Group Hospitalization and Medical Services, Inc.

PRE-HEARING BRIEF

DISB Review of GHMSI Surplus Pursuant to the Medical Insurance Empowerment Act of 2008, D.C. Code §31-3501, *et seq.*

June 10, 2014

INTRODUCTION

Group Hospitalization and Medical Services, Inc. ("GHMSI" or the "Company") respectfully submits this pre-hearing brief, and the 18 exhibits that accompany it, to the District of Columbia Insurance Commissioner pursuant to 26-A DCMR § 4602.2.

In this proceeding, the Commissioner must determine whether "the portion of the surplus of [GHMSI] that is attributable to the District" is "excessive." D.C. Code § 31-3506(e). GHMSI's surplus cannot be excessive unless it is both "unreasonably large and inconsistent with the corporation's obligation" to "engage in community health reinvestment to the maximum feasible extent consistent with financial soundness and efficiency." *Id.* §§ 31-3506(e), 31-3505.01. GHMSI's surplus is not excessive for three key reasons.

First, GHMSI's surplus was not unreasonably large in 2011 and is not now. Since 2005, GHMSI's surplus has been reviewed nine times by professional actuaries retained by GHMSI or State regulators – twice by Rector & Associates ("Rector") on behalf of DISB, twice by actuaries retained by the Maryland Insurance Administration ("MIA"), and five times by Milliman, Inc. and the Lewin Group. Each review concluded that GHMSI's surplus was not excessive and was within or below actuarially sound ranges.

Rector here concludes for the second time that GHMSI's surplus is appropriate. Rector concludes that GHMSI should aim to hold surplus of 958% RBC-ACL and should be deemed to be at that appropriate level anytime its surplus is between 875% and 1,040% RBC-ACL. GHMSI satisfies that benchmark: Its surplus was 998% RBC-ACL at the end of 2011, 921% at the end of 2012, and 932% at the end of 2013. Since 2010, GHMSI's surplus has fallen by 166% RBC-ACL, largely due to Company-initiated rate moderation in 2011 and 2012.

While GHMSI agrees with Rector's conclusion that GHMSI's 2011 surplus was appropriate, GHMSI does not agree with Rector on every point. The GHMSI Board properly relied upon Milliman's 2011 surplus analysis when setting its target surplus range. Milliman found that GHMSI should hold surplus between 1,050% and 1,300% RBC-ACL, s*ee* **Exhibit 12** at 5 (*Development of Optimal Surplus Target Range*, June 29, 2011 ("Milliman 2011 Report")). GHMSI believes that Milliman's analysis should be adopted here, as it was in Maryland in 2011 and 2012 with only minor changes. However, these technical differences between Rector and Milliman have no practical effect at this time. Whether

under Rector's analysis or Milliman's (or the earlier analyses of Lewin, Invotex, or RSM McGladrey ("McGladrey")), GHMSI's surplus was not unreasonably large in 2011 and is not unreasonably large now.

Second, GHMSI's surplus is not "inconsistent with" the obligation to "engage in community health reinvestment to the maximum feasible extent consistent with financial soundness and efficiency." D.C. Code §§ 31-3506(e), 31-3505.01. Under the statute, GHMSI moderates rates and otherwise contributes to the community to the extent it may do so while remaining financially sound. GHMSI has met this requirement, as Rector recognized. *See* Rector Report at 12. GHMSI's community reinvestment efforts include rate reduction and moderation in 2011 and 2012, moderating rate increases in 2014 in the hopes of reducing "sticker shock" from the new Affordable Care Act ("ACA") products, and targeted giving that provides tens of millions of dollars a year to the communities served by GHMSI. These rate reductions and moderations have produced a razor-thin average underwriting margin of just 0.66% over the past five years, including a negative margin the last two years in a row. As Rector found, GHMSI has provided community reinvestment to the maximum feasible extent consistent with financial soundness and efficiency, because GHMSI has done so while retaining the level of surplus required to ensure that GHMSI can uphold its future obligations. It would be neither "sound" nor "efficient" to force GHMSI's surplus below the range that responsible actuarial analysis finds to be necessary.

Third, the ACA has dramatically altered the markets in which GHMSI must operate and imposes significant new risks on the Company. While GHMSI has long supported healthcare reform, it is difficult to exaggerate the degree of risk—and downward pressure on surplus—imposed by the ACA. As discussed below and more fully at **Exhibit 2** (*Report by Group Hospitalization and Medical Services, Inc. (GHMSI) on the Impact of the Affordable Care Act on GHMSI's Surplus*, June 10, 2014 ("ACA Impacts Report")), the new ACA market rules are driving coverage costs up dramatically in the individual and small-group markets while making it difficult for carriers like GHMSI to recover those costs fully through rates. Even when rates are sufficient to cover increased medical costs, (i) the ACA limits the extent to which premiums can exceed those costs – thereby putting a cap on GHMSI's ability to rebuild surplus once lost, (ii) the ACA is imposing tens of millions of dollars in annual implementation and compliance costs, all of which will reduce surplus or hinder GHMSI's ability to rebuild surplus, and (iii) GHMSI's enrollment is rising and is likely to rise further – which would actually require a *larger* surplus in dollar terms just to keep a stable

RBC-ACL. In this environment, GHMSI has significant concerns whether surplus can be maintained within the target range.

For all these reasons, the Commissioner should conclude that GHMSI's surplus is not excessive, a conclusion fully supported by the surplus models of both Rector and Milliman. GHMSI also respectfully requests that the Commissioner confer with Maryland, as required by D.C. law, before setting a target surplus range. *See* D.C. Code § 31-3506(e) (surplus review must be done "in coordination with the other jurisdictions in which the corporation conducts business"). Maryland has adopted a target range for GHMSI that is similar to that developed by Milliman, and GHMSI asks DISB to ensure that GHMSI is not subjected to inconsistent regulatory direction.

