well as BlueChoice's 2011 Annual Statement,<sup>28</sup> and specifically their amended Schedule Ts showing "Premiums and Other Considerations Allocated by States and Territories."<sup>29</sup> When jurisdictions where GHMSI and Blue Choice reported \$0 premium are excluded, the Schedule Ts show the following direct business only-premiums for accident and health premiums and FEP premiums:<sup>30, 31</sup>

---

<sup>28</sup> The Milliman model, both as originally created and as modified by Rector, reflects GHMSI's 50% ownership of BlueChoice. Since BlueChoice was factored into the determination of whether the surplus was excessive, it similarly should be factored into the determination of what portion of the surplus is attributable to the District. The Commissioner therefore rejects GHMSI's request to separately apportion surplus to GHMSI and to BlueChoice. See GHMSI Attribution Resp. at 5-6. Thus, as in the review of the surplus as a whole, the allocation calculus includes 100% of GHMSI's own business and 50% of BlueChoice's business.

<sup>29</sup> The Commissioner informed the parties at the June 25, 2014 hearing that GHMSI's annual statements would be part of the record for this proceeding. See Tr. 11:3. BlueChoice's annual statement, filed with the NAIC, is a publicly available document and, as a practical matter, DISB accesses NAIC filings as it does its own records. Courts routinely take judicial notice of public records, *see, e.g., Renard v. D.C. Dep't of Emp. Services*, 673 A.2d 1274, 1276 (D.C. App. 1996) ("An agency may take official notice of its own records"), as does the Commissioner here.

<sup>30</sup> The FEP (also known as "FEHBP") Premiums reported on the Schedule T are not the same as on Table 4: Premiums by Jurisdiction of Policyholder in GHMSI 1(d) Resp. It appears that the difference may be because, in the GHMSI 1(d) Response, "Premiums for FEP overseas certificate holders were included with reporting for the District of Columbia on the amended 2011 Annual Statement for GHMSI, but have been broken out separately here." *Id.* at Table 4, n. 21. The Commissioner concludes, however, that GHMSI should be bound by its regulatory filings. Therefore, in determining the premiums generated in each jurisdiction, this decision relies upon the amounts reported in the Health Annual Statements' Schedule T forms rather than in GHMSI's 1(d) Response.

<sup>31</sup> Appleseed accurately notes that GHMSI changed its reporting of FEP premiums, shifting the majority of reported premiums from the District to Maryland. See Appleseed Rebuttal Brief at 55, n. 48. But Appleseed incorrectly asserts that there is a "conventional" way to report FEP premiums. By way of example, Kaiser allocates all of its FEP premiums to the District in its Schedule T, while Aetna allocates its FEP premiums across several states. Therefore, GHMSI's reported allocation of premium will be accepted for present purposes, just as DISB has accepted GHMSI's reporting for other regulatory purposes.

**Table 2. Summary of Schedule T Reported Premiums**

<b>Jurisdiction</b>	<b>Accident &amp; Health Premiums</b>	<b>FEP Premiums</b>
DC – GHMSI	\$ 473,305,211	\$ 331,882,869
DC - BlueChoice	\$ 231,586,264	\$ 0
MD – GHMSI	\$ 710,702,600	\$ 733,798,465
MD - BlueChoice	\$1,406,340,822	\$ 174,470,124
VA – GHMSI	\$ 516,253,778	\$ 664,686,724
VA - BlueChoice	\$ 233,708,673	\$ 0

See 2011 Annual Statement, Schedule T (as amended); Health Annual Statement for the year ended December 31, 2011 of the condition and affairs of CareFirst BlueChoice, Inc., Schedule T (as amended).

Thus, the combined reported premiums for GHMSI (100%) and BlueChoice (50%, as per note 29) are as follows:

**Table 3. Combined 100% GHMSI + 50% Blue Choice Schedule T Reported Premiums**

<b>Jurisdiction</b>	<b>Accident &amp; Health Premiums (\$)</b>	<b>Accident &amp; Health Premiums (%)</b>	<b>FEP Premiums (\$)</b>	<b>FEP Premiums (%)</b>
DC	\$ 589,098,343	22%	\$ 331,882,869	18%
MD	\$1,413,873,011	54%	\$ 821,033,527	45%
VA	\$ 633,108,115	24%	\$ 664,686,724	37%
Total	\$2,636,079,469	100%	\$1,817,603,120	100%

Rather than simply add all Accident & Health Premiums to the FEP Premiums and use the resulting percentage allocation, the Commissioner took a more nuanced approach. As a general rule, FEP business is less risky, and therefore less profitable and less likely to contribute to surplus. See NAIC RBC Instructions, *supra*, at 19 (recognizing “the reduced risk associated with safeguards built into the federal employees health benefit program . . .”). The NAIC’s underwriting risk factor for FEP business therefore is substantially lower (0.02) than the underwriting risk factor for the top tier of non-FEP business (0.09), reflecting relative weights of 18%:82% for the two lines of business. See *id.* at 17, 19. Similarly, the surplus allocation for

FEP business should be substantially lower than that for non-FEP business. The Commissioner therefore applied a weighted ratio of 18% to 82% for the FEP and non-FEP premiums, using the NAIC RBC Instructions as a guideline. Using these weighted averages, the premiums allocable to the District are 21%, as shown on Table 4.<sup>32</sup>

**Table 4. Weighted Premium Percentages**

	<b>% from Table 3</b>	<b>Weight</b>
District Share of Combined Total Accident & Health Premiums	22%	82%
District Share of Combined Total FEP Premiums	18%	18%
<b>Weighted Average for District Share of All Premiums</b>	<b>21%</b>	

The applicable regulations also require consideration of the number of policies by jurisdiction. *See* 26A DCMR 4699.2. GHMSI reports that the policies by jurisdiction of policyholder are as follows:

**Table 5. Summary of Policies by Jurisdiction of Policyholder  
(100% GHMSI + 50% BlueChoice)**

<b>Jurisdiction</b>	<b>GHMSI and BlueChoice Policies</b>
<b>DC</b>	54,484 (19%)
MD	130,207 (45%)
VA	86,209 (31%)
Other	17,081 ( 6%)
<i>Total</i>	<i>287,981 (100%)</i>

*See* GHMSI 1(d) Resp., Table 1.

The Commissioner concludes that the number of policies by jurisdiction should be given less weight than premiums in determining how much of GHMSI's surplus is attributable to the District. First, as explained above, the amount of surplus accumulated by GHMSI is largely a

---

<sup>32</sup> Even if the Commissioner had simply added the premiums together without any premium weighting, he would have reached the same 21% allocation: the combined Accident & Health and FEP premiums for the District total \$920,981,212, which is 21% of the combined totals of \$4,453,682,589 for the District, Maryland, and Virginia.

function of the premiums it earns. Policy counts bear only a tenuous relationship to premiums, and therefore to surplus, because the amount of premiums generated by a policy varies greatly. Second, the Commissioner finds that the “Policies by Jurisdiction of Policyholder” data provided by GHMSI is problematic for allocation purposes. Most importantly, GHMSI’s table lumps together individual policyholders, group plans, self-insured plans, and FEP plan certificate holders. *See* GHMSI 1(d) Resp., Table 1 n.1. In terms of surplus contribution and allocation, the Commissioner does not believe that a single, individual policyholder necessarily should be accorded the same weight as a group plan policyholder with thousands of members. Also, self-insured plans contribute less to surplus than do individual and group plans. The Commissioner therefore concludes that the policyholder data from GHMSI should be given significantly less weight in the allocation calculation.

Finally, the regulations require consideration of the number of providers by jurisdiction. *See* 26A DCMR 4699.2. GHMSI reports the following numbers of providers by jurisdiction:

**Table 6. Summary of Network Providers by Jurisdiction  
(100% GHMSI + 50% BlueChoice)**

<b>Jurisdiction</b>	<b>GHMSI and BlueChoice Policies</b>
<b>DC</b>	8,856 (15%)
MD	39,240 (66%)
VA	11,436 (19%)
<i>Total</i>	<i>59,531 (100%)</i>

*See* GHMSI 1(d) Resp., Table 3.

The Commissioner finds that inclusion of the network provider data in the allocation calculus is also problematic. First, the Commissioner sees no relationship between the location of providers and accumulation of surplus. In addition, it is unclear to what extent GHMSI’s response may double-count doctors by including doctors who participate in *both* GHMSI’s RPN



Network, and BlueChoice’s HMO Network. The Commissioner therefore concludes that the network provider data should be given less weight in the allocation.

In making the determination of the surplus attributable to the District, the Commissioner has evaluated the three factors above – premiums, number of policies, and providers – weighing the first factor the most heavily. As discussed above, the Commissioner accords the most weight to policy situs, and uses the premium amounts as the best measure for situs. As detailed above, the Commissioner finds GHMSI’s data on the number of policies by jurisdiction to be problematic. Even more problematic is the use of network provider distribution by jurisdiction, particularly since providers have little if any effect on surplus generation. In his discretion, the Commissioner therefore has determined that a reasonable weighting of these three factors is as follows:

**Table 7. Allocation Factors and Weight**

<b>Factor</b>	<b>% Allocated to District</b>	<b>Weight</b>
Reported Premiums (Table 4)	21%	90%
Policies by Policyholder Jurisdiction (Table 5)	19%	5%
Providers (Table 6)	15%	5%

Under this weighted average, **21%** of GHMSI’s surplus is attributable to the District.

**E. GHMSI’s Community Health Reinvestment**

The Act defines “community health reinvestment” as “expenditures that promote and safeguard the public health or that benefit current or future subscribers, including premium rate reductions.” D.C. Official Code § 31-3501(1A) (2012 Repl.). For GHMSI’s guidance, the Commissioner provides the following analysis of what types of expenditures he deems to constitute community health reinvestment. The guidance addresses the five main categories into which GHMSI divided its past expenditures: (1) corporate giving, (2) open enrollment subsidies,

(3) D.C. Healthcare Alliance Program funding, (4) premium rate reductions, and (5) premium taxes. Rector Report at 35.

### **1. Corporate Giving**

GHMSI categorizes its corporate giving to include: (1) catalytic giving, which is defined as support for programs and initiatives that stimulate improvements in health care systems over the long term (*e.g.*, Mary's Center Patient Centered Medical Chronic Care Initiative), (2) targeted health-related giving through others, which is defined as support to organizations that provide direct care or related services for underserved populations (*e.g.*, Community of Hope South Capital Health and Resource Center), (3) programmatic initiatives, meaning support for programs targeting a specific population or addressing a major health care issue with specific measures for success (*e.g.*, the District of Columbia Department of Health Maternal and Child Case Management Program), and (4) corporate memberships and community sponsorships/memberships with business and civic organizations (*e.g.*, sponsorship of events hosted by the Boys and Girls Clubs of Greater Washington D.C.). Rector Report at 35.

The Commissioner concludes that expenditures in the first three categories of corporate giving clearly qualify as community health reinvestment because they promote and safeguard the public health. Whether expenditures in the last category—corporate memberships and community sponsorships—qualify as community health reinvestment is a closer question, but the Commissioner ultimately concludes that they also qualify. On the one hand, these types of expenditures have a marketing component because they enhance GHMSI's image in the community by providing it with public recognition and goodwill. On the other hand, these expenditures – particularly corporate sponsorships – support the District's business community and organizations that provide health care resources to the District, which indirectly promotes

and safeguards public health and benefits current and future subscribers of GHMSI residing in the District. *Id.* at 35-36.<sup>33</sup>

## **2. Open Enrollment Subsidies**

Under D.C. Official Code § 31-3541 (2012 Repl.), GHMSI is required to provide an open enrollment program for District residents to ensure access to health coverage. Although open enrollment subsidies clearly qualified as community health reinvestment, they will not be part of any future GHMSI spending. The open enrollment program was discontinued in 2014 with the advent of market-wide open enrollment through the District's Health Benefit Exchange.

