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-27

DECISION AND ORDER ON PETITION FOR RECONSIDERATION AND MOTION TO STAY FURTHER PROCEEDINGS BY GROUP HOSPITALIZATION AND MEDICAL SERVICES, INC.

On September 22, 2016, Group Hospitalization and Medical Services, Inc. ("GHMSI") filed a Petition for Reconsideration and Motion to Stay Further Proceedings (the "2016 Petition for Reconsideration") requesting reconsideration of the August 30, 2016 Decision and Order (Order No. 14-MIE-19) (the "August 2016 Order) of the Commissioner of the District of Columbia Department of Insurance, Securities and Banking (the "Commissioner" and "DISB," respectively) and a stay of all further proceedings in this matter.

Under the August 2016 Order, the Commissioner (i) ordered GHMSI to pay premium rebates to certain eligible District of Columbia ("District") subscribers in satisfaction of GHMSI's obligations under the Medical Insurance Empowerment Amendment Act of 2008 ("MIEAA"), D.C. Law 17-369, and (ii) ordered that the denial of requests for premium rate increases for subscriber contracts issued by GHMSI in the District, as established by the Commissioner's Decision and Order on Group Hospitalization and Medical Services, Inc. Plan (Order No. 14-MIE-16) (June 14, 2016) (the "June 2016 Order") would remain in place until GHMSI certified in writing that all rebates required by the August 2016 Order had been issued.

For the reasons stated below, the Commissioner denies the 2016 Petition for Reconsideration in whole, including the request for reconsideration of the August 2016 Order and motion to stay.[1]

I. BACKGROUND

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").[2] 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 and states that GHMSI "shall be licensed and regulated by the District of Columbia in accordance with the laws of the District of Columbia." District of Columbia Appropriations Act, 1994, Pub. L. No. 103-127, § 138, 107 Stat. 1336, 1349 (Oct. 29, 1993).

GHMSI is a wholly-owned subsidiary of CareFirst, Inc., a nonprofit holding company. 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." GHMSI and CFMI share ownership on a 50/50 basis of CareFirst

[1] This Order does not address GHMSI's request to stay the freeze on rate increases since the denial of rate increases imposed by the August 2016 Order has expired. However, the Commissioner may issue other orders to enforce MIEAA pursuant to D.C. Code § 31-3506(i).

[2] 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).

BlueChoice ("BlueChoice"), a health maintenance organization doing business in the District, Maryland and certain counties in Virginia.

In 2009, due to concern over GHMSI's commitment to its mission as a charitable and benevolent institution, the Council of the District of Columbia enacted MIEAA. 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. To ensure GHMSI meets 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 GHMSI's surplus is excessive. *See id.* at § 31-3506(e). If the Commissioner determines that the surplus is excessive, he must order GHMSI 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 [MIEAA]." *Id.* at § 31-3506(i).

II. PROCEDURAL HISTORY

A detailed procedural history of this matter is provided in the Commissioner's August 3, 2017 Decision and Order on GHMSI Motion to Approve Proposed Consent Order (Order No. 14-MIE-26) (the "August 2017 Order"). *See id.* at 4-8. Rather than repeating the procedural history in full, the following summary focuses on the aspects of the history most relevant to this Decision and Order and the developments that have occurred since the August 2017 Order.

On December 30, 2014, following a comprehensive review and evaluation of GHMSI's surplus in accordance with MIEAA, then-Acting Commissioner Chester A. McPherson (the "Acting Commissioner"), issued Order No. 14-MIE-012 (the "December 2014 Order") under which he determined that GHMSI's surplus attributable to the District as of December 31, 2011 was "excessive" as defined by MIEAA. December 2014 Order at 66. As required by MIEAA, *see* D.C. Code § 31-3506(g)(1), the Acting Commissioner therefore ordered GHMSI to submit a plan for dedication of the excess surplus (approximately $56.2 million) to community health reinvestment in a fair and equitable manner. *Id.*

On March 16, 2015, GHMSI submitted a response to the December 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 302014 Order No. 14-MIE-012 (Mar. 16, 2015) (the "2015 Plan"). In the 2015 Plan, GHMSI essentially argued that no substantive plan for reinvestment of its excess 2011 surplus was needed. GHMSI based this position on several grounds but primarily on the argument that it already had reduced its surplus by more than the amount required by the December 2014 Order and therefore, no further reduction would be appropriate. 2015 Plan at 4-6.

On June 14, 2016, the Commissioner issued the June 2016 Order finding that the 2015 Plan did not satisfy the requirements of MIEAA, and therefore GHMSI had failed to submit a plan as required by the December 2014 Order. June 2016 Order at 18. Because GHMSI took the position that no expenditure of surplus was required, the Commissioner determined that he would develop a plan for dedication of the excess 2011 surplus to community health reinvestment in accordance with his authority to "issue such orders as are necessary to enforce the purpose of [MIEAA]." June 2016 Order at 19 (quoting D.C. Code § 31-3506(i)). The

Commissioner established a 30-day period during which interested persons were invited to submit comments to assist in the development of a plan. *Id.* at 19-20. In addition, in accordance with MIEAA, *see* D.C. Code § 31-3506(i), the Commissioner ordered that all requests by GHMSI for premium rate increases in the District would be denied for 12 months or until the Commissioner developed and approved a plan. *Id.* at 19.

The Commissioner received extensive comments from GHMSI, the D.C. Appleseed Center for Law and Justice, Inc. ("Appleseed") and other interested persons in response to the June 16 Order. After due consideration of the comments, the Commissioner issued the August 2016 Order, which requires GHMSI to pay pro rata premium rebates to eligible District subscribers in an aggregate amount equal to its excess 2011 surplus attributable to the District. August 2016 Order at 32-33. The Commissioner further ordered that the freeze on rate increases established by the June 2016 Order would remain in place until GHMSI certified that the rebates had been paid. *Id.* at 31-32. In addition, the Commissioner found that certain rate filings made by GHMSI after 2011 to reduce or moderate premium rates for the benefit of subscribers had reduced its surplus by approximately $5 million and therefore, should be credited as community health reinvestment of the excess 2011 surplus. *Id.* at 25-28. Accordingly, the Commissioner reduced the total excess 2011 surplus required to be dedicated to community health reinvestment to approximately $51 million. *Id.* at 32-33.

In September 2016, GHMSI and Appleseed each filed petitions with the District of Columbia Court of Appeals, Nos. 16-AA-967 and 16-AA-895, for review of the August 2016 Order and related Orders in this proceeding. The GHMSI and Appleseed appeals have been consolidated (as consolidated, the "D.C. Appeal") and held in abeyance pending resolution of GHMSI's 2016 Petition for Reconsideration, which is the subject of this Decision and Order.

Earlier, in July 2016, GHMSI filed a civil action in the United States District Court for the District of Maryland, Civil Action No. 16-CV-2656 (the "Federal Action"). In the Federal Action, GHMSI contends that the August 2016 Order violates an amendment to GHMSI's Charter enacted by Congress in 2015. *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). The Charter amendment is discussed in detail in Section III.B below.