BACKGROUND

A. Surplus In General

"Surplus" is simply the extent to which an insurer's assets exceed its current liabilities, utilizing a formula developed by the National Association of Insurance Commissioners. *See* D.C. Code § 31-2002. An insurance company must retain surplus in order to protect against future risks and contingencies that could impair the company's ability to service its policyholders. These risks include:

- Future premium rates that are inadequate to recover costs, and fluctuations in premium rates due to market changes;
- Fluctuations in the financial markets and varying investment returns;
- Unforeseen catastrophic events such as epidemics and natural disasters;
- Business development and growth risks;
- Cost of capital and credit risks;
- Competitive changes in the health insurance market requiring new and/or different products, capabilities and services or require unexpected expenses;
- Performance guarantees, especially from large, self-insured groups; and
- Regulatory and legal changes that reduce margins or require unexpected financial outlays.

Surplus is "central to the viability and sound operation of any insuring organization" because it "ensure[s] that the promises and commitments" an insurer makes to its subscribers "can continue to be met," and provides the capital "to develop new products" and "build infrastructure" over time. **Exhibit 12** (Milliman 2011 Report) at 3.

Given the importance of surplus for customer protection, health insurance regulators typically have focused on making sure insurers hold *enough* surplus. *See* Milliman 2008 Report at 22;[1] D.C. Code § 31-2002(f) (noting that it is "desirable" that insurance companies hold surplus that safely exceeds minimum requirements). This focus makes sense since adequate surplus is needed to avoid the worst-case scenario of insurer insolvency. When a health insurer goes bankrupt, "the consequences are dire. Real people suffer; subscribers, doctors, hospital employees, business owners, and others all lose money, coverage, or access to treatment." Testimony of Robert H. Dobson (Sept. 10, 2009). This is not a mere theoretical risk—health insurers become insolvent every year.[2]

B. RBC-ACL Minimum Standards

A carrier's surplus level is monitored by reviewing the carrier's multiple of its "authorized control level risk-based capital" ("RBC-ACL"). RBC-ACL was developed as "a method of measuring the minimum amount of capital appropriate for [an insurer] to support its overall business operations in consideration of its size and risk profile." NAIC, *Risk-Based Capital* (July 31, 2013) ("*Risk-Based Capital*").

Regulators utilize minimum RBC-ACL thresholds as red flags to spot insurers in distress. Under an NAIC benchmark since adopted as D.C. law, a carrier is at significant risk of imminent insolvency when its RBC-ACL is below 200 percent or falls below 250 percent and shows "a negative trend." *See* NAIC, *Risk-Based Capital General Overview* (2009)[3]; D.C. Code §§ 31-2003(a)(1), 31-2001. Once that threshold is breached, a carrier must take approved corrective actions, and faces severe regulatory consequences if its RBC-ACL keeps dropping. *Id.* § 31-2003(b); §§ 31-2004-2008.

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[1] *Available at* http://disb.dc.gov/sites/default/files/dc/sites/disb/publication/attachments/miliman _report.pdf.

[2] For example, Sound Shore Health System, Inc. in New York and Universal Health Care Group of Florida filed for bankruptcy in 2013. *See* T. Hals, *NY HealthCare Company Seeks Bankruptcy* (May 30, 2013), a*vailable at* http://www.reuters.com/article/2013/05/30/healthcare-soundshore-bankruptcy-idUSL2N0EB1NJ201 30530; M. Manning, *Universal Health Care Files for Bankruptcy as State Seeks Takeover*, TAMPA BAY BUSINESS JOURNAL (Feb. 6, 2013), *available at* http://www.bizjournals.com/tampa bay/news/2013/02/ 06/universal-health-care-files-for.html.

[3] *Available at* http://www.naic.org/documents/committees_e_capad_RBCoverview.pdf.

Carriers licensed by the Blue Cross and Blue Shield Association ("BCBSA") face additional restrictions. BCBSA deems 375% RBC-ACL to be an "Early Warning Monitoring" threshold; if its insurers fall to that level, they are subject to "intensive monitoring or other sanctions," *see* Invotex 2009 Report at 44,[4] and likely market-share losses. 200% RBC-ACL is the "Licensure Minimum." *Id.* at 32. If GHMSI's surplus were to fall below that number, the BCBSA "would commence actions to terminate that company's license to use the Blue Brands." *Id.* Rector notes in its Report the "severe and potentially catastrophic consequences" that would follow, including GHMSI members' loss of access to BCBSA networks across the country, GHMSI's loss of hundreds of thousands of members participating in the Federal Employee Health Benefits Program, and loss of GHMSI's longstanding trade names and brand identity. Rector Report at 16-17.

C. GHMSI And Its Surplus

GHMSI Background. GHMSI is an independent BCBSA licensee that operates exclusively in the District of Columbia, Maryland, and portions of Northern Virginia. *See* CareFirst, Service Areas: GHMSI.[5] GHMSI's core mission is to provide health benefits to its nearly 1.2 million members, by offering a broad array of quality, innovative insurance plans and administrative services that are affordable and accessible. As mandated in its Congressional charter, *see* Pub. L. 103-127; 106 Stat. 1336 (1993), GHMSI's highest priority is to serve its subscribers.

GHMSI is affiliated with CareFirst of Maryland, Inc. ("CFMI"), a Maryland not-for-profit health service plan, and their holding company, CareFirst, Inc. GHMSI and CFMI jointly own CareFirst BlueChoice, Inc. ("BlueChoice"), a health maintenance organization ("HMO") that serves more than 550,000 members in DC, Maryland, and Virginia.[6] Together, the CareFirst family constitutes the largest health care insurer in the Mid-Atlantic. *Id.*

BlueChoice's surplus is a part of the consolidated surplus of CFMI and GHMSI. The surplus held by GHMSI must meet the surplus needs of not only GHMSI, but also of BlueChoice in an amount proportional to its 49.999% ownership share.

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[4] *Available at* https://www.mdinsurance.state.md.us/sa/docs/documents/consumer/invotexreport tomia-10-30-09final.pdf.

[5] *Available at* http://www.carefirst.com/company/html/GroupHospitalizationMedicalServices.html.

[6] *See* CareFirst BlueChoice, Inc. Annual Statement for the Year 2013.