## **3. Public-Private Partnerships**

The Commissioner concludes that expenditures supporting public-private partnerships are community health reinvestment. The Act specifically requires GHMSI's participation in a public-private partnership program, including a \$5 million annual payment to the Healthy DC Fund (or successor fund) to expand health insurance coverage for low-income District residents, for at least five years beginning in 2009. *See* D.C. Official Code § 31-3501(7A)(A) (2012 Repl.); *see also* Rector Report at 36. The statute permits extension of the program past the 5-year period, i.e., past 2009, upon the mutual written agreement of the District Council and GHMSI. D.C. Official Code § 31-3501(7A)(A)(iii) (2012 Repl.).

## **4. Premium Rate Reductions**

The statutory definition of community health reinvestment expressly includes premium rate reductions, D.C. Official Code § 31-3501(1A) (2012 Repl.), and there is no doubt that premium rate reductions benefit subscribers. Moreover, any rate reduction, whether it is an

---

<sup>33</sup> Corporate memberships in business and civic organizations comprise a very small part of total expenditures in the category of corporate memberships and sponsorships. For example, in 2011 corporate memberships accounted for \$81,650 in expenditures. GHMSI Response to Third Scheduling Order, Attachment E.

outright reduction in rates or a decision to moderate or forego a rate increase, obviously has a direct effect on GHMSI's surplus.

Nevertheless, the Commissioner sees no practical way to quantify past rate reductions or their benefit to subscribers, especially in cases where GHMSI asserts that a rate reduction consists of establishing a rate that is lower than the company's estimate of health care cost trend. In addition, the Commissioner sees no practical way to distinguish between a rate reduction made for competitive purposes versus one made to benefit subscribers. Reductions for competitive purposes arguably do not benefit subscribers to the extent that subscribers may obtain similar rates elsewhere in the market. Thus, although rate reductions may benefit subscribers, the Commissioner makes no attempt to quantify them and therefore does not endorse GHMSI's self-identified \$27 million in premium rate reductions in the District market between 2010 and 2012. Rector Report at 35.

This is not to say, however, that the Commissioner takes no account of rate reductions in this review. The rates GHMSI chooses to charge obviously have a direct effect on its surplus. Thus, the Commissioner indirectly takes into account GHMSI's decisions concerning rates in reviewing the company's surplus to determine whether it is excessive.

## **5. Premium Taxes**

GHMSI provided information about premium taxes paid to the District in response to a request from Rector for information about community health reinvestment expenditures. GHMSI Resp. Third Sched. Order at 23. Although GHMSI's liability for premium taxes was considered in developing the *pro forma* projections used to model its surplus needs, the Commissioner does not consider premium taxes to constitute community health reinvestment. In

a post-hearing filing, GHMSI agreed that premium taxes do not constitute community health reinvestment. *Id.*

## **6. 2011 Community Health Reinvestment Expenditures**

The Commissioner concludes that GHMSI’s quantifiable community health reinvestment expenditures for 2011 were as follows:

**Table 8. GHMSI’s Quantifiable Community Health Reinvestment in 2011**

Corporate giving	\$ 3.4 million
Open enrollment subsidies	\$ 4.5 million
D.C. Healthcare Alliance funding	\$ 5.0 million
<b>Total</b>	<b>\$12.9 million</b>

### **F. Coordination with Other Jurisdictions**

The Act requires that the review of GHMSI’s surplus be “undertaken in coordination with the other jurisdictions in which the corporation conducts business”—namely, Maryland and Virginia. D.C. Official Code § 31-3506(e) (2012 Repl.). In addition, the Act provides that “the Commissioner shall consider the interests and needs of the jurisdictions in the corporation’s service area.” *Id.* at § 31-3506.01(b).

Throughout this proceeding, the Commissioner has taken reasonable steps to coordinate with GHMSI’s regulators in Maryland and Virginia and take into account the interests and needs of those jurisdictions. In addition to publishing hearing notices in the D.C. Register and posting notices on DISB’s website, Department staff emailed notice of and invitations directly to the Maryland and Virginia Insurance Commissioners. The Maryland and Virginia Commissioners declined to testify, but, as noted above, the Maryland Commissioner submitted a pre-hearing written statement. In response to the Commissioner’s post-hearing invitation to comment on the question of allocating GHMSI’s surplus, both the Maryland Insurance Commissioner and the

Virginia State Corporation Commission's Bureau of Insurance (the "Virginia Bureau") submitted written statements.

The Maryland Insurance Commissioner's pre-hearing statement underscored that "Maryland and the District of Columbia share a common interest in ensuring that GHMSI's surplus is neither excessive nor inadequate for the protection of its policyholders." Maryland Pre-Hearing Statement at 1. The statement described Maryland's interest in GHMSI and its own surplus review process; discussed the Act and its application to GHMSI; and asserted that, in the event DISB determined GHMSI's surplus attributable to the District is excessive, "[i]t is [the Maryland Insurance Administration's] . . . position that distribution of any excess surplus to GHMSI policyholders, including, for example, in the form of a premium subsidy or other rate relief, is the *only* 'fair and equitable manner' of distribution." *Id.* at 4. The Commissioner will take Maryland's position into consideration in evaluating GHMSI's plan for dedicating its excess surplus attributable to the District to community health reinvestment.

The Maryland Insurance Commissioner also submitted a post-hearing statement specifically addressing surplus allocation. *See* Maryland Post-Hearing Statement; *see also* Section IV.D., above. As noted above, the Maryland Insurance Commissioner argued that the concept of attributing GHMSI's surplus by geography was "fundamentally flawed." Maryland Post-Hearing Statement at 2. She also emphasized that "a substantial portion of GHMSI's admitted assets are illiquid and not readily available for payment of claims or other obligations." *Id.* at 2. The Commissioner concluded that "the Maryland Insurance Administration stands ready to work together with the District of Columbia Department of Insurance, Securities and Banking and the Virginia State Corporation Commission's Bureau of Insurance in the best

interests of GHMSI and its members and policyholders in all of our respective jurisdictions.” *Id.* at 3.

The Virginia Bureau also addressed the question of surplus allocation. Its post-hearing statement explained that, under Virginia law, “if DISB requires [GHMSI] . . . to provide a program or benefit for the residents of the District of Columbia or Maryland, the [Virginia Bureau] . . . may be directed to conduct an examination of [GHMSI] . . . focusing on the impact on surplus, premium rates for residents of Virginia, and solvency. Statement of the Virginia State Corporation Commission’s Bureau of Insurance, 1 (Sept. 29, 2014) (“Virginia Post-Hearing Statement”). If the Virginia Bureau’s examination concluded that the impact on GHMSI was harmful to Virginia residents, it would issue an order to protect Virginia residents. *Id.* at 2. The Virginia Bureau concluded by observing that, under Virginia law, “the determination of premiums charged to Virginia residents and the determination of surplus attributable to Virginia residents must be based on the number of residents in Virginia compared with the number of residents in other states covered by” GHMSI. *Id.*

The Commissioner carefully reviewed and considered all of the materials submitted by the Maryland and Virginia Commissioners and has taken their submissions into account in reaching his conclusions in this review. In making his determination, he has sought to balance the interests and needs of Maryland and Virginia, as articulated by the regulators in those states, with the interests and needs of the District and the requirements of the Act. In this regard, he notes that although each jurisdiction has its own interests and needs, the District, Maryland, and Virginia share the common goal of ensuring that GHMSI remains financially sound and efficient so that it may continue to fulfill its statutory obligations and commitments to its subscribers.

After careful review and analysis, the Commissioner believes that his decision is consistent with this common goal.

The Commissioner acknowledges that his conclusion that a surplus above 721% RBC-ACL is excessive conflicts with the Maryland Commissioner's conclusion that GHMSI should maintain a surplus in the range of 1,000-1,300% RBC-ACL. *See* Maryland Consent Order (Sept. 14, 2012). The Commissioner will directly inform the Maryland and Virginia Commissioners of this decision.

**G.     Requirements for GHMSI Plan**

Given the determination that GHMSI's surplus attributable to the District is excessive, the next step is for GHMSI to "submit a plan for dedication of the excess to community health reinvestment in a fair and equitable manner." D.C. Official Code § 31-3506(g)(1) (2012 Repl.). The plan "may consist entirely of expenditures for the benefit of current subscribers of the corporation." *Id.* at § 31-3506(g)(2). The Commissioner shall approve the plan if it is fair and equitable. 26A DCMR § 4603.2.

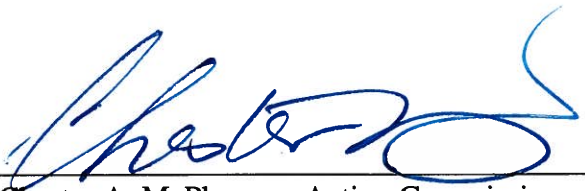
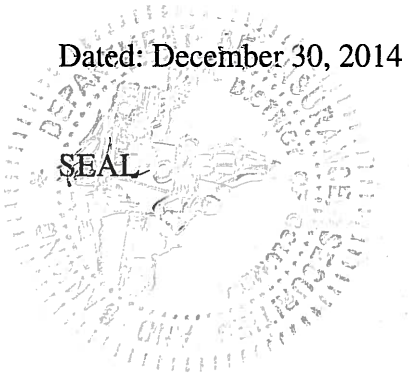


## V. ORDER

GHMSI's surplus attributable to the District as of December 31, 2011 was "excessive" as defined by the Act. Specifically, GHMSI's surplus as of December 31, 2011 was 998% RBC-ACL, whereas the appropriate level was 721% RBC-ACL. The percentage of GHMSI's 2011 surplus attributable to the District was 21%.

It is therefore ORDERED that, within forty-five (45) calendar days, GHMSI shall submit to the Commissioner a plan for dedication of the excess surplus attributable to the District to community health reinvestment in a fair and equitable manner, in accordance with D.C. Official Code § 31-3506(g) and 26A DCMR § 4603.

Dated: December 30, 2014



Chester A. McPherson, Acting Commissioner

## Exhibit 1 – Hearing Record Index for GHMSI 2011 Surplus Review

**“the surplus-related material posted on DISB’s website  
will be the official record for this proceeding.”**

Transcript, *District of Columbia Department of Insurance, Securities and Banking –  
Group Hospitalization and Medical Services, Inc. Surplus Review Hearing* at 11 (June 25, 2014).

---

The GHMSI surplus-related materials that constitute the hearing record on DISB’s website, [www.disb.dc.gov](http://www.disb.dc.gov), are listed on 7 separate webpages: 3 “main” webpages (Review of CareFirst’s 2011 Surplus, Review of CareFirst’s 2008 Surplus, and CareFirst Surplus Report Filings) and four “subsidiary” webpages (GHMSI Financial Statements, MIA Hearing Information, CareFirst Hearing – GHMSI Documents, and GHMSI Rates Filings), as shown:

Review of CareFirst’s 2011 Surplus, <http://disb.dc.gov/node/771622>

GHMSI Financial Statements, [http://disb.dc.gov/publications-list?after\[value\]\[date\]=&before\[value\]\[date\]=&keys=HFAS&type=79&sort\\_by=field\\_date\\_value&sort\\_order=DESC](http://disb.dc.gov/publications-list?after[value][date]=&before[value][date]=&keys=HFAS&type=79&sort_by=field_date_value&sort_order=DESC)

Review of CareFirst’s 2008 Surplus, <http://disb.dc.gov/node/315902>

Maryland Insurance Administration (MIA) Hearing Information,  
<http://disb.dc.gov/node/334192>

CareFirst Hearing – GHMSI Documents, <http://disb.dc.gov/node/333022>

GHMSI Rate Filings, [http://disb.dc.gov/publications-list?after\[value\]\[date\]=&before\[value\]\[date\]=&keys=GHMSIRF&type=79&sort\\_by=field\\_date\\_value&sort\\_order=DESC](http://disb.dc.gov/publications-list?after[value][date]=&before[value][date]=&keys=GHMSIRF&type=79&sort_by=field_date_value&sort_order=DESC)

GHMSI Financial Statements [see “Review of CareFirst’s 2011 Surplus” for link]

CareFirst Surplus Report Filings, <http://disb.dc.gov/node/315992>

In reaching his Decision, the Commissioner considered the record in its entirety.

