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1111 Fourteenth Street, NW
Suite 510
Washington, DC 20005

Phone 202.289.8007
Fax 202.289.8009
www.dcappleseed.org

March 27, 2015

The Honorable Jacqueline K. Cunningham, Commissioner
Bureau of Insurance
Commonwealth of Virginia
P.O. Box 1157
Richmond, Virginia 23218-1157

Re: Commonwealth of Virginia, ex rel. State Corporation Commission, Ex Parte: In the matter of an examination of Group Hospitalization and Medical Services Inc., CASE No. INS-2015-00007

Dear Commissioner Cunningham:

We are writing to you about the December 30, 2014, decision of District of Columbia Acting Commissioner Chester A. McPherson concerning the surplus of Group Hospitalization and Medical Services, Inc. (GHMSI) as of year-end 2011. We understand that the Virginia State Corporation Commission directed you, pursuant to section 38.2-4229.2 of the Code of Virginia, to prepare a report determining whether Commissioner McPherson's decision (the "Surplus Decision") that GHMSI had accumulated $268 million in surplus greater than required for financial soundness as of year-end 2011 harms the residents of Virginia. We welcome Virginia's interest in this proceeding.

As we explain below, Commissioner McPherson's Surplus Decision does not harm Virginia residents and in fact offers significant potential benefit to Virginia residents. Commissioner McPherson's analysis of GHMSI's surplus was required by the Medical Insurance Empowerment Amendment Act of 2008 ("MIEAA"). Having found upon the basis of an extensive record that the surplus was excessive by $268 million, Commissioner McPherson ordered GHMSI to spend down the $56 million portion of the excess attributable to the District. Even after the required spend-down, GHMSI's surplus will exceed levels required for financial soundness.

The Virginia share of GHMSI's surplus is not affected by the D.C. surplus review. The Commissioner's Surplus Decision does not impose any obligation on GHMSI with respect to the spend-down of Virginia's or Maryland's shares of the excess. The submission concerning spend-down that GHMSI filed on March 16 in response to that decision does not address the $70 million portion of the excess surplus that is attributable to Virginia.

In response to the Surplus Decision, the Virginia State Corporation Commission asked you to address the impact of the decision on GHMSI's surplus, premium rates for residents of the Commonwealth covered by policies issued or delivered either in the

Commonwealth or in any other state, and GHMSI's solvency.

As we show below, the spend-down of the D.C. portion will leave GHMSI with a financially sound and efficient surplus; will not result in increased rates for Virginia subscribers; and will not remotely threaten GHMSI's solvency.

Impact on Surplus. GHMSI is a corporation vested with a dual role: to provide health insurance, and to fulfill its mission, stated in its federal charter, to be a "charitable and benevolent" organization. Recognizing GHMSI's dual roles, MIEAA establishes integrated standards for GHMSI's surplus.[1] First, it authorizes surplus necessary for continued "financial soundness" and "efficiency." And, second, with financial soundness maintained, it directs GHMSI to spend the "maximum feasible amount" on community health reinvestment.

MIEAA's integrated standards are expressly designed to allow surplus at levels that are consistent with financial soundness and efficiency. MIEAA reflects a legislative determination that, once surplus is sufficient to ensure financial soundness, additional surplus brings only very slight and declining additional benefits to subscribers that are outweighed by the benefits of directing those excess surplus dollars to community health.[2] The Surplus Decision is the first application of these integrated standards to GHMSI.

Commissioner McPherson reached his decision after a searching analysis of the risks GHMSI confronts and must protect itself against, including the changes resulting from the implementation of the ACA. We provide an overview of the substance of and procedure involved in the Commissioner's analysis.