On September 22, 2016, GHMSI filed the 2016 Petition for Reconsideration that is the subject of this Decision and Order. The 2016 Petition for Reconsideration requested reconsideration of the August 2016 Order and a stay of all further proceedings in this matter, including the rebates and freeze on rate increases required by the August 2016 Order, until the D.C. Appeal and the Federal Action were resolved. Through a series of orders, the Commissioner has granted a temporary stay of the August 2016 Order with respect to the requirement to pay rebates, but not with respect to the freeze on rate increases. *See* Orders No. 14-MIE-26, 14-MIE-25, 14-MIE-20, 14-MIE-22, 14-MIE-21 and 14-MIE-20. The stay expired on September 4, 2017.

In late 2016, DISB staff, representatives of the District of Columbia Office of the Attorney General (the "OAG") and GHMSI's management conducted discussions to negotiate a resolution to this proceeding and settlement of the litigation brought by GHMSI relating to it. The Commissioner did not take part in the negotiations, which ultimately resulted in the filing by GHMSI, on April 17, 2017, of a motion, with an attached Proposed Consent Order, requesting that the Commissioner approve the Proposed Consent Order in resolution of this matter and settlement of all related litigation between GHMSI and the District.

Under the Proposed Consent Order, GHMSI would provide annual funds for community health reinvestment in the amount of at least $7.5 million per year for a period of 10 years by awarding grants to District-based community health organizations. Proposed Consent Order at ¶ 12. The Proposed Consent Order also provided, among other things, that if GHMSI's surplus were to fall below the level determined by the December 2014 Order to be the minimum level necessary to protect GHMSI's financial condition, GHMSI would not be required to provide funding in the following year. *Id.* at ¶ 12.a.i. Instead, GHMSI's spending obligation for that year would be suspended and the 10-year funding period would be extended for another year. *Id.*

The Commissioner solicited public comment on the Proposed Consent Order. *See* Order No. 14-MIE-22. In addition, on July 10, 2017, the Commissioner issued an Order to stay further consideration of the Proposed Consent Order and all other actions in this proceeding to convene a meeting, as requested by Appleseed, presided over by the Commissioner with GHMSI and Appleseed to discuss the terms of a Final Consent Order that would fully resolve this proceeding (Order No. 14-MIE-25). The Order also further stayed GHMSI's obligation to pay rebates to eligible subscribers as directed by the August 2016 Order until August 16, 2017. Pursuant to the Order, the Commissioner convened meetings with Appleseed and GHMSI on July 24 and July 31, 2017, to discuss the Proposed Consent Order and a possible settlement whereby Appleseed could agree to a settlement between the District and GHMSI. Despite the efforts of all the participants, the parties were not able to reach a settlement that Appleseed could endorse. Accordingly, the participants agreed to end the settlement talks.

On August 3, 2017, the Commissioner issued a Decision and Order on GHMSI Motion to Approve Proposed Consent Order (Order No. 14-MIE-26) (the "August 2017 Order"). The August 2017 Order included an Amended Proposed Consent Order, which, among other things,

increased the required funding of community health reinvestment by GHMSI from $7.5 per year for 10 years to $9.5 million per year for 10 years and clarified that the required funding would be in addition to GHMSI's continuing obligation under MIEAA to engage in community health reinvestment, and not a substitute for that obligation. Amended Proposed Consent Order at 3-4. The August 2017 Order extended by 30 days the existing stay of GHMSI's obligation under the August 2016 Order to pay rebates to allow GHMSI time to evaluate the Amended Proposed Consent Order. August 2017 Order at 15. The stay did not apply to the freeze on premium rate increases established by the August 2016 Order. *Id.*

On September 1, 2017, GHMSI submitted a letter to the Commissioner notifying him that it would not accept the Amended Proposed Consent Order. The Commissioner now addresses GHMSI's 2016 Petition for Reconsideration, which remains pending in this proceeding.

III. DISCUSSION

The 2016 Petition for Reconsideration raises a number of objections to the August 2016 Order, most of which have been addressed in previous Orders. Nevertheless, the Commissioner takes this opportunity to review all the objections raised in the 2016 Petition for Reconsideration and explain why they lack merit.

A. The August 2016 Order is Fully Supported by the Record and Meets the Requirements of MIEAA

Referencing certain filings it has made in this proceeding, GHMSI asserts, without further explanation, that the August 2016 Order "lacks support in the record" and "exceeds the requirements of [MIEAA]." 2016 Petition for Reconsideration at 4. The Commissioner interprets these objections to embrace the arguments for reconsideration of the December 2014

Order made in a Motion for Reconsideration and Coordinated Proceedings with Maryland and Virginia filed by GHMSI on January 22, 2015 (the "2015 Motion for Reconsideration"). GHMSI's arguments for reconsideration of the December 2014 Order are relevant to the August 2016 Order insofar as they relate to findings of fact or conclusions of law that provide a basis for the August 2016 Order. The discussion below reviews each such argument.

1. The Method Used by the December 2014 Order to Determine Whether GHMSI's 2011 Surplus Was Excessive Complies with MIEAA

GHMSI argues that the method used by the December 2014 Order to determine whether GHMSI's surplus was excessive is not consistent with the requirements of MIEAA. 2015 Motion for Reconsideration at 10-13. In reaching the determination that GHMSI is required by MIEAA to dedicate excess surplus to community health reinvestment, the December 2014 Order first considered whether GHMSI's 2011 surplus as a whole was excessive and, then, finding that it was, determined what portion of the excess was attributable to the District. December 2014 Order at 18-46, 49-58. GHMSI contends that this procedure is inconsistent with MIEAA. According to GHMSI, MIEAA requires that the Commissioner first determine what portion of GHMSI's total surplus is attributable to the District and only then may determine whether that portion of the surplus is excessive. *See* 2015 Motion for Reconsideration at 10-13.

As explained below, GHMSI's interpretation of MIEAA is incorrect for two reasons—first, it is inconsistent with the stated terms and purposes of MIEAA and, second, it would lead to patently absurd results. In addition, it is entirely at odds with the interpretation of MIEAA repeatedly advanced and propounded by GHMSI until the December 2014 Order was issued, determining that GHMSI's 2011 surplus was excessive. Until that time, GHMSI embraced the same interpretation adopted by the December 2014 Order—*i.e.*, that the surplus must be

considered as a whole to determine if it is excessive. Moreover, GHMSI continued to embrace this interpretation in subsequent positions. *See infra* at 16.