For ease of reference, the following lists documents cited in the Decision and Order and lists specific webpage “nodes” where they may be located:

Short Reference	Full Description	Website Location
2010 Order	DISB, Final Decision and Order, <i>In the Matter of: Surplus Review and Determination Regarding Group Hospitalization and Medical Services, Inc.</i> , Order No. 09-MIE-007 (Oct. 29, 2010)	Review of CareFirst’s 2008 Surplus <a href="http://disb.dc.gov/node/305012">http://disb.dc.gov/node/305012</a>

## Exhibit 1 – Hearing Record Index for GHMSI 2011 Surplus Review

Short Reference	Full Description	Website Location
2011 Annual Statement	Health Annual Statement for the year ended December 31, 2011 of the condition and affairs of Group Hospitalization and Medical Services, Inc.	GHMSI Financial Statements <a href="http://disb.dc.gov/publication/health-annual-statement-%E2%80%93-ghmsi-%E2%80%93-2011">http://disb.dc.gov/publication/health-annual-statement-%E2%80%93-ghmsi-%E2%80%93-2011</a>  Also: <a href="http://www.naic.org">www.naic.org</a>
2011 Surplus Report	CareFirst BlueCross BlueShield, Report on GHMSI Surplus [for 2011] (June 1, 2012)	Review of CareFirst’s 2011 Surplus <a href="http://disb.dc.gov/node/311302">http://disb.dc.gov/node/311302</a>
ACA Reform Memo	Jim Toole, FTI Consulting, Memorandum re: ACA Reform and Surplus Requirements (Sept. 12, 2013)	Review of CareFirst’s 2011 Surplus <a href="http://disb.dc.gov/node/817782">http://disb.dc.gov/node/817782</a>
Appleseed Pre-Hearing Brief	D.C. Appleseed Report to the D.C. Department of Insurance, Securities and Banking: Surplus Review of Group Hospitalization and Medical Services, Inc. (“GHMSI”) (June 10, 2014)	Review of CareFirst’s 2011 Surplus <a href="http://disb.dc.gov/node/844192">http://disb.dc.gov/node/844192</a>
Appleseed Rebuttal Brief	DC Appleseed Center for Law & Justice, Rebuttal Statement – D.C. Department of Insurance, Securities and Banking: Surplus Review of Group Hospitalization and Medical Services, Inc. (“GHMSI”) (Nov. 7, 2014)	Review of CareFirst’s 2011 Surplus <a href="http://disb.dc.gov/node/949752">http://disb.dc.gov/node/949752</a>
Benchmark Memo	Jim Toole, FTI Consulting, Memorandum re: GHMSI Benchmark Surplus Range Reconciliation (March 6, 2014)	Review of CareFirst’s 2011 Surplus <a href="http://disb.dc.gov/node/797112">http://disb.dc.gov/node/797112</a>
Doran Testimony	Testimony of Phyllis Doran, F.S.A., M.A.A.A., District of Columbia Department of Insurance, Securities and Banking Public Hearing to Review the Surplus and Community Health Re-Investment of GHMSI (June 25, 2014)	Review of CareFirst’s 2011 Surplus <a href="http://disb.dc.gov/node/856632">http://disb.dc.gov/node/856632</a>
GHMSI 1(d) Resp.	Response of Group Hospitalization and Medical Services, Inc. to Supplemental Information Request 1(d) in DISB Order No. 14-MIE-08 (October 3, 2014) (Oct. 31, 2014)	Review of CareFirst’s 2011 Surplus <a href="http://disb.dc.gov/node/944602">http://disb.dc.gov/node/944602</a>

## Exhibit 1 – Hearing Record Index for GHMSI 2011 Surplus Review

Short Reference	Full Description	Website Location
GHMSI Attribution Resp.	Group Hospitalization and Medical Services, Inc.’s Further Response to Questions in the Third Scheduling Order and Statement Regarding Attribution (Oct. 10, 2014)	Review of CareFirst’s 2011 Surplus <a href="http://disb.dc.gov/node/920962">http://disb.dc.gov/node/920962</a>
GHMSI Post-Hearing Brief	Group Hospitalization and Medical Services, Inc., Post-Hearing Brief – DISB Review of GHMSI Surplus Pursuant to the Medical Insurance Empowerment Act of 2008, D.C. Code § 31-3501, <i>et seq.</i> (Nov. 7, 2014)	Review of CareFirst’s 2011 Surplus <a href="http://disb.dc.gov/node/949802">http://disb.dc.gov/node/949802</a>
GHMSI Resp. Third Sched. Order	Group Hospitalization and Medical Services, Inc.’s Responses to Questions in the Third Scheduling Order (Sep. 5, 2014)	Review of CareFirst’s 2011 Surplus <a href="http://disb.dc.gov/node/893242">http://disb.dc.gov/node/893242</a>
Invotex Report	Invotex Group, Report on: Surplus Evaluation Consulting Services For the Maryland Insurance Administration Project #D80R92000007 (Oct. 30, 2009)	Review of CareFirst’s 2011 Surplus <a href="http://disb.dc.gov/node/921442">http://disb.dc.gov/node/921442</a>
Lewin Report	The Lewin Group, Recommended Surplus Range for GHMSI: Approach and Considerations for Determining the Appropriate Range of Surplus in 2011 (May 20, 2011)	CareFirst Surplus Report Filings <a href="http://disb.dc.gov/node/311272">http://disb.dc.gov/node/311272</a> (Attachment D)
Maryland Consent Order	Maryland Insurance Administration, Consent Order, <i>In re Targeted Surplus Ranges for CareFirst of Maryland Inc. and Group Hospitalization and Medical Services, Inc.</i> , Case No. MIA-2012-09-006 (Sept. 14, 2012)	Review of CareFirst’s 2011 Surplus <a href="http://disb.dc.gov/node/844182">http://disb.dc.gov/node/844182</a> (Exhibit 15)
Maryland Post-Hearing Statement	Statement of Therese M. Goldsmith, Maryland Insurance Commissioner (Oct. 10, 2014)	Review of CareFirst’s 2011 Surplus <a href="http://disb.dc.gov/node/921442">http://disb.dc.gov/node/921442</a>
Maryland Pre-Hearing Statement	Statement of Therese M. Goldsmith, Maryland Insurance Commissioner (June 25, 2014)	Review of CareFirst’s 2011 Surplus <a href="http://disb.dc.gov/node/849762">http://disb.dc.gov/node/849762</a>

## Exhibit 1 – Hearing Record Index for GHMSI 2011 Surplus Review

Short Reference	Full Description	Website Location
Milliman Report	Milliman, Inc., <i>CareFirst Inc. – Group Hospitalization and Medical Services, Inc. – Development of Optimal Surplus Target Range</i> (May 31, 2011)	CareFirst Surplus Report Filings <a href="http://disb.dc.gov/node/311272">http://disb.dc.gov/node/311272</a> (Attachment C)
Milliman Resp. Supp. Info. Req.	Milliman, Inc., Letter re: Response to DISB October 3, 2014 Order with Supplemental Information Requests (Oct. 15, 2014)	Review of CareFirst's 2011 Surplus <a href="http://disb.dc.gov/node/937622">http://disb.dc.gov/node/937622</a>
Participation Order	DISB, Order on DC Appleseed Participation, <i>In the Matter of: Surplus Review and Determination Regarding Group Hospitalization and Medical Services, Inc.</i> , Order No. 14-MIE-004 (June 10, 2014)	Review of CareFirst's 2011 Surplus <a href="http://disb.dc.gov/node/844202">http://disb.dc.gov/node/844202</a>
Pro Forma Memo	Jim Toole, FTI Consulting, Memorandum re: Milliman Pro Forma Financial Projection Model Methodology Validation (Feb. 7, 2014)	Review of CareFirst's 2011 Surplus <a href="http://disb.dc.gov/node/797122">http://disb.dc.gov/node/797122</a>
Rector Modeling Memo	Sarah Schroeder, Memorandum re: Overview of Milliman Modeling Methodology (May 12, 2014)	Review of CareFirst's 2011 Surplus <a href="http://disb.dc.gov/node/830102">http://disb.dc.gov/node/830102</a>
Rector Premium Growth Memo	Jim Toole, FTI Consulting, Memorandum re: Premium Growth Assumption (May 16, 2013)	Review of CareFirst's 2011 Surplus <a href="http://disb.dc.gov/node/817782">http://disb.dc.gov/node/817782</a>
Rector Report	Rector & Associates, Inc., Report to the D.C. Department of Insurance, Securities and Banking – Group Hospitalization and Medical Services, Inc. (Dec. 9, 2013)	Review of CareFirst's 2011 Surplus <a href="http://disb.dc.gov/node/756762">http://disb.dc.gov/node/756762</a>
Rector Resp. Third Sched. Order	Rector & Associates, Inc., Questions for/ Information Requested from Rector [in Response to Third Scheduling Order] (Aug. 27, 2014)	Review of CareFirst's 2011 Surplus <a href="http://disb.dc.gov/node/888512">http://disb.dc.gov/node/888512</a>

## Exhibit 1 – Hearing Record Index for GHMSI 2011 Surplus Review

Short Reference	Full Description	Website Location
Shaw Pre-Hearing Report	Mark E. Shaw, United Health Actuarial Services, Inc., Report to the D.C. Department of Insurance, Securities and Banking Group Hospitalization and Medical Services, Inc. MIEAA Surplus Review (June 10, 2014)	Review of CareFirst's 2011 Surplus <a href="http://disb.dc.gov/node/844192">http://disb.dc.gov/node/844192</a>
Tr.	Transcript, Group Hospitalization and Medical Services, Inc. Surplus Review Hearing (June 25, 2014)	Review of CareFirst's 2011 Surplus <a href="http://disb.dc.gov/node/858472">http://disb.dc.gov/node/858472</a>
Virginia Post-Hearing Statement	Statement of the Virginia State Corporation Commission's Bureau of Insurance (Sept. 29, 2014)	Review of CareFirst's 2011 Surplus <a href="http://disb.dc.gov/node/905652">http://disb.dc.gov/node/905652</a>
	Health Annual Statement for the year ended December 31, 2011 of the condition and affairs of CareFirst BlueChoice, Inc.	Available at <a href="http://www.naic.org">www.naic.org</a>
	DISB, Third Scheduling Order, <i>In the Matter of: Surplus Review and Determination Regarding Group Hospitalization and Medical Services, Inc.</i> , Order No. 14-MIE-005 (Aug. 7, 2014)	Review of CareFirst's 2011 Surplus <a href="http://disb.dc.gov/node/878702">http://disb.dc.gov/node/878702</a>
	DISB, Order with Supplemental Information Requests, <i>In the Matter of: Surplus Review and Determination Regarding Group Hospitalization and Medical Services, Inc.</i> , Order No. 14-MIE-008 (Oct. 3, 2014)	Review of CareFirst's 2011 Surplus <a href="http://disb.dc.gov/node/914092">http://disb.dc.gov/node/914092</a>
	DISB, Order on DC Appleseed Request for Disclosure of Confidential and Proprietary Information, <i>In the Matter of: Surplus Review and Determination Regarding Group Hospitalization and Medical Services, Inc.</i> , Order No. 14-MIE-010 (Oct. 24, 2014)	Review of CareFirst's 2011 Surplus <a href="http://disb.dc.gov/node/943042">http://disb.dc.gov/node/943042</a>