The starting point for the analysis was GHMSI's surplus at year-end 2011 was $963 million, which is equal to 998% of its 2011 risk-based capital (RBC), which was then $97 million. Commissioner McPherson considered probability distributions for each risk factor that GHMSI urged the Commissioner to consider and that a health insurer might face. The risk factors are:

- Premium Growth Rate
- Equity Portfolio Asset Values
- Rating Adequacy and Fluctuation
- Unpaid Claims Liabilities and other Estimates
- Change in Interest/Discount rate
- Bond Portfolio Impairment

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[1] Importantly, MIEAA addresses GHMSI's surplus and not its reserves. Under D.C. law, surplus is separate from and over and above GHMSI's reserves to pay claims. GHMSI's reserves at year-end 2014 were at $644,674,682. GHMSI, Health Annual Statement for the Year Ended December 31, 2014, at 3, line 4 [hereinafter GHMSI 2014 Health Annual Statement]. These reserves themselves include an allowance for "adverse deviation"—that is, an additional amount to cover under-estimation of medical claims. D.C. Dep't of Ins., Secs. & Banking, Group Hospitalization and Medical Services, Inc., Surplus Review Hearing 134:17–25 (June 25, 2014) [hereinafter Tr.]. MIEAA does not in any way constrain GHMSI in the maintenance or expansion of its reserves.

[2] In recognizing the declining marginal utility of surplus dollars, and the fact that there are more productive uses of surplus dollars once financial soundness is attained, MIEAA reflects the decision of the Pennsylvania Commissioner of Insurance. *See In re: Applications of Capital BlueCross, et al.,* Determination, Misc. Dkt. No. MS05-02-006 at 15 (Ins. Dep't of Commonwealth of Pa. Feb. 9, 2005).

- Overhead Expense Recovery and Other Business Risks
- Catastrophic Events, and
- Unidentified Growth and Development

The Commissioner sought to obtain from all parties probability distributions that were as realistic as possible—not skewed toward underestimation of risks or undue weighting of risks that are extremely remote. The actuarial testimony and the Surplus Decision were based on complex stochastic modeling, using the model developed by GHMSI's own consulting actuaries (Milliman). The probability distributions were used in the model to determine impacts on surplus at every level of probability. These results were fed into a "pro forma" financial model to determine GHMSI's surplus requirements at a reasonable level of probability for all possible outcomes. The probability distributions identify not only a most probable outcome (the 50th percentile) but, critically, the variance in probable outcomes, indicating the uncertainty concerning each risk. Surplus needs are determined by the extent of uncertainty about costs and revenues over a three-year planning horizon. Predictable costs, no matter how large, are covered in rates; only the *uncertainty* around those predictions (expressed statistically as their variability) requires surplus.

The centerpiece of GHMSI's arguments to Commissioner McPherson was that implementation of the ACA presented considerable uncertainties for which GHMSI required a large surplus. To account for perceived ACA uncertainties, Rector, the Commissioner's consulting actuary, substantially adjusted its probability distributions for two major drivers of surplus needs, the Premium Growth factor and the Rating Adequacy and Fluctuation ("RAAF") factor to justify substantial departures from GHMSI's historical experience.[3] Rector's RAAF probability distribution assumed that, due to the ACA, the standard deviation of trends for those currently insured in the individual and small group markets would increase by 20% and that the variability of claims experience for those newly insured under the ACA in individual market would double. Surplus Decision at 40. Commissioner McPherson accepted these changes to take account of perceived ACA uncertainties. He modified only Rector's Premium Growth factor, but he did so in a way that still explicitly and substantially increased estimated premium growth relative to historical experience. *Id.* at 32–40; *see also id.* at 35 (Commissioner's Premium Growth distribution "based on historic growth and ACA growth combined"). Further, neither Rector nor the Commissioner took into account *at all* the risk-mitigating effects of the so-called "3-Rs" under the ACA.[4] These provisions reduce further any need for increased surplus due to the ACA.

