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 Nos. 14-MIE-12 14-MIE-19

GROUP HOSPITALIZATION AND MEDICAL SERVICES, INC.'S RESPONSE TO MOTION OF D.C. APPLESEED CENTER FOR LAW AND JUSTICE, INC. TO EXPEDITE REMAND PROCEEDINGS

Group Hospitalization and Medical Services, Inc. ("GHMSI") files this response to the May 14, 2020 motion by D.C. Appleseed Center for Law and Justice, Inc. ("Appleseed"), in which Appleseed renews its prior request to expedite remand proceedings, following the decision of the District of Columbia Court of Appeals in *D.C. Appleseed Center for Law and Justice, Inc. v. District of Columbia Department of Insurance, Securities and Banking*, 214 A.3d 978 (D.C. 2019). Appleseed now also presents a new request that, before any proceedings are held, the Acting Commissioner "immediately order[] GHMSI to spend down the $51 million of excess surplus[.]" Appleseed Motion at 2. Appleseed's motion grossly misrepresents the holdings of the Court of Appeals and invites the Acting Commissioner to commit manifest reversible error.

The Court of Appeals' opinion makes plain that the existence, amount, and distribution method of any excess 2011 surplus is an *open question* to be resolved on remand *in coordination with Maryland and Virginia*. Appleseed seeks to shortcut this process and force its preferred outcome during a global pandemic and public health emergency to which the District, its partner jurisdictions, and GHMSI are deeply engaged in responding. Appleseed's motion should be denied, and the Commissioner should proceed in a manner that gives appropriate respect to the

statutory requirement that the jurisdictions must coordinate on this key issue that affects each of them.

I. The D.C. Court of Appeals Did Not Hold That a Minimum of $51 Million in Excess 2011 Surplus Is Attributable to the District of Columbia Under the MIEAA, and An Order Immediately Directing GHMSI to "Spend Down" That Amount Would Be Reversible Error.

There is no basis whatsoever for Appleseed's claim that the Acting Commissioner could order an immediate "spend-down" of $51 million. The Court of Appeals did not hold that there is any "minimum" excess 2011 GHMSI surplus that is attributable to the District of Columbia.[1] The Court of Appeals' opinion, in fact, is exactly to the contrary. The Court vacated the attribution analysis set forth in Acting Commissioner McPherson's order of December 30, 2014 (Order No. 14-MIE-12), and remanded for a revised analysis that takes into account objections raised by both GHMSI and Appleseed. As the Court wrote:

> GHMSI and Appleseed raise numerous other objections to the Commissioner's attribution methods and conclusions. We agree that a remand is necessary for the Commissioner to more fully address the issues raised by the parties.

D.C. Appleseed Center, 214 A.3d at 995.

The Court of Appeals could not have been more clear in stating that the result on remand may be that no additional community health reinvestment is warranted. First, in discussing possible apportionment analyses, the Court stated "[o]ne conceivable approach to analyzing what portion of GHMSI's excess surplus ***(if any)*** should be attributed to the District would be as follows," *D.C. Appleseed Center*, 214 A.3d at 995 (emphasis added), and second, in declining to

[1] Appleseed made the same inaccurate claims in a letter to the Acting Commissioner dated April 6, 2020, sent on behalf of itself and Councilmember Mary Cheh. Appleseed did not include GHMSI or its counsel in the list of ten parties to whom that letter was copied. GHMSI became aware of the letter and its misrepresentations of the Court of Appeals' opinion only upon Appleseed's reference to the letter in its remand "Brief" filed *sua sponte* on May 14, 2020.

address the form of any distribution of surplus, the Court explicitly noted that no distribution may be required at all:

> We are remanding the case for further proceedings, however, and therefore ***it is not at present clear whether the Commissioner will ultimately determine that it is appropriate to order community-health reinvestment and if so in what form***.

Id. at 996 (emphasis added). In asserting that the Acting Commissioner should order an immediate $51 million "spend down," Appleseed asks the Acting Commissioner to commit clear reversible error based on a bald misrepresentation of the actual Court of Appeals decision.[2] Appleseed's motion should be denied for that reason alone.

Appleseed's approach also shows no regard whatsoever for the statutory requirement that the Acting Commissioner must coordinate with Maryland and Virginia. The Court of Appeals held that the Acting Commissioner has an "obligation to coordinate" the remand proceedings on the record "with Maryland and Virginia with an eye towards agreement if that is feasible and permissible under applicable law." *D.C. Appleseed Center*, 214 A.3d at 987, 989. Appleseed urges the Acting Commissioner to steamroll Maryland and Virginia by ordering an "immediate" spend down of GHMSI's surplus, during a global pandemic when interstate coordination is more vital than ever and when statutes of Maryland and Virginia continue to prohibit surplus distributions by GHMSI without approval by the coordinate insurance authorities. Again, Appleseed asks the Commissioner to commit reversible error and ignore both the Court of Appeals decision and the statute.