**Exhibit 1 – Hearing Record Index for  
GHMSI 2011 Surplus Review**

<b>Short Reference</b>	<b>Full Description</b>	<b>Website Location</b>
	DISB, Order Closing Record, <i>In the Matter of: Surplus Review and Determination Regarding Group Hospitalization and Medical Services, Inc.</i> , Order No. 14-MIE-011 (Nov. 26, 2014)	Review of CareFirst's 2011 Surplus <a href="http://disb.dc.gov/node/960652">http://disb.dc.gov/node/960652</a>
	Rector & Associates, Inc., Letter re: R&A Review of GHMSI and Milliman 10/15/14 Response To DISB Supplemental Information Request Order No. 14-MIE-08 (Oct. 24, 2014)	Review of CareFirst's 2011 Surplus <a href="http://disb.dc.gov/node/937622">http://disb.dc.gov/node/937622</a>

# **Exhibit 3**



**GOVERNMENT OF THE DISTRICT OF COLUMBIA  
DEPARTMENT OF INSURANCE, SECURITIES AND BANKING**

	)	
IN THE MATTER OF	)	
	)	
Surplus Review and Determination	)	Order No.: 14-MIE-19
For Group Hospitalization and Medical	)	
Services, Inc.	)	
	)	
	)	

**DECISION AND ORDER**

The Commissioner of the District of Columbia Department of Insurance, Securities and Banking (the “Commissioner”) issues this Decision and Order pursuant to his authority under the Hospital and Medical Services Corporation Regulatory Act of 1996, effective April 9, 1997 (D.C. Law 11-245; D.C. Code §§ 31-3501 *et seq.* (2009)) (the “HMSC Regulatory Act”).

In accordance with the HMSC Regulatory Act, and upon consideration of the record in this proceeding, including timely public comments received by the Department of Insurance, Securities and Banking (the “Department”), the Commissioner orders Group Hospitalization and Medical Services, Inc. (“GHMSI”) to dedicate its excess 2011 surplus attributable to the District of Columbia (the “District”), as adjusted in accordance with this Decision and Order, to community health reinvestment by issuing rebates to current subscribers under subscriber contracts with a situs in the District, as further described in this Decision and Order. The rebates must be paid within 120 days of the date of this Decision and Order. The freeze on premium rate increases imposed by the Decision and Order on Group Hospitalization and Medical Services, Inc. Plan, Order No. 14-MIE-016 (June 14, 2016) (the “June 14, 2016 Order”) shall remain in effect until

GHMSI issues the rebates required by this Decision and Order, at which time the freeze shall be lifted.

## **I. BACKGROUND**

### **A. GHMSI's Obligation to Engage in Community Health Reinvestment**

GHMSI is a nonprofit hospital and medical services corporation created in 1939 by Congressional charter. *See* An Act Providing for the incorporation of certain persons as Group Hospitalization, Inc., Pub. L. No. 395, 53 Stat. 1412 (1939), as amended (the “Charter”).<sup>1</sup> The Charter declares GHMSI to be “a charitable and benevolent institution,” *id.* at § 8, 53 Stat. at 1414, and further states that GHMSI “shall be not be conducted for profit, but shall be conducted for the benefit of [its] certificate holders.” *Id.* at § 3, 53 Stat. at 1413. The Charter establishes the District as GHMSI’s legal domicile, *see* District of Columbia Appropriations Act, 1994, Pub. L. No. 103-127, § 138(a), 107 Stat. 1336, 1349 (Oct. 29, 1993), and provides that GHMSI “shall be licensed and regulated by the District of Columbia in accordance with the laws of the District of Columbia.” *Id.*, § 138(b).<sup>2</sup> GHMSI is licensed to operate in the District pursuant to the HMSC Regulatory Act.

---

<sup>1</sup> GHMSI originally was incorporated as Group Hospitalization, Inc. but later merged with Medical Services, Inc. to form Group Hospitalization and Medical Services, Inc. *See* An Act to amend the Act providing for the incorporation of certain persons as Group Hospitalization, Inc., Pub. L. No. 98-493, § 1, 98 Stat. 2272, 2272 (Oct. 17, 1984).

<sup>2</sup> GHMSI is a wholly-owned subsidiary of CareFirst, Inc., a nonprofit holding company. *See* Health Annual Statement for the Year Ended December 31, 2015 for the Condition and Affairs of the Group Hospitalization and Medical Services, Inc. at 33. Through CareFirst, Inc., GHMSI is affiliated with CareFirst of Maryland, Inc. (“CFMI”). *Id.* Together, GHMSI and CFMI do business in the District, Maryland and Virginia as “CareFirst BlueCross BlueShield.” *Id.* Through a jointly-owned intermediate holding company, GHMSI and CFMI share ownership of CareFirst BlueChoice, a health maintenance organization doing business in the District, Maryland and certain counties in Virginia. *Id.*

In 2009, due to its concern over GHMSI's commitment to its mission as a charitable and benevolent institution, the Council of the District of Columbia (the "Council") amended the HMSC Regulatory Act by enacting the Medical Insurance Empowerment Amendment Act of 2008, effective March 25, 2009 (D.C. Law 17-369; 56 DCR 1346) ("MIEAA"). Under MIEAA, GHMSI is required to "engage in community health reinvestment to the maximum feasible extent consistent with financial soundness and efficiency." D.C. Code § 31-3505.01. To ensure GHMSI does not neglect this obligation, MIEAA requires the Commissioner to review GHMSI's surplus at least once every three years and authorizes the Commissioner to issue a determination regarding whether the surplus is excessive. *See id.* at § 31-3506(e). If the Commissioner determines that GHMSI's surplus is excessive, he must order it to "submit a plan for dedication of the excess to community health reinvestment in a fair and equitable manner." *Id.* at § 31-3506(g)(1). MIEAA further provides that if the Commissioner determines GHMSI has "failed to submit a plan [for community health reinvestment] as ordered . . . within a reasonable period . . . the Commissioner shall deny for 12 months all premium rate increases for subscriber policies written in the District sought by the corporation . . . and may issue such orders as are necessary to enforce the purposes of this chapter." *Id.* § 31-3506(i).

#### **B. Review of GHMSI's 2011 Surplus**

Following a multi-year review, pursuant to Decision and Order No. 14-MIE-012 (December 30, 2014) (the "December 30, 2014 Order"), then Acting Commissioner Chester A. McPherson (the "Acting Commissioner") determined that GHMSI's surplus as of December 31, 2011 was excessive under MIEAA and ordered GHMSI to submit a

plan for dedication of the excess attributable to the District—approximately \$56.2 million<sup>3</sup>—to community health reinvestment in a fair and equitable manner. *See* December 30, 2014 Order at 66. GHMSI and the D.C. Appleseed Center for Law and Justice, Inc. (“Appleseed”)<sup>4</sup> both filed motions for reconsideration of the December 30, 2014 Order, which were denied.<sup>5</sup>

On March 16, 2015, GHMSI submitted a response to the December 30, 2014 Order, which it styled as a “plan.” *See* Plan of Group Hospitalization and Medical Services, Inc. filed with the Department of Insurance, Securities and Banking Pursuant to December 30, 2014 Order No. 14-MIE-012 (Mar. 16, 2015) (the “Plan”). In the Plan, GHMSI essentially maintained that no tangible plan for reinvestment of the excess 2011 surplus was needed. GHMSI based its position on several grounds. First, GHMSI argued that it had no excess surplus. *See id.* at 3. Second, and alternatively, GHMSI

---

<sup>3</sup> The precise amount of excess 2011 surplus attributable to the District is \$56,213,088.72. The figure \$56.2 million is used for ease of reference.

<sup>4</sup> Appleseed is a nonprofit public interest center located in Washington, D.C. and has long been involved as an interested person in these proceedings.

<sup>5</sup> In January 2015, GHMSI and Appleseed filed motions with the Department for reconsideration of the December 30, 2014 Order. *See* D.C. Appleseed’s Motion for Reconsideration (Jan. 9, 2015); GHMSI’s, Motion for Reconsideration and Coordinated Proceedings with Maryland and Virginia (Jan. 22, 2015). The Acting Commissioner denied those motions. *See* Order on Appleseed’s Motion for Reconsideration and GHMSI’s Request for Briefing Schedule on Reconsideration, Order No. 14-MIE-013 (Jan. 15, 2015); Order on GHMSI’s Motion for Reconsideration and Coordinated Proceedings with Maryland and Virginia, and on D.C. Appleseed’s Request for Briefing Schedule, Order No. 14-MIE-014 (Jan. 28, 2015).

Also, on January 29, 2015, GHMSI and Appleseed filed petitions for review of the December 30, 2014 Order with the District of Columbia Court of Appeals (the “Court of Appeals”). GHMSI also petitioned for review of the Order denying its motion for reconsideration. In light of these appeals, GHMSI requested a stay of all further proceedings in this matter – including the filing of a plan – until after the appeals’ resolution. The Acting Commissioner denied GHMSI’s motion for a stay. *See* Order on GHMSI’s Motion to Stay Further Proceedings and Appleseed’s Request for Briefing Schedule, Order No. 14-MIE-015 (Mar. 2, 2015). The Court of Appeals dismissed the petitions filed by GHMSI and Appleseed as having been taken from a non-final and non-appealable order, reasoning that the Acting Commissioner had not yet reviewed GHMSI’s plan, and thus the “administrative process [was] not yet complete, and no specific, enforceable obligations regarding the excess assets ha[d] been imposed on GHMSI.” Order, Appeal Nos. 15-AA-108 and 15-AA-109 (D.C. Ct. App. Apr. 28, 2015).

maintained that in the years since 2011, it had spent more than \$56.2 million on community health reinvestment, in addition to incurring underwriting losses and experiencing a decline in surplus, and therefore had fulfilled its obligations under MIEAA. *See id.* at 4-6. GHMSI further argued, among other things, that the Department had not sufficiently coordinated with Maryland and Virginia before issuing the December 30, 2014 Order. *See id.* at 6-8.

### **C. Decision and Order Regarding GHMSI's Plan**

On June 14, 2016, the Commissioner issued a Decision and Order on Group Hospitalization and Medical Services, Inc. Plan, Order No. 14-MIE-016 (June 14, 2016) (the "June 14, 2016 Order"). Under the June 14, 2016 Order, the Commissioner determined that GHMSI had failed to submit a plan as required by the December 30, 2014 Order and ordered as follows:

1. Effective as of the date of the June 14, 2016 Order, all requests for premium rate increases for subscriber policies written by GHMSI in the District were denied for 12 months or until the Commissioner develops and approves a plan for reinvestment of the 2011 excess surplus, whichever occurs first;
2. Pursuant to his authority to issue such orders as are necessary to enforce the purposes of MIEAA, the Commissioner would develop and approve a plan for GHMSI to dedicate the excess 2011 surplus attributable to the District to community health reinvestment in a fair and equitable manner;
3. There would be a 30-day period beginning on the date of the June 14, 2016 Order for the public to comment on the plan to be developed by the Commissioner; and

4. The Commissioner would issue and approve a plan no later than 30 days after the expiration of the public comment period.

June 14, 2016 Order at 19-20.