As we now know with the benefit of hindsight, Commissioner McPherson's probability distribution for Premium Growth (which represented "projections" for the three-year period 2012–2014, *see id.* at 34, actually overstated GHMSI's Premium Growth (and, therefore, its surplus

[3] Commissioner McPherson in turn observed that "the most important factor" in the increase in Rector's analysis of GHMSI's surplus needs between the last review, in 2009, and the current one, "is the uncertainty concerning the impact implementation of the ACA will have on GHMSI's ability to forecast accurate premium rates. . . ." Surplus Decision at 49 n.6.

[4] The permanent Risk Adjustment Program provides payments to health insurers that disproportionately attract higher-risk populations. It transfers funds from plans with lower risk enrollees to plans with higher risk enrollees, to protect against adverse selection. Reinsurance is a temporary program through 2016 that compensates insurers when they pay unusually high claims costs for enrollees either inside or outside the exchanges. Risk Corridors are a temporary program through 2016 that limits the extent of issuer gains or losses inside the exchanges.

requirements) for the three-year period 2012–2014. Commissioner McPherson's probability distribution for average annual non-FEP Premium Growth for the three years beginning with 2012 had a mid-point (*i.e.*, the 50th percentile) of 8%. S*ee id.* at 36. This projected growth rate was *greater than* what turned out to be the average annual growth for the period in non-FEP premiums for GHMSI plus 50% of Blue Choice, which was only 4.4%. Only in 2014, the first year in which the ACA exchanges were activated, did GHMSI's growth rate exceed the Commissioner's mid-point of 8%, and then by less than a percentage point (the rate was 8.8%).

A key factor in considering the effect of the ACA on GHMSI's surplus is that 2014 was the peak of ACA uncertainties. In setting rates for 2015, GHMSI had the benefit of several months of claims experience in the operation of the exchanges under the ACA as well as the assurances against loss provided by the ACA's "3-Rs" provisions. In setting rates for 2016, it will have the further benefit of at least 15 months of claims experience under the ACA (and the protections of the 3-Rs), and for 2017, the final year in the current three-year planning cycle, it will have the benefit of 27 months of claims experience (and the protection of the Risk Adjustment Program). As premium revenues and the medical costs of subscribers under the ACA become a "normal part of the pricing landscape,"[5] uncertainty associated with the ACA will continue to diminish.

That 2014 is the peak year for ACA uncertainties is not a surprise. The Maryland Commissioner retained RSM McGladrey, Inc., to aid her in Maryland's most recent review of GHMSI's surplus. McGladrey's May 2012 report noted, "It is not unreasonable to conclude that a significantly lower targeted surplus range could result from the elimination of various uncertainties with regards to CareFirst's future profitability and operations under the ACA."[6] In GHMSI's June 2014 testimony before the D.C. Commissioner, GHMSI stated that it expected declines of 80 to 100 percentage points in its 2014 RBC ratio,[7] due to the implementation of the ACA. Despite its dramatic characterizations of the risks created by the ACA, and GHMSI's statement that it was intentionally trying to reduce its surplus, GHSMI's surplus remained remarkably stable in 2014, declining just $343,000. GHMSI ended 2014 with $934 million in surplus, equal to 878% of its current $106 million RBC.[8]

A spend-down by GHMSI of the portion of the $56 million of excess surplus that Commissioner McPherson attributed to the District will leave GHMSI with surplus for 2011, at

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[5] In its December 2013 report to Commissioner McPherson, Rector found that the ACA's requirements for unlimited benefits, coverage for dependents to age 26 and the removal of the pre-existing conditions exclusions for children had "become normal part of the pricing landscape and therefore should no longer have an effect on trend miss." Surplus Decision at 39. This expectation applies to other elements enrollment under the ACA as well: individuals who enroll through the exchanges in 2015 and future years are, on average, likely to be relatively healthy compared with those who enrolled earlier, reducing the likelihood of trend miss that would draw down surplus.