While GHMSI's surplus may seem like a large number in dollar terms, GHMSI's expenses and liabilities are even larger. For example, in 2013 GHMSI paid $10.3 million in claims *every day*, including GHMSI's share of claims expenses incurred by BlueChoice. GHMSI's entire 2013 surplus equals only three months of benefit payments. Including its share of BlueChoice, GHMSI paid out more than four times its surplus in benefit payments during the course of 2013, making more than $3.7 billion in benefit payments. If GHMSI's surplus were only 200% RBC-ACL, the level at which regulatory action would begin against the company, it would be equal to less than twenty days of claim payments.

GHMSI's 2011 surplus was equivalent to just over three months of claims expense. Between 2011 and 2013, GHMSI's surplus dropped both in actual dollar terms (by $29 million) and as a percentage of RBC-ACL (from 998% to 932%), which amounts to just under three months of claims expense.

GHMSI's Surplus Constraints. Going forward, GHMSI faces serious limitations on its ability to build surplus, beyond those faced by many other carriers. The Company operates in one of the most competitive health care marketplaces in the nation. Virtually all its competitors are multi-product line, multi-regional, for-profit insurers able to issue stock or debt and to draw upon dividends and distributions from affiliates. As Milliman explained in its 2008 report on GHMSI's surplus: "The capital resources of these larger competitors tend to be enormous. Such resources enable them to invest in new, leading-edge technologies and to aggressively build and contract with provider networks. It gives them negotiating clout, risk-spreading capacity and funding for market acquisition. A large scale of operations also enables them to spread overhead costs more effectively[.]" Milliman 2008 Report at 13.[7]

As a non-profit health plan, GHMSI can build and hold surplus from only a single source: the difference between what it collects in premiums and what it spends to conduct its business. *See* **Exhibit 7** (*Report to the D.C. Department of Insurance, Securities and Banking Regarding GHMSI's Surplus at Year-End 2012*, July 1, 2013 ("DISB 2013 Report")) at 4. GHMSI's underwriting gains (the difference between premiums and total member claims and administrative expense) over the past five years have been historically low even including gains attributable to CareFirst BlueChoice: 0.31% in 2009, 3.85% in 2010, 0.77% in 2011, -1.16% in 2012, and -0.21% in 2013. *See* **Exhibit 11** (*Group Hospitalization and*

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[7] *Available at* http://disb.dc.gov/sites/default/files/dc/sites/disb/publication/attachments/miliman_ report.pdf

Medical Services (GHMSI) Underwriting Margins From 2009 through 2013, Including Proportionate Experience of BlueChoice). The average underwriting margin for GHMSI over this five-year period, even including its share of BlueChoice, was just 0.66%,[8] far below the underwriting margins of even other Blue Cross and Blue Shield Plans. *See* D. Donahue, *Profit Margins Converge for Top Health Plans*[9]; *Industry Browser – Health Care Plans*.[10] In fact, GHMSI's margin exceeded 1% only once during this period, in 2010 – after which time, GHMSI engaged in rate moderation and incurred underwriting losses in 2011, 2012, and 2013. Moreover, GHMSI's experience through the first quarter of 2014 supports the Company's ongoing concerns regarding rate adequacy. As of March 31, 2014, GHMSI had a consolidated first-quarter underwriting loss of 1.5% ($12.6 million), with an underwriting loss of 12.6% ($5.7 million) in the individual under-65 health insurance market. And yet GHMSI's small average margin, along with typically modest investment income from GHMSI's conservative investment of surplus funds, is the Company's only source of capital.

The ACA's new market rules only exacerbate these problems. The ACA's effects are discussed in detail below at pages 16-19, and in the ACA Impacts Report, *see* **Exhibit 2**. Among other things, the ACA makes it more difficult to predict the rates that GHMSI will need and makes it less likely that GHMSI's rates will be adequate, while the ACA's medical loss ratio, or "MLR," rules make it nearly impossible for companies like GHMSI to quickly rebuild surplus once it begins to drop. The ACA and its accompanying regulations make it very easy for carriers like GHMSI to quickly *lose* substantial sums on underwriting—thus cutting into surplus—and very difficult for such carriers to rebuild that lost surplus.

GHMSI Engages in Extensive Community Health Reinvestment. Notwithstanding such limitations on its ability to maintain surplus, GHMSI has in recent years engaged in aggressive rate moderation to benefit its subscribers. At year-end 2010—the only year in the last five when GHMSI's underwriting margin exceeded 1%—GHMSI's surplus stood at 1098% RBC-ACL. In 2011 and 2012, GHMSI reacted by reducing premiums to bring surpluses down to the bottom of target levels. *See* **Exhibit 2** (ACA Impacts Report). As a result, GHMSI's surplus fell by 100 points in 2011, to 998%, and another 66 basis points by the end of 2013, to 932%. *See id.* Moreover, for 2014, GHMSI sought rate increases lower

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[8] GHMSI, by itself, suffered underwriting losses over this period: Its average underwriting margin was negative 0.06% over the past five years if BlueChoice's experience is not included.

[9] *Available at* http://www.markfarrah.com/healthcare-business-strategy/Profit-Margins-Converge-for-Top-Health-Plans.aspx.

[10] *Available at* https://biz.yahoo.com/p/522qpmd.html.