The Commissioner's analysis begins with the plain language of MIEAA. MIEAA states the following with respect to the review of GHMSI's surplus:

> (e) The Commissioner may, on an annual basis, and shall, on a basis no less frequently than every 3 years, review the portion of the surplus of the corporation that is attributable to the District and may issue a determination as to whether the surplus is excessive. Any such review shall be undertaken in coordination with the other jurisdictions in which the corporation conducts business. The surplus may be considered excessive only if:
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> (1) The surplus is greater than the appropriate risk-based capital requirements as determined by the Commissioner for the immediately preceding calendar year; and
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> (2) After a hearing, the Commissioner determines that the surplus is unreasonably large and inconsistent with the corporation's obligation under § 31-3505.01.
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> (f) In determining whether the surplus of the corporation that is attributable to the District is excessive, the Commissioner shall 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. Code §31-3506(e)-(f).

The Commissioner found that it was reasonable and within his discretion to determine that the law an evaluation of GHMSI's surplus as a whole to determine if it is excessive and, if it is, determine how much of the excess is attributable to the District. As explained below, this is the only meaningful way to address whether GHMSI's surplus attributable to the District is

excessive and the only way to conduct an analysis of GHMSI's surplus that is consistent with MIEAA's stated terms and purposes.[3]

MIEAA provides that GHMSI's surplus may be deemed excessive only if two conditions are met. Under the first condition, the surplus must be "greater than the appropriate risk-based capital requirements as determined by the Commissioner ...." D.C. Code § 31-3506(e)(1). Risk-based capital ("RBC") is an analytical tool developed by the National Association of Insurance Commissioners ("NAIC") to determine the minimum amount of surplus an insurer should maintain to support its business operations, taking into consideration the insurer's size and risk profile. December 2014 Order at 16.[4] By definition, RBC standards measure the adequacy of an insurer's surplus as a whole because an evaluation of the entire surplus is the only way to determine whether it provides sufficient protection against insolvency of the insurer. There is no meaningful way to apply RBC standards to a portion of an insurer's surplus because all the various risks faced by an insurer—and any consequential losses—affect the insurer's surplus in its entirety regardless of the type of risk or its origin. If, for example, GHMSI were to suffer unexpected losses on policies written in the District, the fact that the losses have a geographic origin would not change their effect on GHMSI's surplus. The entire surplus would be

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[3] The Commissioner notes that the interpretation of MIEAA he has adopted is fully within his discretionary authority to interpret and apply a statute he is entrusted to enforce in a manner that is reasonable and consistent with the statute's purposes rather than in a manner, as GHMSI would have it, that would lead to absurd results that are inconsistent with the purposes and intent of the statute. *See Sawyer Property Mgmt. of Md., Inc. v. D.C. Rental Housing Comm'n*, 877 A.2 96, 102-03 (D.C. 2005) (Court owes "considerable deference" to an agency's interpretation of the statutes it administers and is obliged to sustain its interpretation of those statutes "unless it is unreasonable or embodies a 'material misconception of the law,' even if a different interpretation also may be supportable."). As explained below, GHMSI's alternative interpretation does not rise to the level of being "supportable."

[4] Under District law, every domestic insurer, including GHMSI, must calculate its RBC using a formula that takes into account the various risks faced by the insurer and file an annual report with the Commissioner presenting the calculation and disclosing the ratio between its actual surplus and a minimum "authorized control level" of surplus. D.C. Code § 31-3451.02. If an insurer's surplus is below the authorized control level, the Commissioner is authorized by law to place the company under regulatory control to prevent its insolvency. D.C. Code § 31-3451.05(a)(2).

diminished. Similarly, if GHMSI were to incur higher claim costs than anticipated because Maryland health care providers raised their fees, any resulting reduction in profitability would affect GHMSI's surplus in its entirety. The same holds true for any other risk and attendant loss or expense faced by GHMSI or, for that matter, any other insurer. Thus, the only way the Commissioner can to determine if GHMSI's surplus is "greater than the appropriate risk-based capital requirements...," as required by D.C. Code § 31-3506(e)(1), is to evaluate the surplus as a whole.

The second condition that must be met before GHMSI's surplus may be deemed excessive is a determination "that the surplus is unreasonably large and inconsistent with the corporation's obligation under § 31-3505.01 [to engage in community health reinvestment to the maximum feasible extent consistent with financial soundness and efficiency]." D.C. Code § 31-3506(e)(2). The District of Columbia Court of Appeals has held that the two determinations required by D.C. Code § 31-3506(e)(2)—*i.e.*, that the surplus (a) is "unreasonably large" and (b) is inconsistent with GHMSI's obligation to engage in community health reinvestment to the maximum feasible extent consistent with financial soundness and efficiency "must be made in tandem, not *seriatim*, to give full effect to the statute." *D.C. Appleseed Center for Law and Justice, Inc. v. D.C. Dep't of Insurance, Securities and Banking*, 54 A.3d 1188, 1215 (D.C. 2012). Following this guidance, the December 2014 Order interpreted D.C. Code § 31-3506(e)(2) to require the Commissioner to determine the level of surplus that would maximize GHMSI's community health reinvestment without undermining its financial soundness or efficiency—in other words, to determine the minimum level of surplus that is consistent with financial soundness and efficiency. December 2014 Order at 15-16. Any surplus above this level would be excessive. *See id.* As with an evaluation of surplus considering appropriate RBC

standards under D.C. Code § 31-3506(e)(1), the analysis required by D.C. Code § 31-3506(e)(2) requires the Commissioner to evaluate GHMSI's surplus as a whole to determine the minimum level of surplus needed to protect the company's financial condition. Here again, all risks bearing on GHMSI's financial condition—and therefore its surplus—affect the surplus in its entirety. Thus, by its stated terms and purposes, the Commissioner determined that MIEAA required him to evaluate GHMSI's surplus as a whole to determine whether it is excessive.

The alternative interpretation of MIEAA sometimes advanced by GHMSI—that the Commissioner must determine whether GHMSI's surplus is excessive by looking solely at the portion attributable to the District—not only is inconsistent with MIEAA but also would lead to patently absurd results. As discussed above, the standards for evaluating whether surplus is excessive under MIEAA require evaluating whether the surplus exceeds the minimum level sufficient to protect GHMSI's financial condition. Making such an evaluation by reviewing the portion of GHMSI's surplus attributable to the District would be meaningless. There is no segregation of surplus by jurisdiction. As with every insurer, the entirety of GHMSI's surplus is dedicated to protecting the company's financial condition against all risks it may encounter, wherever they occur. Even if one could segregate the risks faced by GHMSI to identify just those "attributable" to the District, these risks would affect GHMSI's entire surplus, not just some portion.

It is axiomatic that a statute must be construed in a manner that avoids irrational or implausible results. *See, e.g., Eaglin v. District of Columbia*, 123 A.3d 953, 957 (D.C. 2015) ("When interpreting statutes, we construe them 'in a manner which assumes that [the legislature] acted logically and rationally,'... and 'avoid interpretations of statutes which lead to implausible results,'..." (citations omitted)); *Gilmore v. United States*, 699 A.2d 1130, 1132 (D.C. 1997)

("Basic principles of statutory construction require that the actual language of a statute be ignored or revised to avoid the absurdity that would result if it were read literally." (citations omitted)); *United States v. Brown,* 333 U.S. 18, 27 (1948) ("No rule of construction necessitates our acceptance of an interpretation resulting in patently absurd consequences"). Accordingly, the Commissioner concludes that the only reasonable interpretation of MIEAA, and the only interpretation consistent with the statute's purposes and RBC standards, is that the Commissioner must first determine whether GHMSI's surplus as a whole is excessive and, if it is, then determine what portion of the excess is attributable to the District.