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[2] In addition, Appleseed itself continues to contest the form of community health reinvestment that Commissioner Taylor ordered in the now-vacated Rebate Order. *D.C. Appleseed Center*, 214 A.3d at 996. Presumably, it is now dropping those objections, because otherwise the Acting Commissioner would need to address those issues along with the others in the remand proceedings.

II. Appleseed Inappropriately Attempts to Short-Circuit the Requirement that the District Coordinate with Maryland and Virginia.

The COVID-19 pandemic has caused a seismic interruption to business-as-usual in the Washington, D.C., metropolitan area. District of Columbia Mayor Muriel Bowser has extended her declaration of a public emergency and a public health emergency through at least June 8, 2020, and has suspended non-essential business activities and travel during that time. Understandably, the DISB, as well as the Insurance regulators in Maryland and Virginia, have been focused on responding to this public health emergency.

For GHMSI, the pandemic has required an unprecedented mobilization of resources to address subscriber and community needs. In this difficult period, CareFirst, including GHMSI, has offered assistance and relief to members, providers, and the community at large. These efforts include, but are not limited to, changes to benefits and enrollment periods, advance payments and other financial support for providers, assistance to members and providers for telemedicine, provision of key resources for transmission of accurate information regarding COVID-19, and direct monetary assistance to the community. Appendix A provides only a brief description of the myriad of efforts in which CareFirst has been engaged, and additional efforts and new initiatives continue to be developed.

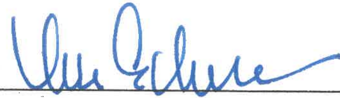
Global pandemics are catastrophic occurrences that require significant focus, while also seeking to limit the spread of the disease. It makes sense for the Acting Commissioner to defer action until, at the very least, Mayor Bowser has declared an end to the COVID-19 public health emergency. The Acting Commissioner's course of action then should begin with the MIEAA's requirement that the remand proceedings "shall be undertaken in coordination with the other jurisdictions in which [GHMSI] conducts business." D.C. Code § 31-3506(e). *See D.C. Appleseed Center*, 214 A.3d at 987 ("the obligation to coordinate is relevant to proceedings on remand").

This coordination requirement "obliges the Commissioner to try to work together with Maryland and Virginia with an eye towards agreement if that is feasible and permissible under applicable law." *Id.* at 989. The first step toward instituting a remand procedure and timetable should be collaboration with the Acting Commissioner's counterparts in Maryland and Virginia about those issues. From that point, in addition to the other points identified in the Court of Appeals' decision, the Commissioner and coordinating jurisdictions will need to review the impact of any distribution on GHMSI's current surplus, the community contributions GHMSI has continued to make since 2016, including current and ongoing contributions throughout the pandemic, and the potential impact of future COVID-19 surges, which are widely predicted by the scientific experts. The COVID-19 pandemic is a new and significant factor in these proceedings that will continue to affect GHMSI's operations and the community in the foreseeable future and that cannot be ignored on remand.

Given that this process has not yet begun, GHMSI will not at this time respond to the numerous inaccuracies, errors, and misrepresentations in Appleseed's remand Brief, which was filed *sua sponte*. Appleseed's positions, and the analyses of Mark Shaw on which they largely rely, are fundamentally flawed and require a detailed substantive rebuttal, and many of the issues for which remand has been ordered may necessitate further analysis by outside experts. Some issues, such as the jurisdictional apportionment of surplus, have never been addressed at a hearing, but were raised by Acting Commissioner McPherson only after the June 2014 hearing had ended. GHMSI requests that any remand procedure adopted by the Acting Commissioner in coordination with Maryland and Virginia afford GHMSI a period of at least 60 days in which to respond to the many claims made by Appleseed in its Brief, following suspension of the District of Columbia public health emergency. Further, given the complexity of the issues before the Acting

Commissioner on remand, GHMSI also submits that a coordinated hearing will be essential to appropriately address these issues.

Respectfully submitted,



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CERTIFICATE OF SERVICE

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APPENDIX A

CareFirst Support for Members, Providers and the Community

in the District of Columbia During the COVID-19 Pandemic

As a not-for-profit health services company, CareFirst BlueCross BlueShield (CareFirst) has been relentlessly committed to its mission during the COVID-19 crisis – to help the many constituencies that we serve in the District of Columbia and region-wide: our individual members and employer groups; our partners in the health care delivery system; our communities and community-based organizations; and our own employees.

Our members are at the forefront of our efforts, as they are facing unprecedented economic pressures, making difficult decisions to close businesses, furlough or lay off workers, or are employees taking sudden pay cuts – all amidst a global pandemic. Many of our members are local small business employers who are the backbone of the National Capital Region's economy.