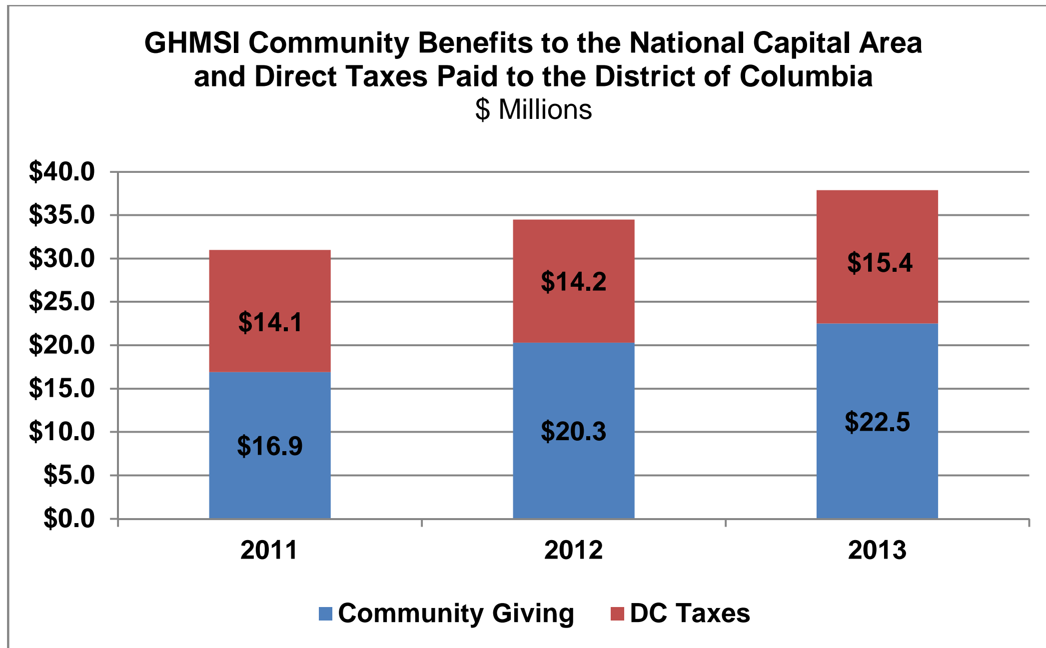
than some actuarial models projected would be necessary in order to cover the medical costs for the new guaranteed issue products. In DC, for example, GHMSI sought an average rate increase of 35% for its 2014 individual and small group market rates, even though some actuarial models suggested that an average increase of 60% or more would be needed to break even in 2014. *See id*.

GHMSI also gives tens of millions to the community on an annual basis to help benefit its subscribers. *See* **Exhibit 1** (*Report by Group Hospitalization and Medical Services, Inc. (GHMSI) on 2013 Community Giving*, June 10, 2014 ("GHMSI 2013 Community Giving Report")). Over the past five years, CareFirst (referring collectively to CFMI and GHMSI) has contributed several hundred million dollars to a wide variety of initiatives dedicated to improving health-care access for the communities they serve. The CareFirst Commitment program focuses on catalytic giving, designed to stimulate long-term, systemic improvements in the health care delivery system. GHMSI also contributes substantially to organizations that provide direct health care services to vulnerable D.C. populations that otherwise would have little access to care. *See id.* at 1-4. As only a few examples:

- Since 2006, CareFirst has committed nearly $11 million to efforts to improve maternal and child health, including grants to the D.C. Department of Health for home visiting services, a grant to the D.C. Vulnerable Neighborhood breastfeeding program, and two grants to the Latin American Youth Parents program. *Id.* at 3.
- Since 2006, CareFirst has invested $3.8 million in efforts to reduce childhood obesity, including $1 million to the YMCA of Metropolitan Washington. *Id.*
- Since 2006, CareFirst has invested more than $19 million in safety net health clinic programs, in efforts to provide the medically underserved with alternatives to hospital emergency rooms. *Id.* at 4.

The 2013 Community Giving Report provides many such concrete examples of GHMSI's commitment to the communities that it serves. *See id.*

The Company's generosity is well recognized; the *Washington Business Journal*, for example, recognized GHMSI as one of the leading corporate contributors in the National Capital Area**.** As can be seen in the chart below, GHMSI's community giving has risen steadily in recent years, totaling an estimated $59.7 million for the years 2011-2013. That includes $22.5 million in 2013 alone. **Exhibit 1**(GHMSI 2013 Community Giving Report) at 2**.**



Moreover, although it is a not-for-profit company, GHMSI is not exempt from taxes. It paid nearly $73.4 million in corporate income, premium, personal and real property taxes to the District between 2008-2012, over and above its rate moderation and charitable contributions to the community. *See* **Exhibit 7**(DISB 2013 Report) at 8.

GHMSI Carefully Monitors Its Surplus. GHMSI works to strike the right balance with its surplus, holding only a prudent amount that accounts for all of the risks faced by the Company. GHMSI's Board of Trustees has adopted a formal surplus policy, under which the Company strives to hold surplus in an optimal range and increases or decreases premium rates as needed to keep surplus in that range.

GHMSI has long engaged independent actuarial experts to advise the Board on appropriate surplus ranges. GHMSI generally evaluates its surplus on a three-year horizon to accommodate natural fluctuations in the business.

Since 2005, GHMSI has initiated six full-scale independent studies by actuarial consultants Milliman and Lewin, along with interim updates in 2012 and 2013. The most recent full reviews were conducted in mid-2011 and address the same time period as the latest Rector report. Milliman and Lewin made largely overlapping recommendations for appropriate ranges for the years 2011-2014—1,050% to 1,300% RBC-ACL from Milliman, and 1,000% to 1,550% RBC-ACL from Lewin. *See* **Exhibit 12** (Milliman 2011 Report); **Exhibit 16** (*Recommended Surplus Range for CFMI: Approach and Considerations for*

Determining the Appropriate Range of Surplus in 2011, June 24, 2011 ("Lewin 2011 Report")). The CareFirst, Inc. and GHMSI Boards adopted the lower recommended figures from the top and bottom of the range, producing a target range for GHMSI of 1,000% to 1,300% RBC-ACL. **Exhibit 6** (*Letter to Commissioner Therese Goldsmith from GHMSI CEO Chester Burrell*, July 1, 2013) at 1. GHMSI has continued to use this target range in 2012 and 2013, and has sought updates from Milliman where appropriate.