GHMSI itself recognizes that the alternative interpretation of MIEAA it now promotes is invalid. *See* Letter to Commissioner Stephen C. Taylor from Chet Burrell, CareFirst President and CEO, dated July 14, 2016 at 3 ("actuaries who have reviewed this concept in District law of 'attributing' surplus have pointed out that it is invalid to divide or attribute surplus in the case of a health insurance company operating in multiple jurisdictions."). Indeed, up until the time the Acting Commissioner issued the December 2014 Order finding that GHMSI's 2011 surplus was excessive, GHMSI consistently took the position that the proper way to determine whether its surplus is excessive under MIEAA is to evaluate it as a whole.

For example, the brief filed by GHMSI just after the June 2014 hearing offers the following explanation of how the Commissioner's surplus review under MIEAA must be conducted:

> Under the MIEAA, the Commissioner must look backward to determine whether GHMSI's surplus was "excessive" at a specific point in time—year-end 2011. If GHMSI's surplus was not excessive at that time, this proceeding is at an end. If the surplus was excessive, the Commissioner must determine what portion of the surplus is attributable to the District of Columbia....

GHMSI Post-Hearing Brief at 4 (November 7, 2014) (citations omitted). This is precisely the procedure followed in this proceeding.

Examples abound of GHMSI's endorsement of the concept that its surplus must be considered as a whole to determine whether it is "excessive" as defined by MIEAA. DISB's regulations implementing MIEAA require GHMSI to file an annual report "which details the company's surplus and examines whether the company's surplus is considered excessive under [MIEAA]." 26A DCMR § 4601.1. On June 1, 2012, GHMSI filed the required report for its 2011 surplus, concluding that the surplus was not "excessive" under the test required by MIEAA. CareFirst BlueCross BlueShield, Report on GHMSI Surplus at 11 (June 1, 2012). In support of this conclusion, GHMSI cited several actuarial studies, every one of which evaluated the company's surplus *as a whole*. Similarly, GHMSI's pre-hearing brief and its testimony at the surplus review hearing held in June of 2014 reflected its view that the proper way to determine whether the company's surplus is excessive under MIEAA is to evaluate the surplus as a whole. *See, e.g.*, GHMSI Pre-Hearing Brief at 11-6 (June 10, 2014) (endorsing the use of risk-based capital standards, which evaluate surplus as a whole, as proper metric for determining whether surplus is excessive under MIEAA); Hear Tr. 88:8-19, 12-2, 293:17-20 (again endorsing the use of risk-based capital standards to determine whether surplus is excessive under MIEAA).

A central subject of inquiry during the hearing was the report prepared for the Acting Commissioner by Rector & Associates evaluating whether GHMSI's 2011 surplus was excessive. 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"). The Rector Report based its findings and conclusions on a review of GHMSI's surplus

as a whole. At the hearing, GHMSI's CEO endorsed the Rector Report, calling it "essentially a creditable piece of work" that "represents a sound set of conclusions." Hearing Tr. 101:13-15.

Perhaps the clearest statement of GHMSI's position on this issue is found in its response to the following question posed by the Acting Commissioner after the hearing: "Please provide your recommendations regarding how the Commissioner should determine the amount of GHMSI's surplus that is attributable to the District." Third Scheduling Order, Order No. 14-MIE-005 (Aug. 7, 2015). In response, GHMSI stated,

> GHMSI recommends that the Commissioner not address the attribution of GHMSI's surplus at this time. *The Commissioner is not required to address attribution unless he concludes that GHMSI's surplus, as a whole, is excessive.*

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) (emphasis added). GHMSI's position on this issue prior to the December 2014 Order was clear and unwavering. Moreover, the Commissioner notes that GHMSI continues to file annual MIEAA reports evaluating whether its surplus is excessive that are based on an assessment of the surplus as a whole. *See* Letter to the Hon. Stephen Taylor from Chet Burrell, President and CEO of CareFirst Blue Cross Blue Shield, dated June 1, 2017; Letter to the Hon. Stephen Taylor from Chet Burrell, President and CEO of CareFirst Blue Cross Blue Shield, dated June 1, 2016; Letter to the Hon. Chester A. McPherson from Chet Burrell, President and CEO of CareFirst Blue Cross Blue Shield, dated June 19, 2015 (all letters available at https://disb.dc.gov/page/carefirst-surplus-report-filings). GHMSI cannot credibly argue that MIEAA requires an alternative approach, especially when the method it promotes would lead to meaningless results.

The fact that one must evaluate GHMSI's entire surplus to determine if it is excessive does not mean it is unreasonable for the Commissioner to determine what portion of any excess

is attributable to the District. By definition, excess surplus is surplus that is not required to guard against risks to GHMSI's financial condition. Therefore, the considerations that apply when evaluating whether the surplus is excessive do not apply to an analysis to determine what portion of any excess is properly attributable to the District and thus available for community health reinvestment, which is what MIEAA requires.

2. The Method of Attributing Surplus to the District Used by the December 2014 Order Complies with MIEAA

GHMSI also argues that the method adopted by the December 2014 Order for attributing surplus to the District did not adequately address the complexities inherent in making such a determination and was not properly coordinated with insurance regulators in Maryland and Virginia. 2015 Motion for Reconsideration at 13-14. In fact, the December 2014 Order used a nuanced and reasonable method of determining how much of GHMSI's excess surplus was attributable to the District and was reasonably coordinated with Maryland and Virginia consistent with the requirements of MIEAA.

MIEAA does not specify any particular method for attributing surplus to the District. Moreover, as GHMSI acknowledges, there is no established financial methodology for determining how much of an insurer's surplus is attributable to a particular jurisdiction in which it does business. 2015 Motion for Reconsideration at 14. Absent an explicit standard for such a determination, the December 2014 Order adopted a reasonable methodology for attribution based on three factors consistent with the definition of "attributable to the District" found in DISB's regulations implementing MIEAA at 26A DCMR § 4699.2. The factors used by the December 2014 Order are as follows: (1) premiums reported by GHMSI for policies written in the District; (2) the number of policies reported by GHMSI written in the District; and (3) the number of

health care providers reported as under contract with GHMSI in the District. December 2014 Order at 51-58.