#### **D. State and Federal Responses to the December 30, 2014 Order**

The State of Maryland, the Commonwealth of Virginia and the federal government took various actions in response to the December 30, 2014 Order. On February 10, 2015, the Maryland Insurance Commissioner sent a letter to GHMSI's President and Chief Executive Officer stating that the Maryland Insurance Administration ("MIA") would initiate an investigation to determine whether the December 30, 2014 Order would be harmful to the interests of Maryland residents. *See* Motion to Stay Further Proceedings by Group Hospitalization and Medical Services, Inc. (Feb. 10, 2015), Exhibit B (Letter from Al Redmer, Jr., to Chet Burrell at 3 (Feb. 10, 2015)). The letter stated that while the MIA's investigation was ongoing, "GHMSI is prohibited from reducing or distributing its surplus as a result of the [December 30, 2014 Order] and is prohibited from submitting a plan to the D.C. Commissioner for dedication of its excess of 2011 surplus attributable to D.C. until submitted, reviewed, and approved by the MIA." *Id.* On June 10, 2015, following a proceeding to consider the effect of the December 30, 2014 Order on Virginia residents, the Virginia State Corporation Commission ("VA SCC") issued an order stating that GHMSI should not distribute or reduce any portion of its surplus without approval of the VA SCC. *See* Order, Case No. INS-2015-00007, Commonwealth of Virginia, State Corporation Commission (June 10, 2015).

In addition, both Maryland and Virginia enacted legislation in the first months of 2015, the intended effect of which is to prohibit GHMSI from distributing or reducing its surplus in response to an order by the Commissioner to enforce MIEAA without the approval of Maryland and Virginia state insurance regulators. *See* Md. Code, Ins. § 14-124(a)(3), (6); Va. Code § 38.2-4229.2(D). The Maryland legislation was enacted on April 14, 2015. The Virginia legislation was enacted on March 23, 2015.

In December 2015, Congress amended GHMSI's federal charter to provide that GHMSI may not divide, attribute, reduce or distribute its surplus pursuant to any law or order of any jurisdiction without the express agreement of the District, Maryland, and Virginia. *See* Financial Services and General Government Appropriations Act, 2016 § 747, *enacted as part of* Consolidated Appropriations Act of 2016, Pub. L. No. 114-113, 129 Stat. 2242 (Dec. 18, 2015). Congress made this requirement applicable with respect to GHMSI's surplus for any year after 2011. *Id.* at § 747(b).

## **II. PUBLIC COMMENT**

The June 14, 2016 Order requested public comment on the plan to be developed by the Commissioner to enforce the December 30, 2014 Order. The Commissioner received and considered numerous thoughtful and helpful comments. Persons submitting comments included members of the Council, GHMSI, Appleseed, GHMSI subscribers and contractholders, two coalitions of local organizations dedicated to improving public health and welfare, nonprofit groups providing community health services in the District, the Maryland Insurance Commissioner, local trade associations, and other interested persons.<sup>6</sup> The discussion below summarizes major aspects of the comments received.

---

<sup>6</sup> All public comments are hereby incorporated as part of the record in this proceeding and can be found at <http://disb.dc.gov/node/771622>.

### **A. GHMSI's Comments**

GHMSI's comments revisit many of the same arguments it has made before in this proceeding. *See* GHMSI Comments in Response to DISB's Order of June 14, 2016 ("GHMSI Comments"). The Department has addressed these arguments in its previous decisions and orders in this proceeding.

New issues raised by GHMSI include the following: GHMSI argues that the amendment to its Charter enacted by Congress in 2015 prohibits the Commissioner from ordering reinvestment of the excess 2011 surplus without the agreement of Maryland and Virginia. *See id.* at 2-5. In addition, GHMSI asserts that since 2011, it has made premium rate filings that resulted in a reduction to its surplus of \$42.44 million, which should be credited as community health reinvestment. *See id.* at 10-13.<sup>7</sup> Finally, GHMSI argues that the Commissioner lacks authority under MIEAA to develop and approve a plan for reinvestment of GHMSI's excess surplus on his own initiative. *See id.* at 14.

### **B. Comments from Members of the Council**

The Commissioner received comments from Councilmember At-Large Elissa Silverman and Ward 3 Councilmember Mary M. Cheh. *See* Letter from Councilmember At-Large Elissa Silverman to Commissioner Taylor (July 14, 2016); ("Silverman Letter"); Letter from Councilmember Mary M. Cheh to Commissioner Taylor (July 14, 2016) ("Cheh Letter"). Councilmembers Silverman and Cheh both urge the Commissioner to maintain the rate freeze on GHMSI for a full 12 months as a penalty for failing to comply with the December 30, 2014 Order. *See* Silverman Letter at 1-2; Cheh

---

<sup>7</sup> As it has before, GHMSI also argues that its community giving, contributions to the Healthy DC fund, and losses attributable to the District's open enrollment program should be credited as expenditures of excess surplus for community health reinvestment. *See* GHMSI Comments at 13-14.



Letter at 1. The Councilmembers state that MIEAA requires this result. *See* Silverman Letter at 2; Cheh Letter at 1. In addition, both Councilmembers support the recommendation made by two coalitions of nonprofit organizations to establish a fund for reinvestment of the excess surplus. *See* Silverman Letter at 1; Cheh Letter at 1. The coalitions' recommendations are summarized below. Finally, both Councilmembers urge the Commissioner to require reinvestment of the excess surplus in ways most likely to improve public health in the District. *See* Silverman Letter at 2; Cheh Letter at 2.

### **C. Appleseed's Comments**

Appleseed urges the Commissioner to adopt a plan similar to that suggested by the coalitions, as summarized below. Specifically, Appleseed proposes requiring GHMSI to place the excess surplus in a trust fund managed by an independent and experienced third party acting in the public interest. *See* D.C. Appleseed's Comments on the Commissioner's Plan for Holding GHMSI Accountable to the Requirements of the Medical Insurance Empowerment Amendment Act at 3-5 (July 14, 2016) ("Appleseed Comments"). Appleseed further suggests that the Commissioner require the fund manager to invest the excess surplus in community health initiatives over a five-year period. *See id.* at 5. Appleseed recommends that spending by the fund be guided by independent assessments of the District's community health needs, such as those provided in a report from the Urban Institute examining the District's health care needs and the types of community investments that could be made with the excess surplus (the "Urban Institute Report")<sup>8</sup> and a report issued by the District of Columbia Department of

---

<sup>8</sup> Urban Institute, *Health Needs in the Washington Metropolitan Area* (June 2016), available at <http://www.urban.org/sites/default/files/alfresco/publication-pdfs/2000833-Health-Needs-in-the-Washington-Metropolitan-Area-Potential-Intiaitives-for-Investment-by-CareFirst.pdf>.

Health in April, which provides baseline information on District community health indicators (the “DOH Report”).<sup>9</sup> *See id.*

Appleseed bases its recommendation to establish a community reinvestment fund on two grounds. First, Appleseed states that although MIEAA defines “community health reinvestment” broadly, the legislative history of MIEAA suggests that the Council was particularly interested in promoting community healthcare-related programs, which is what a community reinvestment fund would be designed to achieve. *See id.* at 1-2. Second, Appleseed argues that a reinvestment fund is a better option than requiring GHMSI to pay rebates because rebates would likely not be “fair and equitable,” as required by MIEAA. *See id.* at 8. Appleseed offers several reasons for this view, most of which center on the view that the rebate received by each subscriber should be directly proportional to the subscriber’s contribution to the excess 2011 surplus, and it would be difficult to ensure that this goal is achieved. *See id.* at 8-9. Appleseed also argues that the payment of rebates would not advance MIEAA’s purpose of promoting and safeguarding the public health. *See id.* at 9-10.

Appleseed urges the Commissioner not to credit GHMSI for any reductions in surplus it has made since 2011 as community health reinvestment. Appleseed maintains that any such reductions must be intentional to qualify as community health reinvestment. *See id.* at 10. According to Appleseed, there are several reasons why GHMSI cannot show the requisite intent. *See id.* First, Appleseed states that GHMSI has consistently maintained it has no excess surplus and therefore cannot now argue that it intentionally

---

<sup>9</sup> D.C. Department of Health, *DC Health People 2020 Framework* (April 2016), available at <http://doh.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/FINAL%20DC%20HP2020%20Framework%20Report%205-23-16.pdf>.

sought to reduce its surplus for purposes of community health reinvestment. *See id.* at 10-11. Second, Appleseed asserts that, until now, GHMSI has never indicated that it intended to reduce its surplus for the purpose of engaging in community health reinvestment. *See id.* at 11. In addition, Appleseed states that, although it found three rate filings by GHMSI effective after 2011 in which GHMSI intentionally sought to reduce its surplus, none of these filings identifies community health reinvestment as the purpose of the reduction and none is distinguishable from rate changes made for competitive reasons. *See id.*

Finally, Appleseed argues that because the Commissioner has determined GHMSI failed to submit a timely plan for community health reinvestment, he is required by MIEAA to deny rate increases by GHMSI for a full 12 months and has no discretion to lift the freeze on rates until the 12-month period has ended. *See id.* at 12-14.

#### **D. Comments from GHMSI Contractholders and Subscribers**

The Commissioner received comments from a number of GHMSI contractholders and subscribers. These comments generally urge the Commissioner to devote the excess surplus to the payment of rebates or rate reductions.

#### **E. Comments from Coalitions**

The Commissioner received comments from two coalitions of local organizations whose missions include improving the health and welfare of District residents.<sup>10</sup> The

---

<sup>10</sup> The comments of the first coalition were submitted on the letterhead of the Community Foundation for the National Capital Region, which was joined as a signatory by the following organizations: The Morris & Gwendolyn Cafritz Foundation; The Moriah Fund; Eugene and Agnes Meyer Foundation; The Washington Area Women's Foundation; and The Consumer Health Foundation. The comments of the second coalition were signed the following organizations: Bread for the City; Children's Law Center; DC Fiscal Policy Institute; Families USA; Family and Medical Counseling Service, Inc.; Family Voices of the District of Columbia, Inc.; Greater Washington Society for Clinical Social Work; Legal Aid Society of the District of Columbia; Miriam's Kitchen; National MS Society, Greater DC-Maryland Chapter; ONE DC; University Legal Services; and Washington Interfaith Network.

comments from both coalitions are very similar. Each coalition recommends dedicating the \$56.2 million in excess surplus to a fund from which grants would be made over no more than a five-year period to support community health initiatives in the District. *See* Letter from the Community Foundation for the National Capital Region to Commissioner Taylor at 2 (July 14, 2016) (“Community Foundation Letter”); Letter from Bread for the City, *et al.*, to Commissioner Taylor at 1 (July 14, 2016) (“Bread for the City Letter”). Although their recommendations differ in some details, both coalitions envision that the fund would be administered by one or more private foundations with oversight by the Commissioner. *See* Community Foundation Letter at 4-8; Bread for the City Letter at 1. Both coalitions also suggest that priorities for grant-making could be guided by the Urban Institute Report. *See* Community Foundation Letter at 2; Bread for the City Letter at 2. In addition, one coalition identifies the DOH Report as a guidepost that could be used to track the effectiveness of the fund over the course of its operations. *See* Community Foundation Letter at 2.

#### **F. Comments from Community Health and Welfare Service Providers**

The Commissioner received comments from a number of District-based organizations that provide community health and welfare services in the District.<sup>11</sup> These comments generally provide recommendations regarding specific programs that should receive funds for community health reinvestment.

Whitman-Walker Health makes the more general suggestion that the Commissioner either order GHMSI to reinvest the excess surplus using GHMSI’s

---

<sup>11</sup> The following health and welfare service providers submitted comments: Walker Whitman Health; District of Columbia Primary Care Association; Miriam’s Kitchen; Capital Area Food Bank; ONE DC; Amerihealth Caritas DC; Food & Friends; DC Campaign to Prevent Teen Pregnancy.

existing grant-making procedures or require GHMSI to contribute the excess to a fund dedicated to providing financial support to individuals and families insured by GHMSI. *See* Letter from Donald Blanchon, Chief Executive Officer, Whitman-Walker Health to Commissioner Taylor at 2 (July 14, 2016).