These analyses have incorporated part, but not all, of the increased risk associated with the ACA. Milliman's 2011 report—which Rector discusses in detail—recommends a 1,050-to-1,300% surplus range after "taking into account the impact of federal health care reforms currently in effect." *See* **Exhibit 12** (Milliman 2011 Report) at 5.[11] Milliman did not attempt to adjust GHMSI's target surplus range at that time to account for ACA reforms that had *not* yet been implemented (but which have since taken effect), but Milliman estimated that those ACA reforms could drive GHMSI's surplus target up another 100 to 150 points. *Id.*[12]

D. GHMSI's Surplus Has Also Been Subject To Extensive External Scrutiny

To GHMSI's knowledge, its surplus has been subjected to more external scrutiny than that of any other health insurance company in the country. Each time the appropriate regulator concluded that GHMSI's surplus was appropriate:

- In 2009, the Commissioner reviewed GHMSI's 2008 surplus and concluded that it was "neither unreasonably large nor excessive" after hearing from no less than five actuaries and other analysts. *In re Surplus Review and Determination Regarding GHMSI* at 12, Order No. 09-MIE-007 (Oct. 29, 2010).[13] Both Rector

[11] Those reforms included "(a) the new [MLR] standards . . . requiring the payment of rebates if minimum loss ratio levels are not met, (b) the increased regulatory review of premium rate increases, and (c) the new benefit coverage requirements that became effective in 2010 as a result of the passage of the [ACA]." *Id.*

[12] Milliman has since conducted supplemental updates, most recently in the summer of 2013. Its 2013 review noted that "a great deal of uncertainty remains" regarding the ACA's implementation. **Exhibit 13** (*Group Hospital and Medical Services, Inc.: Review and Consideration of Optimal Surplus Target Range*, June 28, 2013 ("Milliman 2013 Update")) at 6. That continued uncertainty "entails financial risk to the Company, and therefore tends to indicate the need for higher levels of surplus than would otherwise be considered prudent." *Id.* "In particular," Milliman noted, "the potential for significant membership growth as the individual mandate takes effect in 2014 would call for conservatism in selecting a surplus target range, given the direct correlation between growth in membership and an increase in the RBC-ACL value." *Id.* In other words, more members means GHMSI must carry more surplus to remain at the same RBC-ACL percentage.

[13] The D.C. Court of Appeals vacated that decision and remanded for further proceedings, but did not conclude that the Commissioner's ultimate determination was incorrect. Rather, the Court asked the Commissioner to look in

and Milliman participated in those proceedings, and both found that GHMSI's surplus fell within an appropriate range.

- The MIA reviewed the Company's surplus in 2009 and 2011, after retaining its own actuarial consultant each time. Both reviews determined the Company's surplus was not unreasonably large or otherwise inappropriate. *See* **Exhibit 14** (*In re: Targeted Surplus Ranges for CareFirst of Maryland, Inc. and Group Hospitalization And Medical Services, Inc.*, Case No. MIA-2011-05-040 (May 26, 2011) ("MIA 2011 Consent Order")); **Exhibit 15** (*In re: Targeted Surplus Ranges for CareFirst of Maryland, Inc. and Group Hospitalization And Medical Services, Inc.*, Case No. MIA-212-09-006 (Sept. 14, 2012) ("MIA 2012 Consent Order")).
- In 2011, the MIA formally adopted the surplus range of 1,000% to 1,300% RBC-ACL as "[t]he approved target surplus range for GHMSI." **Exhibit 15** (MIA 2012 Consent Order) at 7.

DISCUSSION

GHMSI's surplus is plainly not "excessive" under D.C. Code § 31-3506(e). GHMSI's Board has set reasonable surplus targets for the Company, based on expert actuarial recommendations, and the Company has kept its surplus at or slightly below those ranges. As *every* regulator and actuarial expert to have studied the issue has concluded, the resulting surplus is neither unreasonably large nor inconsistent with the community health reinvestment obligation. That conclusion is strongly underscored by the dramatic downward pressures the ACA is placing on the Company's surplus.

I. GHMSI'S SURPLUS IS NOT EXCESSIVE

A. The MIEAA's Requirements

Under the Medical Insurance Empowerment Amendment Act of 2008 ("MIEAA"), the Commissioner periodically must determine whether GHMSI's surplus is "excessive." D.C. Code §§ 31-3501 *et seq.* DC Code § 31-3506(e) provides that surplus can only be considered excessive if it is both "unreasonably large" and "inconsistent with the corporation's obligation under § 31-3505.01," which requires GHMSI to "engage in community health reinvestment to the maximum feasible extent consistent with financial

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tandem at whether surplus is unreasonably large and whether it is inconsistent with the community-health-reinvestment obligation, and to articulate the Commissioner's reasoning in greater detail. *D.C. Appleseed Ctr. For Law & Justice, Inc.* v. *DISB*, 54 A.3d 1188, 1212 (D.C. 2012).

soundness and efficiency." "Community health reinvestment" is defined to mean "expenditures that promote and safeguard the public health or that benefit current or future subscribers, *including premium rate reductions*." *Id.* § 31-3501(1A) (emphasis added).

In making this determination, "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 [District's] open enrollment program[.]" *Id.* § 31-3506(f). If the Commissioner were to find that the portion of the surplus attributable to the District of Columbia were excessive, the Commissioner would order GHMSI to "submit a plan for dedication of the excess to community health reinvestment in a fair and equitable manner." *Id.* § 31-3506(g)(1). By statute, this plan "may consist entirely of expenditures for the benefit of current subscribers of the corporation." *Id.* § 31-3506(g)(2).[14]

In reviewing the Commissioner's decision regarding GHMSI's 2008 surplus, the D.C. Court of Appeals concluded that "the two determinations required by § 31-3506(e)(2)—whether GHMSI's surplus is 'unreasonably large' and whether the surplus is 'inconsistent' with GHMSI's community health reinvestment obligations under § 31-3505.01—must be made in tandem." *D.C. Appleseed*, 54 A.3d at 1215. The Court, however, emphasized that the Commissioner must exercise his "reasonable discretion" in determining how to implement that guidance. *Id.* at 1212. Rector, in its analysis and at the Commissioner's direction, explicitly considers these instructions from the Court of Appeals.

B. GHMSI's Surplus Is Not Unreasonably Large

GHMSI's surplus is not "unreasonably large" because it is at or slightly below the target range adopted by GHMSI's Board, based on the advice of independent, respected actuarial experts, and it is at the target determined by Rector, the Commissioner's own expert.