[6] RSM McGladrey, *State of Maryland Maryland Insurance Administration Examination and Auditing Surplus Evaluation Consulting Services Report: CareFirst of Maryland, Inc. Group Hospitalization and Medical Services, Inc.* 3 (May 29, 2012). The Maryland Commissioner in her 2012 decision referred to the analyses by CareFirst and their consultants as positing "additional, potentially substantial risks associated with implementation of the ACA, in *the short term at least . . . .*" *In Re: Targeted Surplus Ranges for: CareFirst of Maryland, Inc., et al.*, Consent Order, Case No. MIA-2012-09-006 at 6 (Md. Ins. Admin. Sept. 12, 2012) (emphasis added).

[7] Tr. at 129:9–:13.

[8] Numbers in this paragraph are reported in or calculated from GHMSI 2014 Health Annual Statement at 29, lines 14–15, columns 1–2.

$907 million, well above what it requires for financial soundness. In its 2014 filing, GHMSI recalculated its RBC level at $106 million; its surplus stands at $934 million, which is 878% of its current RBC. Commissioner McPherson determined that GHMSI's surplus ratio at year-end 2011 should be 721% under D.C. law. There is no reason to believe that GHMSI's surplus needs have increased since year-end 2011. In fact, there are strong reasons to believe that GHMSI's surplus need has *decreased* since year-end 2011 so that GHMSI no longer requires 721% of RBC to maintain a very high probability of paying subscribers' medical claims in the very unlikely event that its reserves were exhausted. There are no new emergent risks—no sources of major uncertainty—to support a belief that GHMSI's need for surplus has increased since 2011 and that it's surplus/RBC ratio should be higher than 721%. No conclusion that GHMSI's surplus should be higher than 721% would be possible without another full-scale surplus review.

Even without updating the 2011 ratio to reflect the intervening reduction in uncertainty, if we reduce 2014 surplus of $934 million by the $56 million Commissioner McPherson ordered to spend, GHMSI's ratio to its current RBC, after the spend-down, would be 825%, which is 104 percentage points (or more than 14%) above 721%. As already noted, there are strong reasons to believe the required RBC ratio itself would be lower if updated today, so that its increased RBC would not reduce the ratio to below the required level.

In summary, following the spend-down, GHMSI's surplus will in the future be lower than it would be if GHMSI were left to accumulate surplus without an upper limit. Commissioner McPherson's decision dealt with an *excess* surplus that took years to accumulate; with ground rules established and affirmed on judicial review, GHMSI will be able to manage its surplus to avoid such large accumulations of excess in the future. The Surplus Decision is thus a transition to a clarified regulatory regime established by MIEAA.

Impact on Solvency. The spend-down order would not remotely create a risk of insolvency for GHMSI, nor would it threaten GHMSI's ability to pay claims as they come due. Commissioner McPherson's assessment of efficient surplus consistent with financial soundness fully considered the likelihood that GHMSI's substantial claims reserves might be inadequate, and conservatively assessed the potential that the company would need to use surplus to pay claims that would exceed its reserves. A surplus at 721% RBC achieves that objective.

Impact on Rates. Surplus levels that exceed what is required for financial soundness are the result of charging excessive rates to subscribers. GHMSI itself has made this point. *See* Tr., 103–104; *see also* September 10, 2011 GHMSI Surplus Review Hearing Transcript 51:3–7 (Testimony of Chester Burrell, characterizing as "overcharges" rates that cause excess surplus.) The Surplus Decision, by determining the surplus appropriate for financial soundness but no more, avoids such overcharges in the future. It would not necessitate an increase in rates for Virginia subscribers.