Of the three factors, the December 2014 Order gave the most weight to premiums because, as GHMSI acknowledges, "GHMSI's surplus was built from premiums paid by or on behalf of subscribers." GHMSI Further Response to Questions in the Third Scheduling Order and Statement Regarding Attribution at 2 (Oct. 10, 2014). To analyze premiums, the December 2014 Order began by tallying the annual written premiums reported by GHMSI and its subsidiary, BlueChoice, in their 2011 Annual Statements for policies with a situs in the District, Maryland or Virginia. *Id.* at 52-55. Because GHMSI owns 50% of BlueChoice, only 50% of BlueChoice's premiums were included. *Id.* at 55. The analysis then assigned relative weights of 18% and 82% to premiums written for Federal Employee Program ("FEP") and non-FEP business, respectively. *Id.* at 55-56. This approach was taken because, as a general rule, FEP business is less risky and therefore less profitable and less likely to contribute to surplus. *Id.* The selected weights correspond to the underwriting risk factors given to FEP and non-FEP business under the instructions for calculating risk-based capital developed by the NAIC for health insurers. *Id.* at 55. Applying the assigned weights to the District share of FEP and non-FEP business, the December 2014 Order then calculated a weighted average for the District share of premiums written by GHMSI and BlueChoice. *Id.* at 56.

As required by DISB's regulations, the attribution of surplus under the December 2014 Order also considered the number of policies reported by GHMSI and BlueChoice in the District and number of providers reported as being under contract with the companies in the District. *Id.* at 56-58. These factors can provide an indication of how much business GHMSI does in a particular jurisdiction and therefore what portion of the surplus is attributable to that jurisdiction;

however, because they bear a less direct relationship to surplus and because there were certain limitations in the policy count data reported by GHMSI, they were given much less weight in the analysis. *See id.* Accordingly, premiums, policy count and number of providers were given relative weights 90%, 5% and 5%, respectively, to reflect the much greater contribution to surplus provided by premiums. *Id.* at 58. Using this weighted average, the December 2014 Order concluded that 21% of GHMSI's surplus was attributable to the District. *Id.* This ratio was then used to calculate the portion of excess 2011 surplus attributable to the District and therefore available for community health reinvestment.

The Commissioner acknowledges that other methods could be employed to determine the attribution of GHMSI's surplus; but concludes that the method used by the December 2014 Order, which was developed in consultation with DISB's expert staff, is a thoughtful and reasonable approach to determining the amount of surplus attributable to the District and is supported by the record.

3. DISB Appropriately Coordinated with Maryland and Virginia

GHMSI further argues that the December 2014 Order violates MIEAA because DISB did not coordinate sufficiently with Maryland and Virginia in determining whether GHMSI's surplus was excessive and in arriving at a method for attributing excess surplus to the District. 2015 Motion for Reconsideration at 2, 14. The Commissioner disagrees.

MIEAA states,

> The Commissioner may, on an annual basis, and shall, on a basis no less frequently than every 3 years, review the portion of the surplus of the corporation that is attributable to the District and may issue a determination as to whether the surplus is excessive. Any such review shall be undertaken in coordination with the other jurisdictions in which the corporation conducts business.

D.C. Code § 31-3506(e). This provision requires the Commissioner to coordinate any review of GHMSI's surplus with Maryland and Virginia, which, as explained below, is what the Acting Commissioner did. It does not require that any final determination regarding GHMSI's surplus be approved by other jurisdictions. That authority is reserved to the Commissioner and requires the application of standards under MIEAA that are unique to the District.

As discussed in the December 2014 and June 2016 Orders, DISB coordinated with Maryland and Virginia throughout the lengthy review of GHMSI's surplus that culminated in the December 2014 Order. *See* December 2014 Order at 62-65, June 2016 Order at 15-16. Over the period of the review, the Acting Commissioner and his staff communicated with the Maryland and Virginia insurance commissioners and their staffs about various issues relating to the review, including whether GHMSI's surplus was excessive and the proper attribution of excess surplus to the District. *See* December 2014 at 62-65; June 2016 Order at 15-16. These communications included, among other things, correspondence soliciting the participation of the Maryland and Virginia commissioners in the surplus review hearing that was held in June of 2014. December 2014 Order at 62; June 2016 Order at 16. DISB would have welcomed in-person testimony from Maryland and Virginia regulators at the hearing, but they chose instead to submit written statements. December 2014 Order at 62-63; June 2016 Order at 16. The Acting Commissioner also requested input from the Maryland and Virginia insurance commissioners after the hearing. June 2016 Order at 16. In response, Maryland and Virginia both provided statements addressing issues raised by the Acting Commissioner. *See* December 2014 Order at 63-64. All the information provided by Maryland and Virginia was carefully considered and taken into account in reaching the determinations reflected in the December 2014 Order. December 2014 Order at 64. Based on these facts, the Commissioner concludes that the deliberative process leading to

the determination that GHMSI's 2011 surplus was excessive and the attribution of excess surplus to the District, as provided in the December 2014 Order, was properly coordinated with Maryland and Virginia in accordance with MIEAA.

GHMSI's position on coordination essentially amounts to an argument that the only coordination that can satisfy MIEAA is one resulting in agreement among the jurisdictions concerning any required determination. *See, e.g.*, 2015 Motion for Reconsideration at 2 ("'Coordination' under the MIEAA ... requires Maryland, Virginia and the District to come to agreement regarding the many multi-jurisdictional issues relating to GHMSI's surplus."). MIEAA requires no such thing.

It would be unreasonable for the Council of the District of Columbia to make the Commissioner's authority to enforce MIEAA conditioned upon discretionary actions by government officials in other states. On the contrary, MIEAA vests sole responsibility in the Commissioner to make the determinations required to enforce the law's standards. *See* D.C. Code § 31-3506(f), (h). The Commissioner may not abdicate this responsibility by making a final determination only if all other jurisdictions agree or by substituting standards adopted by other jurisdictions for those required by MIEAA so as to reach agreement. Rather than requiring agreement among the jurisdictions, MIEAA requires the Commissioner to coordinate with Maryland and Virginia in a reasonable manner and consider their interests and needs in conducting a surplus review, which is what the Acting Commissioner did.

4. The 95% Confidence Level Used by the December 2014 Order is Reasonable and Consistent with MIEAA

GHMSI argues that the 95% confidence level used by the December 2014 Order to evaluate GHMSI's surplus is arbitrary and capricious. September 2015 Motion for

Reconsideration at 15-17. As explained below, the 95% confidence level is a reasonable standard and is consistent with the requirements of MIEAA.

The December 2014 Order used a risk modeling process to determine whether GHMSI's surplus was excessive. This process involved identifying the various risks and contingencies to which GHMSI might be subject and then evaluating the probability that each risk or contingency might occur and its likely effect on surplus if it did occur. December 2014 Order at 30. The probability/severity factors used for this analysis were based on relevant historical experience and reasonable projections regarding how GHMSI's future experience might deviate from historical experience. *Id.* Ultimately, the analysis sought to identify a level of surplus as of year-end 2011 that would provide a certain level of confidence that GHMSI's surplus would not decline below a benchmark level in future years. *Id.* at 24, 30-31. Two benchmark levels were used for this purpose, each of which is expressed as a multiple of GHMSI's "authorized control level" of risk-based capital ("RBC-ACL"). *Id.* at 23-24. The authorized control level is the level of surplus at which the Commissioner is authorized by law to place GHMSI under regulatory control to prevent its insolvency.[5] The two benchmarks were 200% RBC-ACL and 375% RBC-ACL. *Id.* at 24.