[14] In these proceedings, the Commissioner has begun by examining GHMSI's surplus as a whole, rather than only that portion that is attributed to the District of Columbia. GHMSI agrees with Rector that its surplus as a whole is neither unreasonably large nor inconsistent with GHMSI's community reinvestment obligations, and if the Commissioner adopts Rector's analysis, it will be unnecessary to apportion GHMSI's surplus between Maryland, the District, and Virginia. Should the Commissioner determine that GHMSI's surplus as a whole were excessive, the statute requires the Commissioner to apportion that surplus and apply the statute only to the District's portion. It is GHMSI's understanding that it is not necessary to address that issue at this time, and GHMSI does not waive its right to be heard on that issue should it become necessary.

Milliman concluded that the Company's target surplus range should be 1,050%-1,300% RBC-ACL. *See supra* at 3. The GHMSI Board properly relied upon this analysis in setting its target surplus ranges.

In reviewing GHMSI's 2011 surplus, the Maryland Insurance Commissioner agreed with Milliman and the GHMSI Board, and adopted 1,000%-1,300% RBC-ACL as "[t]he approved target surplus range for GHMSI." **Exhibit 15** (MIA 2012 Consent Order) at 7. The Maryland Commissioner concluded that the Company's surplus was not excessive, unreasonably large or otherwise inappropriate, based upon an actuarial review by McGladrey. *Id.*

Rector, the District's own consultant, has now conducted its own analysis and again concluded that GHMSI's surplus is not unreasonably large. Rector, like Milliman, calculated the level of surplus that GHMSI would need to remain above 200% RBC-ACL with 98% confidence. Rector Report at 14.[15] As discussed above, falling below 200% RBC-ACL would be catastrophic for GHMSI, triggering intensive monitoring and corrective action by state regulators and loss of GHMSI's trademarks and BCBSA license. *Id.* at 15. To stay above this threshold, Rector determined that GHMSI "should have a surplus target of 958% RBC." *Id.* at 12. Rector recognized, however, that a specific point target is impossible to manage—the amount of surplus available to GHMSI depends upon claim costs and other unpredictable factors and GHMSI at best can try to stay within a reasonable range on either side of its target. Rector concluded that "if GHMSI's surplus stays within the 875%-1,040% RBC range, it is the functional equivalent of GHMSI being at the 958% RBC target for purposes of the MIEAA standards." *Id.* at 12-13.

GHMSI's surplus fully meets the standards defined by Rector. GHMSI's surplus at year-end 2011—the time frame technically under review in this proceeding—was 998% RBC-ACL. *See* **Exhibit 1** (GHMSI 2013 Community Giving Report) at 1. The Company's surplus has dropped further since then, falling to 921% RBC-ACL at year-end 2012 and holding at 932% RBC-ACL at year-end 2013. *See id.* All of those figures fall within the range Rector derived, and accordingly all are "the functional equivalent of GHMSI being at the 958% RBC target" developed by Rector. Rector Report at 13.

[15] DC Appleseed also conceded in preliminary discussions in these proceedings that a 98% confidence level that GHMSI would exceed 200% RBC-ACL was an appropriate standard.

GHMSI submits that, like Maryland, the Commissioner should use the range developed by Milliman and adopted by the GHMSI Board in concluding that GHMSI's surplus is not unreasonably large.[16] Even under Rector's approach, however, GHMSI's surplus is at the appropriate level. It is not unreasonably large under either analysis.

C. GHMSI's Surplus Is Consistent With Its Community-Health-Reinvestment Obligation.

GHMSI's community-health-reinvestment obligation is to moderate rates, or otherwise invest in the community, to the maximum feasible extent "*without undermining* GHMSI's 'financial soundness and efficiency.' " *D.C. Appleseed*, 54 A.3d at 1214 (emphasis added) (quoting MIEAA). When GHMSI engages in community health reinvestment in a manner that keeps its surplus at an actuarially-determined reasonable level, GHMSI fully meets this obligation.

1. GHMSI Must Remain Financially Sound, Now And In The Future. As made clear in GHMSI's corporate charter, adopted by Congress, it is GHMSI's primary duty to provide health insurance to its subscribers and to meet the promises that it has made to them both now and in the future. That is why the MIEAA requires GHMSI to engage in community health reinvestment *only* where it is "consistent with financial soundness and efficiency." D.C. Code §§ 31-3501.01 (emphasis added). "Soundness" in this context means "financial security: solvency[.]" *Webster's Third New International Dictionary (Unabridged)* 2177 (2002). A "sound" entity is one that is securely in a position to "cover future liabilities and expenses for all claims." *See, e.g.*, *Barber* v. *Ritter*, 196 P.3d 238, 243 (Colo. 2008); *Board of Administration* v. *Wilson*, 52 Cal. App. 4th 1109, 1134-35 (1997). "Soundness" does not refer only to a company's present condition, but also to the minimization of future risks: A practice is ***un***sound if it creates an "abnormal risk of loss," *Matter of Seidman*, 37 F.3d 911, 927, 932 (3d Cir. 1994), or a "reasonably foreseeable undue risk to the institution," *Landry* v. *F.D.I.C.*, 204 F.3d 1125, 1138 (D.C. Cir. 2000).

GHMSI has been able to moderate its rates in recent years, including both reduced premium increases and some outright premium reductions, precisely because it has maintained an appropriate surplus—one that ensures it can cover its obligations and avoids undue risk to subscribers. Indeed, GHMSI provided approximately $27 million in

[16] Rector's analysis was less conservative than Milliman's in several respects. *See* **Exhibit 3** (*Pre-Filed Testimony of Phyllis Doran, F.S.A., M.A.A.A., June 10, 2014*).

rate moderation in 2011 and 2012, and its surplus fell by 166% RBC-ACL between year-end 2010 and year-end 2013. For 2014, GHMSI filed rates much lower than suggested by some actuarial models, precisely to minimize the "sticker shock" that members would experience from the new guaranteed issue ACA products. *See supra* at 13. The Company's rate moderation and giving have produced a surplus that, both in 2011 and now, has been within or below the actuarially-determined appropriate ranges. *Id*. *Further* rate moderation or other community reinvestment would be likely to drive the surplus below, or further below, the target ranges, thereby impairing the Company's ability to respond to the financial risks quantified by Rector and Milliman in their reports. Such an approach would not be "sound" because it would create a "reasonably foreseeable undue risk to the institution," *Landry*, 204 F.3d at 1138, by increasing the risk that the Company's surplus would drop to "potentially catastrophic" levels. Rector Report at 15. By moderating rates without driving its surplus dangerously low, and by otherwise engaging in significant community giving, GHMSI has maximized its community health reinvestment, as defined by the MIEAA.