#### **G. Comments from Trade Associations**

The Commissioner received comments from three District trade associations representing the insurance industry and the business community at large.<sup>12</sup> Each expressed concern over the effect a distribution or reduction of excess surplus might have on GHMSI's financial position.

#### **H. Comments from Maryland Insurance Commissioner**

The Commissioner also received comments from Maryland Insurance Commissioner Al Redmer, Jr. Commissioner Redmer states that, under the 2015 amendment to GHMSI's federal Charter, any order by the Commissioner that will cause GHMSI's present or future surplus to be distributed or reduced requires the agreement of the District, Maryland and Virginia. *See* Statement of Al Redmer, Jr., Maryland Insurance Commissioner at 1-2 (July 11, 2016) ("Redmer Comment"). Commissioner Redmer further states that any such order would conflict with a consent order issued in 2012 by former Maryland Insurance Commissioner Therese M. Goldsmith as well as with Commissioner Redmer's own assessment of the appropriate target level for GHMSI's surplus and the 2015 amendment to Maryland law requiring the consent of the Maryland Insurance Commissioner before GHMSI may distribute or reduce its surplus in

---

<sup>12</sup> District of Columbia Association of Health Plans; DC Chamber of Commerce; District of Columbia Insurance Federation.

response to a law or order from another jurisdiction. *See id.* at 2-3. Commissioner Redmer also asserts that coordination among the District, Maryland and Virginia should precede any such order. *See id.* at 3-4.

### **III. DISCUSSION**

The discussion below addresses the major comments received in response to the June 14, 2016 Order, especially as they relate to the Commissioner's authority under MIEAA and the actions necessary to enforce MIEAA's purposes.

#### **A. Commissioner's Authority Under MIEAA**

The Commissioner construes MIEAA to authorize him to enforce the December 30, 2014 Order by directing GHMSI to issue rebates and by lifting the freeze on rate increases imposed by the June 14, 2016 Order at such time as GHMSI complies with the directive to issue rebates.

##### **1. Authority to Lift Rate Freeze**

Appleseed and Councilmembers Cheh and Silverman urge the Commissioner not to lift the freeze on rate increases imposed by the June 14, 2016 Order under any circumstances. They assert that MIEAA requires the freeze to remain in place for 12 months as a punitive measure.

MIEAA provides that if the Commissioner determines that a hospital or medical service corporation has failed to submit a plan for community health reinvestment within a reasonable period following an order to do so, "the Commissioner shall deny for 12 months all premium rate increases for subscriber policies written in the District sought by

the corporation . . . and may issue such orders as are necessary to enforce the purposes of this chapter.” D.C. Code § 31-3506(i) (emphasis added). The Commissioner interprets the authority under this provision to issue such orders as are necessary to enforce the purposes of MIEAA to permit him to lift the freeze on GHMSI’s rates if he reasonably determines that doing so is necessary to enforce the purposes of MIEAA.<sup>13</sup>

MIEAA was enacted “to ensure that nonprofit hospital and medical service corporations pursue their public health mission.” *D.C. Appleseed Ctr. for Law & Justice, Inc. v. D.C. Dep’t of Ins., Sec. & Banking*, 54 A.3d 1188, 1201 (D.C. 2012) (quoting D.C. Council, Report on Bill 17-934, the “Medical Insurance Empowerment and Amendment Act of 2008” at 2 (Oct. 17, 2008)). In specific, the Council’s twin objectives were “(1) obligating GHMSI to reinvest in community health ‘to the maximum feasible extent,’ (2) without undermining GHMSI’s ‘financial soundness and efficiency.’” *D.C. Appleseed*, 54 A.3d at 1214. These objectives are explicitly stated in Section 2(c) of MIEAA, which is codified at D.C. Code § 31-3505.01. In addition, if the Commissioner determines that GHMSI’s surplus is excessive, MIEAA requires dedication of the excess attributable to the District to community health reinvestment. *See* D.C. Code § 31-3506(g)(1).

For several reasons, the Commissioner believes a continued freeze on rate increases after GHMSI complies with this Decision and Order would be contrary to the purposes of MIEAA. First, so long as GHMSI complies with the Commissioner’s order to issue rebates, it will have engaged in community reinvestment to the maximum

---

<sup>13</sup> The Department’s regulations provide that if GHMSI fails to submit a plan as ordered, “the Commissioner shall deny all premium rate increases for subscriber policies written in the District until the company complies with the order or the Commissioner may issue any other order as necessary to enforce the purposes of the Act.” D.C. Mun. Regs. tit. 26-A, § 4603.3. The Commissioner also construes this provision to permit him to lift the freeze on GHMSI’s rates if he reasonably deems it necessary to enforce the purposes of MIEAA.

feasible extent, as determined by the December 30, 2014 Order—*i.e.*, GHMSI will have reinvested all of the excess 2011 surplus attributable to the District. Thus, a continued freeze on rate increases will not be necessary or consistent with the purposes of MIEAA. Second, a freeze on rates following the distribution of the excess 2011 surplus attributable to the District would likely cause a further reduction in GHMSI's surplus to the extent that GHMSI seeks rate increases during the freeze period to maintain rates that are adequate to meet claims costs and expenses. Any such reduction would reduce the surplus attributable to the District in excess of the amount determined in the December 30, 2014 Order.

Finally, the Commissioner is concerned that a continued freeze on rates could have an adverse effect on GHMSI's financial efficiency, which also would be contrary to MIEAA's purposes. The record in this proceeding documents the disruption to the health insurance marketplace resulting from, and uncertainty surrounding, the reforms mandated by the Affordable Care Act ("ACA") and District law implementing the ACA. *See, e.g.*, December 30, 2014 Order at 32-49 (citing Rector & Associates, Inc., *Report to the D.C. Department of Insurance, Securities and Banking – Group Hospitalization and Medical Services, Inc.* (Dec. 9, 2013)). This disruption includes uncertainty regarding the expense of insuring, and appropriate premium rates for, new entrants to the health insurance pool, who may be less healthy than existing participants and in need of more costly services. *See id.* The Commissioner is mindful of the fact that a lengthy freeze on rates could require GHMSI to increase rates in the future by a larger amount than would otherwise be the case. In this case, larger-than-expected rate increases could be detrimental to GHMSI's contractholders and subscribers, especially individuals and small businesses,



who may not have the resources to manage unplanned-for increases in the cost of health insurance. Accordingly, the Commissioner concludes that lifting the rate freeze after GHMSI's compliance with this Decision and Order is necessary to ensure that GHMSI engages in community health reinvestment, but only to the extent consistent with the purposes of MIEAA.

## **2. Authority to Order Implementation of a Plan**

GHMSI disputes the Commissioner's authority to develop and approve a plan for dedication of its excess 2011 surplus to community health reinvestment. According to GHMSI, MIEAA provides only two remedies following a determination that its surplus is excessive: (1) that GHMSI submit, and the Department approve, a plan for reinvestment of the excess attributable to the District or (2) that the Commissioner deny premium rate increases for 12 months if GHMSI fails to submit a satisfactory plan when required by MIEAA. *See* GHMSI Comments at 14. GHMSI therefore argues that the Commissioner has no authority under MIEAA to approve and issue a plan for the reinvestment of the excess surplus on his own initiative as stated in the June 14, 2016 Order. *See id.* at 15.

GHMSI's argument ignores the Commissioner's statutory authority to "issue such orders as are necessary to enforce the purposes of [MIEAA]." D.C. Code § 31-3506(i). This broad grant of authority allows the Commissioner to issue such orders as he reasonably determines are necessary to enforce MIEAA's purposes. *See Wisconsin-Newark Neighborhood Coal. v. D.C. Zoning Comm'n*, 33 A.3d 382, 388 (D.C. 2011) ("[W]e will accord deference to an agency's interpretation of the statute which it is responsible for administering if it is reasonable and not plainly wrong or inconsistent with its legislative purpose.") (internal quotation omitted); *Smith v. D.C. Dep't of Emp't*

*Servs.*, 548 A.2d 95, 97 (D.C. 1988) (“Where an administrative agency is delegated broad authority to administer a statutory scheme . . . we defer to a reasonable construction of the statute made by the agency.”) (citations omitted).

To accept GHMSI’s formulation of MIEAA’s remedies would render the public policies embodied in MIEAA unenforceable and simply ignores the authority conferred upon the Commissioner to issue such orders as are necessary to enforce the purposes of the law. As discussed above, the central purpose of MIEAA is to require GHMSI to engage in community health reinvestment to the maximum extent feasible consistent with financial soundness and efficiency. The development and approval of a plan for reinvestment of excess surplus, and not just a rate freeze, clearly is necessary to enforce this purpose. Without such a plan, GHMSI would be free to ignore its full obligations under MIEAA as determined by the December 30, 2014 Order. Accordingly, the Commissioner concludes that he has discretion to develop, approve and order GHMSI to implement a plan for community health reinvestment.<sup>14</sup>

## **B. GHMSI’s 2015 Charter Amendment**

On December 18, 2015, Congress passed and the President signed into law the Financial Services and General Government Appropriations Act, 2016 (the “Appropriations Act”), which was enacted as part of the Consolidated Appropriations Act, 2016, Pub. L. No. 114-113, 129 Stat. 2242. Section 747 of the Appropriations Act states:

Sec. 747. (a) The Act entitled “An Act providing for the incorporation of certain persons as Group Hospitalization and Medical Services, Inc.”, approved August 11, 1939 (53 Stat. 1412), is amended—

---

<sup>14</sup> Moreover, it is immaterial whether the Commissioner’s orders under this Decision and Order are characterized as a “plan” or otherwise. Regardless of how they are characterized, they are orders necessary to enforce the purposes of MIEAA and therefore squarely within the Commissioner’s authority.

- (1) by redesignating section 11 as section 12; and
- (2) inserting after section 10 the following:

Sec. 11. The surplus of the corporation is for the benefit and protection of all of its certificate holders and shall be available for the satisfaction of all obligations of the corporation regardless of the jurisdiction in which such surplus originated or such obligations arise. The corporation shall not divide, attribute, distribute, or reduce its surplus pursuant to any statute, regulation, or order of any jurisdiction without the express agreement of the District of Columbia, Maryland, and Virginia—

- (1) that the entire surplus of the corporation is excessive; and
- (2) to any plan for reduction or distribution of surplus.

(b) The amendments made by subsection (a) shall apply with respect to the surplus of Group Hospitalization and Medical Services, Inc. for any year after 2011.

Appropriations Act, § 747; 129 Stat. 2242, 2468 (Dec. 18, 2015) (emphasis added).

GHMSI contends that under Section 747, the Commissioner must obtain the approval of Maryland and Virginia before he may order GHMSI to distribute or reduce its excess 2011 surplus or impose a freeze on rates for policies issued in the District. *See* Letter from Chet Burrell, President and C.E.O., CareFirst, to Commissioner Taylor at 5 (July 14, 2016); GHMSI Comments at 2. According to GHMSI, because any order to dedicate the excess 2011 surplus to community health reinvestment necessarily would affect GHMSI's present or future surplus, the Commissioner may not take such action without the agreement of Maryland and Virginia. *See id.* at 3. Thus, GHMSI concludes that in amending the Charter, Congress chose not to interfere with the Commissioner's review of GHMSI's 2011 surplus but intended to require that any decision by the Commissioner requiring a reduction in GHMSI's present or future surplus would require the agreement of Maryland and Virginia. *Id.* at 4.