The 200% RBC-ACL benchmark was selected because it is an important threshold under both District law and the contractual rules governing GHMSI as a licensee of the BlueCross BlueShield Association ("BCBSA"). Under District law, if GHMSI's surplus falls below 200% RBC-ACL, it is required to submit a plan to the Commissioner for corrective action to bring its surplus up to a safer level. *Id.*; *see* D.C. Code § 31-3451.03. In addition, if GHMSI's surplus

[5] *See* n. 2, *supra.*

falls below 200% RBC-ACL, it could lose certain important contractual rights as a licensee of the BCBSA. *Id.* at 24-25.

The 375% RBC-ACL benchmark was selected because it is the "Early Warning" threshold for surplus used by the BCBSA. *Id.* at 28. If GHMSI's surplus falls below 375% RBC-ACL, it must submit a recovery plan to the BCBSA outlining the steps it will take to increase the surplus and submit to increased monitoring of its financial condition by BCBSA. *Id.*

The December 2014 Order used different confidence levels for each benchmark, calibrating the confidence level for each according to degree of risk to GHMSI's financial condition if GHMSI's surplus were to fall below the benchmark and the requirements of MIEAA. Based on the consequences to GHMSI if its surplus were to fall below 375% RBC-ACL, the December 2014 Order used an 85% confidence level for this benchmark. *Id.* at 28-29. In other words, the December 2014 Order identified a level of surplus as of year-end 2011 that would provide an 85% confidence level that GHMSI's surplus would not fall below 375% RBC-ACL in future years. Because the consequences of falling below 200% RBC-ACL pose a greater risk to GHMSI's financial condition, the December 2014 Order adopted a 95% confidence level for this benchmark. *Id.* at 24-26.

GHMSI argues that the 95% confidence level adopted by the December 2014 Order is arbitrary and capricious. 2015 Motion for Reconsideration at 15-17. On the contrary, the 95% confidence level is reasonable and consistent with the requirements of MIEAA. The December 2014 Order chose the 95% confidence level after a comprehensive analysis of the risks to GHMSI if its surplus were to fall below 200% RBC-ACL. *See* December 2014 Order at 24-26. Based on this analysis, the December 2014 Order concluded that a 95% confidence level was appropriate because it provides a very high level of confidence that GHMSI's surplus will not

fall below 200% RBC-ACL, and therefore is consistent with protecting GHMSI's financial soundness and efficiency, but also maximizes GHMSI's community health reinvestment by eliminating that amount of surplus that is inefficient or unnecessary for financial soundness. *Id.* at 26. This conclusion is consistent with the Court of Appeals' instructions that the Commissioner must calibrate the confidence levels used to evaluate GHMSI's surplus in accordance with the dual analysis required by MIEAA in determining whether GHMSI's surplus is excessive—namely, whether the surplus is (a) "unreasonably large" and (b) inconsistent with GHMSI's obligation under MIEAA to engage in community health reinvestment to the maximum feasible extent consistent with financial soundness and efficiency. *See D.C. Appleseed Appeal, supra,* 54 A.3d at 1215, 1218-19.

GHMSI contends the 95% confidence level is too low because its consultants and others used a 98% confidence level in their own analyses. 2015 Motion for Reconsideration at 15. As the Court of Appeals noted under similar circumstances, *see D.C. Appleseed, supra*, at n. 42, the analyses cited by GHMSI do not consider GHMSI's obligation under MIEAA to reinvest in community health to the maximum feasible extent. The Acting Commissioner reasonably determined that GHMSI proposed confidence levels were too high to be consistent with MIEAA based on the analysis in the December 2014 Order.

GHMSI also notes that DISB's own consultant, Rector & Associates, recommended using a 98% confidence level with respect to the 200% RBC-ACL benchmark. 2015 Motion for Reconsideration at 15. Yet Rector did not insist that a 98% confidence level is the only reasonable standard for this review. Instead, as Rector testified at the June 2014 hearing, the selection of a confidence level is "a matter of judgment," and DISB could reasonably select a lower level. Tr. 40:24 – 41:10.

Indeed, as the December 2014 Order points out, one of GHMSI's expert consultants, Lewin, did select a 95% confidence level with respect to the 200% RBC-ACL benchmark in conducting an analysis to determine the appropriate level for GHMSI's surplus. December 2014 Order at 27. The Lewin analysis used a 95% confidence level even without taking into consideration the requirements of MIEAA. *See* The Lewin Group, Recommended Surplus Range for GHMSI; Approach and Considerations for Determining the Appropriate Range of Surplus in 2011 (May 20, 2011). Thus, it is clear that a 95% confidence level is not an arbitrary or unreasonable standard for evaluating surplus sufficiency, even when one factors out MIEAA's requirement to calibrate the selected confidence level so as to maximize GHMSI's community health reinvestment.

Nevertheless, GHMSI insists that a 95% confidence level creates an unacceptable risk that its surplus will fall below 200% RBC-ACL. *See* 2015 Motion for Reconsideration at 16. It is important to note that while a decline in surplus to 200% RBC-ACL would be material, GHMSI would not be insolvent at this level, but rather subject to additional regulatory oversight to prevent insolvency. *See* D.C. Code § 31-3451.03 (requiring insurer to submit a corrective plan to the Commissioner if its RBC falls below 200% RBC-ACL).

Moreover, GHMSI's argument ignores that fact that a reduction in surplus from the 721% RBC-ACL target point established by the December 2014 Order to the 200% RBC-ACL benchmark is unlikely to occur precipitously. The probability/severity factors used by the December 2014 Order to model the risks and contingencies that might affect GHMSI consider the impact on surplus over a three-year period. *See* December 2014 Order at 29-47; Rector & Associates, Inc., Report to the D.C. Department of Insurance, Securities and Banking – Group Hospitalization and Medical Services, Inc. (Dec. 9, 2013). This time horizon would provide

opportunities for GHMSI and DISB to take mitigating actions to reverse a declining surplus even before it approached 200% RBC-ACL.

GHMSI, of course, may act at any time if it believes its surplus shows a declining trend. If GHMSI for any reason where not to act, the Commissioner has broad authority to order corrective action. Under District law, if GHMSI's surplus declines to 300% RBC-ACL and shows a downward trend, GHMSI must submit a report to the Commissioner identifying the conditions that are causing the decline and propose a plan of action to bring the surplus to a higher level. D.C. Code §31-3451.03(a). If the Commissioner finds the plan to be unsatisfactory, he may order the company to take corrective action. D.C. Code §§ 31-3451(d), 31-3451.04(a)(3). Finally, as an added measure of safety, under the rules governing BCBSA licensees, GHMSI is required to provide a plan for corrective action to the BCBSA and submit to enhanced financial reporting and monitoring requirements if its surplus falls below the BCBSA "Early Warning" threshold of 375% RBC-ACL. December 2014 Order at 28.