2. Efficiency. "Efficient" means "[m]arked by qualities, characteristics, or equipment that facilitate the serving of a purpose or the performance of a task in the best possible manner . . . effective to an end." *Webster's Third New International Dictionary (Unabridged)* 725. Courts have explained that to be "efficient," a process cannot consider one factor alone—for example, cost—but must "incorporate the full range of possible externalities[.]" *Cross-Sound Ferry Servs., Inc.* v. *I.C.C.*, 934 F.2d 327, 345 (D.C. Cir. 1991). In the context of a company like GHMSI, those externalities could include (i) forcing inadequately-protected consumers to shoulder increased risk, (ii) leaving the Company with insufficient funds to update its operating systems and undertake the myriad other capital improvements required to provide subscribers with top-quality service, and (iii) setting surplus at a level such that GHMSI repeatedly may be required to seek large rate increases to rebuild surplus in order to avoid dropping to dangerous RBC-ACL levels.

GHMSI has moderated its rates "to the maximum feasible extent consistent with . . . efficiency" because it has kept surplus appropriately low without going *too* low. As explained in the ACA Impacts Report, **Exhibit 2**, if GHMSI's surplus drops below the target range, it will be nearly impossible for the Company to bring the surplus back up under the ACA's rules. Operating with insufficient surplus under a too-low surplus threshold will spawn problematic "externalities" like the ones just mentioned. *Cross-Sound Ferry*, 934 F.2d at 345. For example, if the surplus threshold is too low or the target surplus range is

too narrow, GHMSI could be required to give back funds one year, when surplus rises above a low threshold; then to seek a large rate increase in the next to avoid falling into regulatory danger; followed by more rate moderation the year after that, if surplus rises too much. Whipsawing consumers between rate increases and rate moderation in alternating years is a classic "inefficiency" that the MIEAA explicitly seeks to avoid. Such inefficiencies are avoided by maintaining an actuarially sound level of surplus and a broad enough target range to account for normal market variations.

Similarly, if GHMSI has insufficient surplus available to modernize its systems or comply with new legal mandates, it cannot "efficiently" provide health insurance to its members. When the Company fails to hold enough funds to accomplish such tasks, its subscribers end up paying the price sooner or later. That would be both inappropriate and inefficient.[17]

3. Rector's Conclusion. Rector reached the same conclusion with regard to community health reinvestment. It explained that its 958% RBC-ACL benchmark is the RBC level "that GHMSI should strive not to fall below *in order not to become financially unsound.*" Rector Report at 12 (emphasis added). And it explained that "GHMSI has engaged in community health reinvestment to the maximum feasible extent consistent with financial soundness and efficiency" when GHMSI engages in giving in a manner such that its surplus does not exceed the benchmark. *Id.* GHMSI agrees. GHMSI's surplus does not exceed the benchmarks set by either Milliman or Rector, and its surplus is not inconsistent with the MIEAA's community-health-reinvestment obligation.

II. RISKS IMPOSED BY THE ACA UNDERSCORE THE CONCLUSION THAT GHMSI'S SURPLUS IS NOT EXCESSIVE.

For all of the reasons stated above, GHMSI's 2011 surplus was not excessive because it was neither unreasonably large nor inconsistent with GHMSI's community reinvestment obligation. Here in 2014, however, no analysis of GHMSI's surplus can be complete without taking full account of the dramatic market changes faced by the Company, which will act to drive surplus down and prevent rebuilding of surplus once lost. GHMSI encourages the

[17] The D.C. Council itself recognized the need to avoid such inefficiencies when it enacted the MIEAA. The Council committee report emphasized that "[t]he Mayor . . . must take into account the need to keep the company financially sound and efficient. The intent of the legislation is that the company maintain reserves adequate to pay its subscribers' claims, fund capital improvements, meet contingencies, and remain a healthy participant in the market." Report, D.C. Council Comm. on Public Servs. & Consumer Affairs, *Bill 17-934, the "Medical Insurance Empowerment Amendment Act of 2008*" at 13 (Oct. 17, 2008).

Commissioner to recognize these unprecedented risks and to work with the Company to ensure that it can *maintain* its existing surplus in future years, for the good of subscribers from the community the surplus is designed to protect.

The ACA Impacts Report at **Exhibit 2** provides a full description of these key market changes and their effects on GHMSI. These are the key points:

First, the ACA's guaranteed-issue requirement requires GHMSI to provide coverage to anyone who wants to sign up, including individuals who were previously unable to purchase coverage. Preliminary enrollment numbers show increased enrollment in the individual market, most dramatically for the HMO plans offered by BlueChoice. As of May 1, 2014, GHMSI's individual market enrollment had increased nearly 8% since the end of 2013 (from 52,013 enrollees to 56,063 enrollees), while BlueChoice's individual market enrollment increased by approximately 256% between the end of 2013 (35,746 enrollees) and May 1, 2014 (127,388 enrollees). These numbers do not include some late enrollees who received an extension of time at the end of the open enrollment period and who had not yet paid as of May 1. *See* **Exhibit 2** (ACA Impacts Report) at 16. This is good for public health, but GHMSI faces very real uncertainty regarding how sick or healthy these new members really are. *See id.* at 2. In 2013, the Society of Actuaries predicted that 2014 medical claims costs in the individual market would increase by an average of 51.9% for the District of Columbia, the 9th highest increase in the nation. *See id.* at 2. GHMSI did not increase its individual market rates by nearly that much. The merger of the individual and small market risk pools in the District make this uncertainty worse, by extending it into the small group market as well. GHMSI faces similar uncertainties in Maryland and Virginia.