GHMSI's argument regarding the effect of the Charter amendment ignores the plain language of the Appropriations Act and contravenes established principles of statutory construction. The Charter amendment under Section 747(a) provides that

GHMSI “shall not divide, attribute, distribute, or reduce its surplus pursuant to any statute, regulation, or order of any jurisdiction without the express agreement of the District of Columbia, Maryland, and Virginia—(1) that the entire surplus of the corporation is excessive; and (2) to any plan for reduction or distribution of surplus.” Section 747(b) provides that this requirement “shall apply with respect to the surplus of [GHMSI] for any year after 2011.” It is very clear from this language that the required agreement among jurisdictions regarding whether surplus is excessive and as to any plan for reduction or distribution of surplus applies only to surplus for any year after 2011. In other words, by the plain language of the statute, GHMSI may divide, attribute, distribute or reduce its surplus as to any year through 2011 pursuant to a law or order of the District without the express agreement of all three jurisdictions in which it operates.

GHMSI argues that any such action will affect its present or future surplus—*i.e.*, its surplus after 2011—and therefore is prohibited by the Charter amendment. This argument makes nonsense of the savings clause found in Section 747(b). MIEAA requires the Commissioner to review GHMSI’s surplus and, if it is determined to be excessive, permits him to order dedication of the excess to community health reinvestment. By practical and logical necessity, any such order must affect GHMSI’s present or future surplus. In other words, it must affect the surplus after the reference date used to determine whether the surplus is excessive. In this proceeding, that date is December 31, 2011.

Congress was clearly aware of this fact when it enacted the Charter amendment. GHMSI itself acknowledges that Congress was “well aware of the [December 30, 2014 Order] and the changes in law enacted in Maryland and Virginia . . .” and was acting in

response to those developments when it amended the charter. *CareFirst, Inc. v. Taylor*, Case No. 1:16-cv-02656-CCB (D. Md. July 22, 2016), Complaint, ¶ 32. Moreover, under accepted principles of statutory construction, Congress is presumed to be aware of such circumstances when it enacts legislation. *See Mississippi ex rel. Hood v. AU Optronics Corp.*, 134 S. Ct. 736, 742, 187 L. Ed. 2d 654 (2014) (“[W]e presume that ‘Congress is aware of existing law when it passes legislation.’”) (quoting *Hall v. United States*, 132 S.Ct. 1882, 1889 (2012)); *United States v. Wilson*, 290 F.3d 347, 354 (D.C. Cir. 2002) (interpreting statutory amendment by presuming that Congress considered the broader context of the amendment, including “the contextual background against which Congress was legislating, including relevant practices . . . which presumably informed Congress’s decision, prior legislative acts, and historical events”).

Therefore, in enacting the savings provision under Section 747(b), Congress could only have intended to preserve the Commissioner’s authority to order a distribution or reduction with respect to GHMSI’s excess 2011 surplus pursuant to the December 30, 2014 Order. To construe the savings clause otherwise would render it entirely superfluous and meaningless, as there would be no surplus to which it could apply. A basic principle of statutory interpretation is that statutes should be construed “so as to avoid rendering superfluous” any statutory language. *Astoria Fed. Savings & Loan Ass’n v. Solimino*, 501 U.S. 104, 112 (1991). GHMSI’s suggested interpretation would render the savings clause a nullity and stands in direct conflict with basic principles of statutory construction.

GHMSI further argues that, in enacting the Charter amendment, Congress intended not to interfere with the Commissioner’s review of GHMSI’s 2011 surplus, but

to prohibit any decision by the Commissioner to order a distribution or reduction of excess 2011 surplus. This argument again renders the savings clause entirely superfluous. Creating an exception to the Charter amendment solely for the review of GHMSI's 2011 Surplus would be meaningless given that the review was completed under the December 30, 2014 Order nearly a year prior to when Congress amended GHMSI's charter on December 18, 2015.<sup>15</sup> As stated above, Congress was clearly aware of these facts and is presumed by law to have been aware of them. Thus, Congress cannot reasonably be said to have intended to create an exception for a review that had already occurred. The only reasonable interpretation of the savings clause is that it was intended to allow enforcement of MIEAA with respect to GHMSI's excess 2011 surplus.<sup>16</sup>

A statement released by Congresswoman Eleanor Holmes Norton just after the Charter amendment was passed indicates that the saving clause was intended to permit the Commissioner to enforce MIEAA with respect to GHMSI's excess 2011 surplus. According to Congresswoman Norton, she "did succeed in allowing any of the jurisdictions to order such a disposition without the consent of the other jurisdictions for any surplus before 2012, thereby allowing D.C. to enforce, if it so chooses, the D.C. Insurance Commissioner's order that GHMSI reinvest \$56 million from its 2011 surplus." Press Release, Congresswoman Eleanor Holmes Norton, *Norton Gets Record Funding for DCTAG and Other D.C. Priorities, Prevents New Social Riders, Despite*

---

<sup>15</sup> Indeed, the two petitions for reconsideration of the review were received by the Department in early 2015 and denied many months before Congress acted. *See supra* note 5.

<sup>16</sup> If Congress had intended the Charter amendment to prohibit enforcement of the December 30, 2014 Order, there was no need for the Congress to enact Section 747(b) as the language in section 747(a) would prohibit the District from enforcing the December 30, 2014 Order without consent from Maryland and Virginia.

*First Republican Controlled Congress in Eight Years* (Dec. 16, 2015). Accordingly, the only reasonable interpretation of the savings clause is to permit enforcement of the December 30, 2014 Order.

### **C. Coordination with Maryland and Virginia**

MIEAA requires any review of GHMSI's surplus by the Commissioner to determine whether it is excessive to be "undertaken in coordination with the other jurisdictions in which the corporation conducts business." D.C. Code § 31-3506(e). At various points in this proceeding, GHMSI has argued that the Department did not coordinate sufficiently with Maryland and Virginia. *See, e.g.*, Plan at 6-7. The Maryland Insurance Commissioner also asserts that the Department has not sufficiently coordinated with his state, citing the conflict between Maryland law and the December 30, 2014 and June 14, 2016 Orders. *See* Redmer Comment at 3.

As a threshold matter, the Commissioner notes that MIEAA requires coordination with Maryland and Virginia only as to any review to determine whether GHMSI's surplus is excessive. *See* D.C. Code § 31-3506(e). Once such a determination is made, MIEAA does not contemplate coordination with other jurisdictions with respect to ordering a plan to dedicate excess surplus attributable to the District to community health reinvestment, the imposition of a rate freeze if timely plan is not provided, or the issuance of other orders necessary to enforce the purposes of the statute. *See id.* §§ 31-3506(h), (i). Thus, to the extent that GHMSI or the Maryland Insurance Commissioner contends that the Commissioner is required by MIEAA to coordinate with other jurisdictions with respect to these aspects of the statute, their assertions are incorrect.

As to the determination under the December 30, 2014 Order that GHMSI's 2011 surplus was excessive, the fact remains that the Department fully coordinated with Maryland and Virginia in reaching that determination. As explained in the December 30, 2014 and June 14, 2016 Orders, during the review of GHMSI's 2011 surplus, the Department actively coordinated with Maryland and Virginia by communicating with the state insurance commissioners and their staff, advising them of the review, soliciting their participation, carefully considering their comments, and responding to their inquiries. *See* June 14, 2016 Order at 16. Indeed, Virginia regulators reported not that the Department failed to coordinate with them, but rather that they did not take full advantage of the opportunities presented by the Department to coordinate and intend to participate more fully in future surplus reviews. *See* Commonwealth of Virginia State Corporation Commission Bureau of Insurance, Bureau Report Regarding the Impact of the Distribution of GHMSI's Excess Surplus on Virginia Residents at 7 (Apr. 15, 2015).

As the Department also has explained previously, *see* June 14, 2016 Order at 16, at its root, GHMSI's assertion that the Department failed to coordinate with Maryland and Virginia rests on the erroneous assumption that MIEAA's requirement for coordination requires agreement among the affected jurisdictions. This conclusion is directly contrary to the plain language of MIEAA. Nothing in MIEAA suggests that the Commissioner must come to agreement with regulators in Maryland and Virginia in determining whether GHMSI's surplus is excessive or, as explained above, issuing orders to enforce the purposes of MIEAA once such a determination is made. To the contrary, MIEAA vests sole authority in the Commissioner in this respect. *See* D.C. Code §§ 31-3506(e)-(i).



#### **D. Reductions in Surplus After 2011**

In its comments to the Commissioner, GHMSI repeats many of the arguments it has made in the past concerning expenditures, costs, underwriting losses and changes in surplus it asserts should be credited as community health reinvestment with respect to the excess 2011 surplus. *See* GHMSI Comments at 5-14. The Department reviewed and addressed these arguments, *see* June 14, 2016 Order at 6-15, and will not revisit them here, except to reiterate the following: As stated in the June 14, 2016 Order, it is important to recognize that the analysis the Acting Commissioner conducted of GHMSI's 2011 surplus to determine whether it was excessive was based on reasonable projections of GHMSI's post-2011 performance, including the possibility of underwriting losses and fluctuations in surplus. *See, e.g.*, December 30, 2014 Order at 30, 39 (discussing modeling generally and the rating adequacy and fluctuation risk factor in particular). In other words, the fact that GHMSI has experienced some underwriting losses and has undergone modest fluctuations in surplus does not change the determination that the 2011 surplus was excessive. In this regard, the Commissioner notes that GHMSI's surplus as of June 30, 2016 was \$982 million, which is above its level of \$964 million on December 31, 2011.

GHMSI also argues that expenditures such as its annual community giving should be credited as community health reinvestment of the excess 2011 surplus. *See* GHMSI Comments at 9-10. As the Commissioner explained in the June 14, 2016 Order, the determination that the 2011 surplus was excessive took into account anticipated, programmatic expenditures by GHMSI for community giving as well as open enrollment subsidies and contributions to the District's Healthcare Alliance. *See* June 14, 2016

Order at 9. In other words, the excess 2011 surplus identified by the December 30, 2014 Order is in excess of amounts needed by GHMSI to satisfy these obligations.

In addition, GHMSI argues that, beginning in 2011, it took steps to reduce its rates in order to reduce surplus, which should be credited as expenditures of the excess 2011 surplus for community health reinvestment. *See* GHMSI Comments at 10-13. As explained in the June 14, 2016 Order, the Commissioner believes rate filings that reduced or moderated premium rates can reasonably be characterized as dedication of excess surplus to community health reinvestment if they demonstrably were intended by GHMSI as a deliberate effort to reduce surplus to benefit subscribers. *See* June 14, 2016 Order at 10. Such rate filings are distinguishable from reductions merely aimed at bringing rates in line with experience or made purely for competitive reasons and are not intended to reduce surplus. *See id.* at 9-10.

On this basis, the Commissioner concludes that six rate filings made by GHMSI that affected premium rates after December 31, 2011, set forth in Table 1 below, should be credited as community health reinvestment of excess 2011 surplus. Each of these filings identifies an express negative Contribution to Reserves (“CTR”)<sup>17</sup> resulting from the filed rates. These filings are distinguishable from other rate filings for which GHMSI claims credit for community health reinvestment in that they can reasonably be characterized as intended to reduce surplus for the benefit of subscribers.

GHMSI claims that certain other rate filings also should be credited as community health reinvestment because they identify two rates—a “proposed rate” for which approval was requested and higher “required rate” for which GHMSI claims it could have

---

<sup>17</sup> CTR is the portion of premium that is intended to impact the surplus of GHMSI. A negative CTR equates to a reduction in surplus.

sought approval but did not. GHMSI Comments at 11 n.5. None of these filings expressly identifies a negative CTR. On the contrary, all of them expressly identify either zero or a positive CTR. GHMSI's argument appears to be that by not charging the unfilled, hypothetical higher rates, it was foregoing what would have been a greater CTR and therefore should be credited with the difference between the estimated higher contribution that would have resulted from the "higher rate" and the estimated contribution that was identified for the filed rate for which Department approval was actually sought and obtained. The Commissioner cannot agree with this argument. No documentation was provided by GHMSI at the time of the filings to show that the higher rates were appropriate, and there is nothing to suggest that the Department would have approved the higher rates if they had been presented for review. Thus, there is no credible basis for GHMSI's assertion that these filings were intended to expend excess surplus for community health reinvestment.