It is not possible to conclude based on information currently available that a spend-down to the level of surplus deemed adequate by Commissioner McPherson, much less by the $56 million attributable to the District, would justify GHMSI increasing its rates in 2016 or thereafter, above what they would have been absent the spend-down. To justify an allowance for additional surplus in those rates, GHMSI would have to show that proper projections demonstrate that its surplus would likely be at a level below financial soundness, and any such projections would need to be evaluated in a full-scale review proceeding, whether under MIEAA or in the rate proceeding itself. As we have already shown, there are strong reasons to believe that proper projections will not demonstrate need for any additional surplus; accordingly, there could be no basis for concluding that GHMSI will seek

such increases, or that you would find them justified.[9]

The Process for Determining Excess Surplus. We believe that it is important that your report take account, not only of the conclusions reached by Commissioner McPherson, but the detailed examination and analysis that led to those conclusions. In determining GHMSI's requirements for financial soundness as of year-end 2011, Commissioner McPherson retained two consulting firms (Rector and NovaRest) to advise him. He allowed extensive discovery, held a full-day hearing, and reviewed both opening and rebuttal submissions of evidence and argument by both GHMSI and DC Appleseed. The result is an extensive record of factual information and legal arguments.

We believe that this extensive record and analysis are unique and invaluable resources for you. This record is the single best source for determining the surplus that GHMSI requires for financial soundness. It is the most recent surplus determination,[10] the only one conducted through an adversary proceeding, and the only one that included extensive discovery. A contrary determination would not be defensible without a new record of comparable scope and depth.

Commissioner McPherson's decision relates to GHMSI's year-end 2011 surplus. Under MIEAA, mandatory review of GHMSI's surplus is required every three years, and authorized yearly. Because MIEAA directs that the D.C. Commissioner coordinate with insurance commissioners in Virginia and Maryland, Virginia (and Maryland) will have further opportunities in the future to consult with the D.C. Commissioner about appropriate levels of surplus for GHMSI in future surplus reviews.

* * *

Put simply, the spend-down will leave GHMSI's surplus well above any level required for financial soundness, will not cause rates to Virginia subscribers to be higher than they otherwise would be, and will not threaten GHMSI's solvency. Because surplus will remain above levels required for financial soundness, and will not cause rates to increase, there will be no "subsidizing" by Virginia subscribers of GHMSI subscribers elsewhere. The spend-down order will not harm the interests of Virginia subscribers. Indeed, we believe that it would be in the interests of Virginia and Virginia subscribers to consider a process for spending down the portion of GHMSI's excess surplus that is attributable to Virginia.

We hope that you find these comments to be a useful contribution to the report that you are currently preparing. Should you have any questions, please do not hesitate to telephone Walter Smith at 202-289-8007, ext. 17.

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[9] Also as we have discussed, the same conclusions apply with respect to a spend-down of $126 million. Should you disagree with that view, the simple preventive is for you to decline to order spend-down of Virginia's share of the excess surplus.

[10] Maryland's proceeding leading to the consent decree that GHMSI now invokes was concluded in June 2012, and relied on an Invotex report prepared in 2009 using 2008 data, a Milliman report, and a Lewin report submitted in May 2011 (which therefore could not have relied on year-end 2011 data).

Sincerely,

Walter Smith, Executive Director
DC Appleseed Center

Richard B. Herzog
Harkins Cunningham LLP

Marialuisa S. Gallozzi
Covington & Burling LLP

Deborah Chollet, Ph.D.

Mark E. Shaw, FSA, MAAA, CERA, FLMI
Senior Consulting Actuary
United Health Actuarial Services, Inc.

cc: The Honorable Chester A. McPherson, Acting Commissioner
D.C. Department of Insurance, Securities and Banking

The Honorable Alfred W. Redmer, Jr., Commissioner
Maryland Insurance Administration

Mr. Philip Barlow, Associate Commissioner for Insurance
D.C. Department of Insurance, Securities and Banking

Mr. Adam Levi, Assistant General Counsel
D.C. Department of Insurance, Securities and Banking

Ms. Michele T. Oshman, Associate Deputy Commissioner
Maryland Insurance Administration

Ms. Sharon Kraus, Appeals Clerk
Maryland Insurance Administration

Mr. Randolph Stuart Sergent, Vice President and Deputy General Counsel
CareFirst BlueCross BlueShield

Mr. Dominic F. Perella
Hogan Lovells US LLP