Second, the rate increases attributable to the ACA are phased in over many years, as the market changes come fully into effect, and ACA's new rate-review requirements will make it difficult for carriers to obtain future increases to their rates that match the increases in the cost of coverage. *See id.* at 4. Given the many factors acting to drive insurance rates upward in the coming years, GHMSI has a long-term concern that publicity surrounding insurance rates may increase the difficulty of obtaining adequate rates in the future. *See id.* That likely will mean many more years where GHMSI's rates don't cover its costs—where, in other words, the Company is taking a substantial underwriting loss, and drawing down surplus as a result.

Third, the ACA's MLR rules make it nearly impossible for companies like GHMSI to rebuild surplus. Starting in 2011, a carrier must pay rebates if its medical costs are less

than 85% of premium in the large group or 80% of premium in the small group and individual markets. *See id.* at 4-5; *see also* 45 C.F.R. § 158.210. And crucially, *contributions to surplus do not count as medical costs*. *See id.* That will place significant constraints on GHMSI's ability to rebuild surplus, for two reasons. First, meeting the MLR target is already difficult enough—employee salaries, broker commissions, equipment, administration, and other such expenses must come out of the 15% to 20% non-medical-cost allowance—so carriers will not be able to make substantial contributions to surplus without violating the MLR rules. *See* **Exhibit 2** (ACA Impacts Report) at 5, 12. Second, the MLR rules operate market-by-market, and jurisdiction-by-jurisdiction, dicing GHMSI's market into 18 segments, including both GHMSI and subsidiary CareFirst BlueChoice, and they do not allow GHMSI to offset excessive non-medical costs in one segment with low non-medical costs in another. *See id.* at 5, 12. That means the MLR rules will operate as a one-way ratchet: GHMSI will have to pay rebates in segments where its non-medical costs exceed the MLR percentage limit even if GHMSI has underwriting losses in other segments. And that minimizes the likelihood that a carrier's rates would be adequate and makes it more likely that losses would not be recovered. *See id.* at 5.

***Fourth*,** the ACA provides for two new subsidies for low-income persons who purchase insurance through the exchanges—the advance premium tax credit and the cost sharing reduction subsidy. *See id.* at 7. Under both subsidies, carriers are dependent upon both the Exchange and the federal government to accurately determine and pay a significant portion of the premium dollars needed to pay medical claims. While subsidies can be positive, carriers are at risk of delays in payment or of changes to the subsidy rules mid-stream by regulators or legislators. *See id.* This is particularly true in today's environment, where the Exchanges have not yet been fully implemented, and the federal government has yet to fully implement its processes to administer subsidies or the other federal programs associated with the ACA.[18]

[18] Risks related to changes in processes and federal rules are not limited to the subsidies. For example, the "risk corridors" program is a transitional program under which carriers share gains from exchange products with the federal government, and the federal government is supposed to share in losses that carriers may incur. But HHS recently announced that the risk corridors payments it is supposed to make to carriers are "subject to the availability of appropriations," *see id.* at 10, and no funds have been appropriated directly for the program. There accordingly is a risk that the government will not take the full share of losses that it should take under the ACA. GHMSI's 2014 rates were developed with the assumption that the risk corridor program would be in place as written. If that assumption turns out to be incorrect, there is a real risk that the rates for GHMSI's Exchange products are inadequate.

Fifth, the ACA significantly limits carriers' ability to respond to changed market conditions in their rate filings. *See id.* at 8. That is so because individual and small group rates for a calendar year must be filed in May and June of the year before, but financial adjustments under various risk-adjustment programs designed to mitigate insurers' losses will not be completed until mid-way through the next calendar year. *Id.* In short, it will take a carrier more than two years to fully respond, in its rates, to changes in market conditions in the individual or small group markets.

Sixth, the ACA has imposed massive additional expenses on GHMSI, and likely will continue to do so. *See id.* at 13. CareFirst and GHMSI spent well in excess of $100 million dollars in 2013 alone on costs associated with implementation of the ACA. *Id.* These ongoing implementation costs will continue for many years, and many millions of dollars, more. *See id.* at 13-14.[19] The ACA also imposes significant new taxes and fees, which are then built into rates. Among other things, carriers pay a new "patient centered outcome research institute" fee and a new federal health insurance tax, known as a "health insurance providers fee," which may by itself add as much as $6 per member per month to rates. *See id.* at 10 & n.13.

These are only a few of the many, interrelated markets changes, all spurred on by the ACA, that GHMSI is trying to work through as the health care reform rollout continues. These changes, taken together, create a perfect storm as far as surplus goes: *All* of them tend to pull surplus inexorably downward by (1) increasing costs of coverage, (2) decreasing revenue and the potential for future revenue, (3) making appropriate rates more difficult to calculate, or (4) saddling GHMSI with massive new administrative expenses. Taken together, they create an environment where it is much more likely than ever that GHMSI and other insurers will be unable to obtain rates that cover rising medical and other costs and where, once surplus begins to fall below "optimal" levels, it will be exceedingly difficult to increase it to an adequate level.

The bottom line: In the face of the risks, demands, and constraints listed above, the central challenge will be to ensure that GHMSI continues to have *enough* surplus in the coming years, not how to further reduce its already below-range surplus position.

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[19] As merely one example, Maryland has recently announced its intention to change operations by utilizing the Connecticut exchange rather than the exchange software developed by Maryland. GHMSI and other CareFirst affiliates will incur significant additional expenses associated with this decision by Maryland. The exchange interfaces and operational rules will be significantly different.

CONCLUSION

Time and again, independent actuaries and regulators have reviewed GHMSI's surplus, and time and again they have concluded that it is not excessive. GHMSI's two independent actuaries and Rector so concluded again in this proceeding. The Commissioner should adopt that conclusion.

June 10, 2014

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