Table 1 below identifies the six filings which the Commissioner will credit as expenditures of excess surplus for community health reinvestment and explains the Commissioner's calculation of their effect on surplus.

The Commissioner concludes that the rate filings identified in Table 1 resulted in an aggregate reduction in surplus of \$4,887,618. Applying the aggregate reduction in surplus attributable to these filings to the total excess 2011 surplus attributable to the District of \$56,213,088.72 yields a revised excess 2011 surplus attributable to the District of \$51,325,470.72.

**Table 1: GHMSI Rate Filings Credited as Community Health Reinvestment of Excess 2011 Surplus**

<b>SERFF Tracking #</b>	<b>Effective Period</b>	<b>CTR<sup>18</sup></b>	<b>Annualized \$ Impact<sup>19</sup></b>	<b>Effective \$ Impact<sup>20</sup></b>	<b>Effective \$ Impact after 12/31/2011<sup>21</sup></b>
CFAP-127118704	Aug. 1 - Oct. 31, 2011	-7.10%	(14,462,645)	(3,676,493)	<b>(2,450,995)</b>
CFAP-127350283	Nov. 1 - Dec. 31, 2011	-6.10%	(12,296,447)	(2,112,187)	<b>(1,848,164)</b>
CFAP-127159629	Oct. 1 - Dec. 31, 2011	-8.00%	(1,780,699)	(443,331)	<b>(369,443)</b>
CFAP-127159563	Oct. 1 - Dec. 31, 2011	-8.00%			
CFAP-127360767	Jan. 1 - Mar. 31, 2012	-4.00%	(945,266)	(219,016)	<b>(219,016)</b>
CFAP-127360790	Jan. 1 - Mar. 31, 2012	-4.00%			
<b>Total</b>					<b>(4,887,618)</b>

### **E. Dedication of Excess 2011 Surplus to Community Health Reinvestment**

The public comments submitted in response to the June 14, 2016 Order provide a range of suggestions for the reinvestment of the 2011 excess surplus, including establishing a fund for community reinvestment administered by one or more private foundations, requiring GHMSI to pay rebates to its subscribers or engage in rate reductions, ordering GHMSI to reinvest the excess using its existing procedures for making community grants, or ordering GHMSI to contribute the excess to a fund that would provide financial support for individuals and families insured by GHMSI.

<sup>18</sup> “CTR” is Contribution to Reserves and is the portion of premium that is intended to impact the surplus of GHMSI.

<sup>19</sup> “Annualized \$ Impact” represents the total dollar impact on surplus of the CTR factor as stated by GHMSI in the Actuarial Memorandum provided with the rate filing.

<sup>20</sup> “Effective \$ Impact” represents the Department’s estimated dollar impact on surplus. This amount is calculated by applying the CTR factor to the premium for the experience period as stated in the Actuarial Memorandum for the filing, as adjusted based on the effective period of the filing (*e.g.*, if the effective period spans one calendar quarter, or three months, then the CTR factor is applied to one quarter of the premium for the experience period).

<sup>21</sup> “Effective \$ Impact after 12/31/2011” represents the estimated amount of the dollar impact that was realized after December 31, 2011, the closing date of the surplus review. For example, for a rate filing effective between 8/1/2011 and 10/31/2011, there are three possible renewal dates for the affected policies (8/1/2012, 9/1/2012, and 10/1/2012). Of the aggregate 36 months during which the rates for these policies could possibly be in effect (8/1/2011 - 7/31/2012, 9/1/2011 - 8/31/2012, 10/1/2011 - 9/30/2012), the rates are effective for 7, 8, or 9 months in 2012, respectively. Therefore, the effective dollar impact of the CTR factor applies to  $(7 + 8 + 9) = 24$  out of 36 aggregate months for the effective rates in the filing, and the “Effective \$ Impact after 12/31/2011” would be  $(24/36) \times$  the “Effective \$ Impact.”

As discussed above, the expressly stated purpose of MIEAA, as affirmed by the Court of Appeals, is to obligate GHMSI to reinvest in community health to the maximum feasible extent but without undermining GHMSI's financial soundness and efficiency. *See D.C. Appleseed*, 54 A.3d at 1214; D.C. Code § 31-3505.01 ("A corporation shall engage in community health reinvestment to the maximum feasible extent consistent with financial soundness and efficiency."). MIEAA defines "community health reinvestment" as "expenditures that promote and safeguard the public health or that benefit current or future subscribers, including premium rate reductions." D.C. Code § 31-3501(1A). MIEAA further states that a plan for community health reinvestment must be "fair and equitable," *id.* § 31-3506(g)(1), and "may consist entirely of expenditures for the benefit of current subscribers of the corporation." *Id.* § 31-3506(g)(2).

The Commissioner has carefully considered the comments received and the record in this proceeding<sup>22</sup> and concludes that the purposes of MIEAA are best served by requiring GHMSI to issue rebates for current subscribers. Appleseed argues that the payment of rebates to current subscribers of GHMSI would likely not be fair and equitable because the rebates would benefit many current subscribers, who may not have contributed premium dollars to the surplus build-up that resulted in the 2011 excess. *See Appleseed Comments* at 9. This argument ignores MIEAA's definition of community health reinvestment, which includes "expenditures that . . . benefit current or future subscribers . . . ." D.C. Code § 31-3501(1A) (emphasis added). Moreover, Appleseed

---

<sup>22</sup> The Commissioner is very appreciative of the innovative concepts advanced by the foundation coalitions, the Members of the Council, and Appleseed that could promote and safeguard public health in the District. However, the Commissioner could not find the authority in the MIEAA to establish a trust as contemplated by the foundations, or the regulations and procedures required to administer such a trust. Additionally, MIEAA does not provide authority for the Commissioner to oversee and regulate a private trust. In the absence that necessary authority, the Commissioner cannot implement such a plan.

ignores the fact that the type of expenditures it advocates would benefit persons who may not have contributed any amount to the excess 2011 surplus. That such expenditures are authorized by MIEAA further confirms there is no requirement that a plan benefit only persons who contributed to the excess 2011 Surplus.

The dedication of the excess surplus to rebates will have three beneficial effects, all of which directly advance the purposes of MIEAA to promote and safeguard the public health and benefit subscribers. First, it will ensure that the funds are distributed now, to the immediate benefit of GHMSI's subscribers and in an administratively efficient manner. Second, it will promote and safeguard public health by reducing the cost of health insurance for subscribers, including not only the costs associated with the payment of insurance premiums and contributions, but also deductibles, co-pays, coinsurance and other out-of-pocket costs. Finally, the payment of rebates for the benefit of all subscribers provides for a dedication of the excess surplus in the most fair and equitable manner.

Consistent with the method by which a portion of GHMSI's excess 2011 surplus was attributed to the District under the December 30, 2014 Order, *see* December 30, 2014 Order at 50-58, the Commissioner focuses primarily on the location or "situs" of GHMSI's subscriber contracts to determine the eligibility of subscribers for rebates. Only subscribers insured under subscriber contracts with a situs in the District—*i.e.*, subscriber contracts issued in the District—will be eligible to receive a rebate. In addition, consistent with the surplus attribution methodology used in the December 30,

2014 Order, only Federal Employee Program (“FEP”) subscribers who reside in the District will be eligible for rebates.<sup>23</sup>

Because MIEAA defines community health reinvestment to include expenditures that “benefit current or future subscribers,” *see* D.C. Code § 31-3501(1A), without reference to contractholders, the Commissioner intends that rebates will be paid only to subscribers, and not to contractholders who are not also subscribers. A subscriber is “any person entitled to benefits under the terms and conditions of a subscriber contract.” D.C. Code § 31-3501(8). A contractholder is any “person entering into a subscriber contract with a [hospital or medical services] corporation.” *Id.* § 31-3501(1B). In the case of an individual contract, the contractholder also is a subscriber. In the case of a group contract, the contractholder, which may be an employer or other entity, may not be a subscriber. Thus, for example, in the case of employer group contracts, the employer contractholder will not be eligible for a rebate unless the employer is a natural person and a subscriber under the contract.

Finally, for practical reasons, the Commissioner intends that rebates will be paid to the primary insured subscriber under any group or individual contract, and not to spouses, domestic partners or dependents who also may be covered under the contract.

#### **IV. ORDER**

Based on the foregoing, the Commissioner hereby ORDERS:

1. The denial of requests for premium rate increases for subscriber contracts issued by GHMSI in the District, as established by the June 14, 2016 Order, shall remain

---

<sup>23</sup> Under the method used to attribute excess surplus to the District, the Department followed the allocation of premiums by jurisdiction reported on Schedule T of the 2011 Annual Statements for GHMSI and CareFirst BlueChoice. *See* December 30, 2014 Order at 54. On the 2011 Annual Statements, only premiums for FEP subscribers who resided in the District were reported as allocated to the District.

in effect until GHMSI certifies in writing to the Commissioner that all rebates required by this Decision and Order have been issued.

2. No later than 120 days following the date of this Decision and Order, GHMSI shall pay rebates in the total amount of its revised excess 2011 surplus attributable to the District. The rebates shall be paid only to Eligible Subscribers, which are individuals who are GHMSI subscribers as of the date of this Decision and Order, who are the primary insured under the subscriber contract, and who meet one or more of the following criteria:

- a. Subscribers with an individual in-force major medical contract issued in the District;
- b. Subscribers with a policy or certificate from an in-force group major medical contract, excluding FEP business, issued in the District;
- c. Subscribers with a certificate from the FEP who reside in the District;
- d. Subscribers with a policy or certificate from an in-force group dental or vision contract issued in the District;
- e. Subscribers with an in-force Medicare Supplement contract issued in the District;
- f. Subscribers with any other type of in-force contract not listed above issued in the District.

3. The amount of each Eligible Subscriber's rebate shall be calculated in proportion to the Eligible Subscriber's current annual premium for health insurance as follows: A rebate percentage shall be calculated as the ratio of the total rebate amount

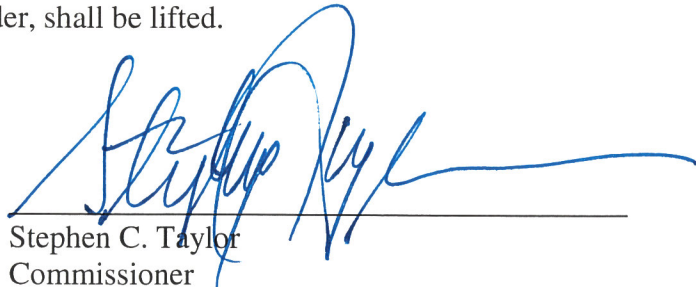


(\$51,325,470.72) to the sum of the annual premium (12 times the current monthly premium) as of the date of this Decision and Order for all Eligible Subscribers identified above. Each Eligible Subscriber's rebate will be the rebate percentage times the Eligible Subscriber's annual premium and then rounded to the nearest dollar. If an individual is an Eligible Subscriber under more than one contract—for example, a major medical contract and a dental or vision contract—all such contracts shall be taken into account in calculating the rebate.

4. The cost of calculating, preparing and distributing the rebates shall be borne by GHMSI.

5. As of the date that GHMSI certifies in writing to the Commissioner that all rebates required by this Decision and Order have been issued, the denial of requests for premium rate increases for subscriber contracts issued by GHMSI in the District, as established by the June 14, 2016 Order, shall be lifted.

Dated: August 30, 2016



Stephen C. Taylor  
Commissioner  
Department of Insurance, Securities and Banking

[Seal]