Given the margin of safety provided by these controls and the analysis provided in the December 2014 Order, the Commissioner believes a 95% confidence level with respect to the 200% RBC-ACL benchmark is reasonable and consistent with MIEAA's requirement that the Commissioner determine a level of surplus that is consistent with financial soundness and efficiency but requires GHMSI to engage in community health reinvestment to the maximum feasible extent.

5. The December 2014 Order's Use of a Single Target Point for Surplus Is Reasonable

Based on a comprehensive modeling of the risks faced by GHMSI and its attendant surplus needs, the December 2014 Order concluded that the appropriate target point for

GHMSI's surplus was 721% RBC-ACL, and any surplus above that level would be excessive. December 2014 Order at 46. GHMSI argues that the use of single target point to determine whether surplus is excessive, rather than establishing a range, is inconsistent with MIEAA's purpose of ensuring GHMSI's retains enough surplus to remain financially sound. 2015 Motion for Reconsideration at 17-18. If the December 2014 Order had established an acceptable range of surplus levels, GHMSI argues, rather than a single target point, it would seek to keep its surplus near the midpoint of the range through rate filings and other planning. *Id.* at 18. According to GHMSI, having to comply instead with a single target point for surplus forces it to keep its surplus below the target point so that natural fluctuations outside its control do not bring the surplus above the target point. *Id.* According to GHMSI, this situation is inconsistent with MIEAA because the target point identified by the 2014 Order is the minimum amount of surplus consistent with preserving GHMSI's financial soundness. *Id.*

GHMSI's argument concerning the surplus target point established by the 2014 Order ignores the Commissioner's discretion under MIEAA, which will allow the Commissioner to avoid the adverse consequences GHMSI describes. MIEAA provides that once a determination is made that GHMSI's surplus is excessive, the Commissioner must order GHMSI to submit a plan for dedication of the excess surplus to community health reinvestment and then determine whether GHMSI has submitted and executed such a plan within a reasonable period of time. D.C. Code § 31-3506(g) and (i). GHMSI's argument against a single target point appears to assume that once rebates in satisfaction of the August 2016 Order are issued, if its surplus later rises above the target level, it will be ordered to disgorge its excess surplus immediately, regardless of the consequences. Nothing in MIEAA requires such a result. Instead, the

Commissioner would have to conduct a new review of GHMSI's surplus before making a future determination of excess surplus.

B. The August 2016 Order Does Not Conflict with GHMSI's Federal Charter

The 2016 Petition for Reconsideration states that the August 2016 Order "ignores Congress's express instructions in GHMSI's federal charter ...." 2016 Petition for Reconsideration at 4. GHMSI has made this same argument in previous filings. *See, e.g.,* GHMSI Comments in Response to DISB's Order of June 14, 2016 (the "June 2016 Comments"); Letter from Chet Burrell, President and C.E.O., CareFirst, to Commissioner Taylor (July 14, 2016) (the "July 2016 Letter"). For the reasons stated below, the Commissioner concludes that the August 2016 Order does not conflict with GHMSI's federal charter.

On December 18, 2015, the President signed 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 provides:

> 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—
>
> (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 of the Appropriations Act, 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* July 2016 Letter at 5 (July 14, 2016); June 2016 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. June 2016 Comments 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 that any *decision* by the Commissioner resulting from that review which ordered 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 the review of a 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, requires 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 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 enforce the dedication of GHMSI's excess 2011 surplus to community health reinvestment pursuant to the December 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 fails for two reasons. First, the Commissioner determined the excess surplus and ordered compliance with MIEAA before the Charter Amendment was enacted. Second, 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 2014 Order nearly a year prior to when Congress amended GHMSI's charter on December 18, 2015.[6] As stated above, Congress was clearly aware of these facts and is presumed by law to have been aware of them. Thus, Congress cannot

[6] Indeed, GHMSI submitted a petition for reconsideration of the review to DISB in early 2015, and the petition was denied many months before Congress acted. *See* 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).

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 in accordance with the December 2014 Order.[7]

A statement released by Congresswoman Eleanor Holmes Norton just after the Charter amendment was passed confirms that the saving clause was intended to permit the Commissioner to enforce MIEAA in accordance with the December 2014 Order. 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 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 2014 Order.

C. The August 2016 Order Does Not Constitute a Demand for Duplicative Relief

GHMSI asserts that the August 2016 Order constitutes a "defective demand for duplicative relief" because it does not take into account GHMSI's community reinvestment activities in the District that occurred after 2011 and a reduction in surplus by more than what was required by the December 2014 Order. 2016 Petition for Reconsideration at 4. These

[7] If Congress had intended the Charter amendment to prohibit enforcement of the December 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 2014 Order without consent from Maryland and Virginia.

assertions appear to be a reprise of the argument made in the March 2015 Plan and elsewhere that after 2011, GHMSI reduced its surplus by more than the amount required by the December 2014 Order through the following losses and expenditures: (a) underwriting losses attributable the District; (b) expenditures on community giving, open enrollment subsidies and funding of the District's Health Care Alliance; and (c) premium rate reductions and moderation. March 2015 Plan at 4-5.

The December 2014 Order determined that GHMSI had excess surplus attributable to the District in the amount of approximately $56 million. As required by MIEAA, the December 2014 Order therefore ordered GHMSI "to submit a plan for dedication of the excess to community health reinvestment in a fair and equitable manner." D.C. Code § 31-3506(g)(1); *see* December 2014 Order at 66. To comply with this requirement, any plan proposed by GHMSI must satisfy two criteria: First, the plan must involve the expenditure of excess surplus. Second, the plan must dedicate the excess surplus to "community health reinvestment." D.C. Official Code § 31-3506(g)(1). 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. Official Code § 31-3501(1A). Third, the plan must dedicate the excess surplus to community health reinvestment "in a fair and equitable manner." D.C. Official Code § 31-3506(g)(1). The Commissioner evaluated the losses and expenditures claimed by GHMSI considering these criteria. Except for certain rate filings resulting in negative contributions to surplus, the Commissioner concluded that the losses and expenditures claimed by GHMSI did not constitute expenditures in satisfaction of the December 2014 Order.

1. Underwriting Losses

To the extent GHMSI contends that its underwriting losses between 2012 and 2014 should be credited towards compliance with the December 2014 Order,[8] the Commissioner must reject that assertion because such losses, by themselves, are not "community health reinvestment." 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). Underwriting losses do not promote and safeguard the public health. Nor do they necessarily benefit current or future subscribers. Thus, underwriting losses, by and of themselves, are not community health reinvestment and therefore cannot be credited towards GHMSI's obligations under the December 2014 Order.

It also is important to recognize that the analysis the December 2014 Order 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. *See, e.g.*, December 2014 Order at 30, 39 (discussing surplus modeling generally and the rating adequacy and fluctuation risk factor in particular). In other words, the fact that GHMSI experienced modest underwriting losses does not change the December 2014 Order's determination that the 2011 surplus was excessive.