In these extraordinary times, CareFirst has taken significant action to ensure that **we are immediately supporting our members and the employers who rely on us for health coverage in the District**. Some of these measures are now regulatory requirements by the Department of Insurance, Securities and Banking (DISB). These measures include:

- **Addressing member medical needs related to COVID-19**: We proactively made changes to our benefits during the emergency to reduce any barriers in getting our members the care they need. We waived cost sharing for any testing, visits, or treatment related to COVID-19, prior to DISB's requirement going into effect.
- **Ensuring access for our members to other needed care:**
  - Telehealth: We have enhanced coverage of virtual visits to ensure members continue to have access to urgent care and other needed care. We have waived cost sharing for all telehealth visits through CareFirst Video Visit platform and to in-network providers for medically appropriate services.
  - Telephone visits: We are temporarily reimbursing for telephonic consultations for primary care, OB/GYN, family medicine, pediatrics, and behavioral health, at no cost to our members.
  - Access to medications: We have also waived early medication refill limits and have worked with our pharmacy partners to provide free delivery of medications and assist with mailing prescriptions.
  - Prior authorization: We have waived prior authorizations for tests or treatments that are medically necessary and consistent with CDC guidance for members diagnosed with COVID-19.
- **Building and maintaining a web resource of information relating to COVID-19:** We have built a comprehensive web resource for our members, employers, providers, and communities so they are informed about federal and state resources available to them, as well as the most up-to-date benefit changes and other announcements from CareFirst.
- **Providing economic relief for those who need it**: In recognition of the extraordinary economic pressures our members and accounts may be facing, we have implemented a 60-day grace period for premiums. Members and accounts should reach out to their broker or directly to us for assistance should they need it. We are also in compliance with DISB's orders on suspension of terminations and repayment rules.

Consistent with our relentless focus on our members, CareFirst has also taken several other steps to **support our health care delivery system and the provider community in the National Capital Region**, including:

- **Implementing a new accelerated payment program:** We provided the opportunity for advance funds to hospitals and an array of independent providers experiencing financial strain due to the coronavirus pandemic.
- **Conducting outreach to CareFirst's most vulnerable and at-risk members to better prepare them to navigate the COVID-19 pandemic:** Members have been identified based on their clinical conditions, demographics, age, core target status, social vulnerability index score, and several other factors, across all lines of business and geographies. We identified over 160,000 members living in all 50 states with demonstrated health risks high enough to place them on the CareFirst outreach list. Our nurses are targeting a population of 62,000 for outbound calls. Support, education, assistance with community resources and securing appropriate supplies of medications have been key priorities. These efforts are ongoing.
- **Developed a data tool to support local health departments and hospitals:** To support local health departments and hospital resources in the identification and analysis of populations at higher risk to the effects of COVID-19, as well as ongoing surge readiness and management, we utilized health indicators and member data to develop an interactive web-based resource. This tool and accompanying resource support have been made available to every hospital and health department in the region, including the District.
- **Developed a volunteer program for licensed clinicians:** As hospitals are reaching capacity at an alarming rate and demand for medical professionals substantially increases across the region, we have implemented a paid volunteer program that offers licensed nurses and behavioral health clinicians working at CareFirst the opportunity to volunteer their services to support direct patient care.
- **Adjusted utilization management policies and practices to reduce administrative burdens on the healthcare system**: We relaxed our authorization requirements for hospital admissions, surgeries, and hospital transports during the emergency. In addition, we are honoring prior authorizations for elective surgeries for a period of up to 12 months, contingent on member eligibility.

We have taken action to continue to **support our local communities at large**, a core part of our not-for-profit mission, including:

- **Announcing a $2 million investment in nonprofit organizations** working on the front lines to provide relief for communities' health, social and economic needs that may arise during the COVID-19 pandemic. These funds will help close gaps in medical care access, minimize food insecurity and support the needs of populations disproportionately impacted during the crisis. We are currently reviewing grant applications for these funds.
- **Launched a Community Food Relief Program** in partnership with Aramark. Cafeteria staff at three CareFirst facilities will prepare and package cold, boxed meals for impacted organizations in the District.

- **Developed and implemented a new creative campaign in D.C.** to reinforce the importance of **staying home to save lives** to help our front line, essential workers. The campaign brings home the messaging that staying home saves the lives of family and friends.

Lastly, CareFirst has taken action to **significantly increase our associates' ability to work remotely and ensure their safety** if their jobs require them to be onsite, including:

- **Activated enhanced daily cleaning and an extensive sanitation process** at all CareFirst offices.
- **Initiated a $1.2 million remote work plan** and increased **remote capacity** so that 95% of CareFirst associates are now working from home.
- **Created and deployed a confidential COVID-19 Hotline** for CareFirst associates, to ensure the CareFirst workforce has the resources they need in the midst of the pandemic.

CareFirst has invested millions of dollars in the District of Columbia and throughout the region to fulfill our obligations to CareFirst members and support our stakeholders in D.C. and elsewhere throughout this crisis. We will continue to evaluate and implement ways that we can lend support to our members, healthcare delivery system, employees, and communities, as well as maintain our mission.