[8] GHMSI states that, between 2012 and 2014, it incurred $62 million in underwriting losses attributable to the District. 2015 Plan at 4.

2. Community Giving, Open Enrollment Subsidies and HealthCare Alliance Funding

According to 2015 Plan, between 2012 and 2014, GHMSI expended $11 million in direct community giving, $24 million in subsidies for the District's open enrollment program and $15 million in funding for the District's HealthCare Alliance Program. 2015 Plan at 5-6. GHMSI's reported expenditures in these categories were very consistent from year to year. *See* 2015 Plan, Exhibit 3.[9] MIEAA requires that a compliant plan must, among other things, consist of expenditures of excess surplus. D.C. Official Code § 31-3506(g)(2). GHMSI's expenditures for community giving, open enrollment subsidies and HealthCare Alliance funding do not meet this requirement. In determining the level of surplus that was sufficient to protect GHMSI's financial condition against future risks and contingencies, the December 2014 Order took into account GHMSI's likely and planned obligations, including annual expenditures for community giving, open enrollment subsidies and the HealthCare Alliance consistent with historical levels. *See* December 2014 Order at 21-23, 29, 49-50. Indeed, MIEAA required the December 2014 Order to consider GHMSI's open enrollment subsidies and HealthCare Alliance funding in determining whether its surplus was excessive. D.C. Official Code § 31-3506(f). In other words, the excess surplus identified by the December 2014 Order was surplus over and above the amount of surplus necessary to meet these and other obligations of GHMSI. Accordingly, such expenditures were taken into consideration in the determination of excess surplus and therefore

[9] GHMSI's expenditures in 2011 included $3.4 million for community giving, $5 million for the HealthCare Alliance, and $4.5 million for open enrollment subsidies. Between 2012 and 2014, GHMSI's annual community giving varied between $3.4 million and $3.9 million; funding for the HealthCare Alliance was even more consistent, at $5 million per year, each year; and open enrollment subsidies varied between $7.5 million and $10.3 million annually, but also were consistent over time. *See* 2015 Plan, Exhibit 3.

do not constitute expenditures of excess surplus. Thus, they cannot be credited towards satisfaction of the December 2014 Order.

3. Premium Rate Reduction

GHMSI argues that, beginning in 2011, it took steps to reduce or moderate its rates to reduce surplus, which should be credited as expenditures of excess 2011 surplus for community health reinvestment. *See* GHMSI Comments at 10-13. For premium rate reductions to be part of a plan in compliance with MIEAA, they must constitute community health reinvestment, which is defined 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). This definition expressly includes premium rate reductions, but only if such reductions benefit current or future subscribers. The Commissioner evaluated the rate filings GHMSI claims should be credited as community health reinvestment in accordance with this standard.

As explained in the August 2016 Order, the Commissioner believes rate filings by GHMSI 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 an effort to reduce surplus to benefit subscribers. August 2016 Order at 26. Such rate filings are distinguishable from reductions aimed merely at bringing rates in line with experience or made purely for competitive reasons, which are not intended to reduce surplus for the benefit of subscribers. *See id.*

On this basis, the Commissioner concluded that six rate filings made by GHMSI that affected premium rates after December 31, 2011 should be credited as community health reinvestment of excess 2011 surplus because each of these filings identified an express negative

Contribution to Reserves ("CTR")[10] resulting from the filed rates. *Id.* The Commissioner concluded that these filings are distinguishable from other rate filings for which GHMSI claimed credit for community health reinvestment in that they can reasonably be characterized as intended to reduce surplus for the benefit of subscribers. *Id.*

GHMSI claimed 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 sought approval but did not. GHMSI Comments at n.5. None of these filings, however, expressly identified 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 unfiled, 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 DISB approval was sought and obtained. As stated in the August 2016 Order, the Commissioner cannot agree with this argument. *Id.* at 26-27. 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 DISB 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.

[10] CTR is the portion of premium that is intended to impact the surplus of GHMSI. A negative CTR equates to a reduction in surplus.

Under the August 2016 Order, the Commissioner concluded that six rate filings claimed identified by GHMSI should be credited as community health reinvestment of excess 2011 surplus, resulting in an aggregate reduction in surplus of $4,887,618. *Id.* at 27. 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 yielded a revised excess 2011 surplus attributable to the District of $51,325,470.72. *See id.*

D. The Payment of Rebates is Consistent With, And Advances the Purposes of, MIEAA

After the Commissioner found in his June 2016 Order that GHMSI had failed to submit the plan required by the December 2014 Order, the Commissioner developed a plan to dedicate the excess surplus to community health reinvestment. *See* August 2016 Order. Construing MIEAA to authorize him to enforce the December 2014 Order by devising a plan for GHMSI, the Commissioner directed GHMSI to pay pro rata premium rebates to eligible District subscribers in an aggregate amount equal to its excess 2011 surplus attributable to the District. *Id.* at 32-33.

In its 2016 Petition for Reconsideration, GHMSI claims that two technical issues require the Commissioner to reconsider his plan established by the August 2016 Order. First, GHMSI argues that the August 2016 Order failed to address the tax liability that employee subscribers who receive rebates may incur if their coverage was subsidized by their employers. 2016 Petition for Reconsideration at 4. Second, GHMSI claims the August 2016 Order failed to indicate whether the Commissioner conferred with the Office of Personnel Management ("OPM") "to resolve how any rebates will be allocated between the federal government and federal employee subscribers." *Id.* at 5.

Neither of these arguments require reconsideration of the rebate plan. MIEAA does not require a plan under D.C. Code § 31-3506(g) to be tax neutral for subscribers. Rather, MIEAA simply requires that the excess surplus be dedicated to community health reinvestment. Such reinvestment includes expenditures "that benefit current or future subscribers, including premium rate reductions." D.C. Code §31-3501(1A); *see also* D.C. Code §31-3506(g) (a plan may consist entirely of expenditures for the benefit of current subscribers of the corporation). The payment of rebates required by the August 2016 Order meets these requirements. Moreover, there is nothing in the definition of "community health reinvestment" or the criteria for a plan under by D.C. Code §31-3506(g) requiring the Commissioner to confer with OPM prior to ordering payments to subscribers. Instead, MIEAA explicitly authorizes a plan consisting of expenditures for the benefit of current subscribers, which is "any person entitled to benefits under the terms and conditions of a subscriber contract." D.C. Code §31-3501(8). Thus, federal employee subscribers are eligible to receive rebates under a MIEAA plan, while the federal government, which is not entitled to receive benefits under the FEP contract, is not eligible.

IV. ORDER

Based on the foregoing, the Commissioner hereby ORDERS:

The 2016 Petition for Reconsideration is DENIED in whole, including the request for reconsideration of the August 2016 Order and motion to stay further action in this proceeding.

Dated: February 20, 2018

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

[Seal]