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

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

DECISION AND ORDER

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

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

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

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I. JURISDICTION

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

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

II. PROCEDURAL HISTORY

A. Brief Description of GHMSI and Surplus Review

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

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

B. Review of GHMSI 2008 Surplus

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

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

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

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

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

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

C. Review of GHMSI 2011 Surplus

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

D. The Record

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

III. FACTUAL BACKGROUND

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

CFH, the vast majority of which consists of CareFirst BlueChoice.[4] *See id.* For purposes of this review, "GHMSI" means the combination of 100% of the business of GHMSI itself and GHMSI's approximately 50% ownership of CFH.

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

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

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

[4] CFH also owns certain other subsidiaries that are much smaller than BlueChoice and which do not significantly affect the analysis here.

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

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

IV. ANALYSIS OF GHMSI SURPLUS

A. Applicable Law

1. District of Columbia Statutes and Regulations

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

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

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

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

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

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

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

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

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

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

The Act further states:

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

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

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

2. Court of Appeals Framework

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

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

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

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

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

B. GHMSI Surplus is Greater than the Appropriate RBC Standards

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

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

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

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

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

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

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

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

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

1. Defining Financial Soundness and Efficiency

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

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

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

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

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

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

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

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

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

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

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

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

2. Estimating Surplus Needs

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

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

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

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

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

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

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

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

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

Tr. 20:15-24.

3. Model Assumptions and Operation

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

a) Benchmark RBC Levels and Corresponding Confidence Levels

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

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

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

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

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

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

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

Moreover, the consequences to GHMSI under its licensing agreement with BCBSA if its surplus falls below 200% RBC-ACL are potentially severe. If this occurred, the BCBSA could revoke GHMSI's licenses to use the Blue Cross and Blue Shield names and trademarks. GHMSI Resp. Third Sched. Order at 9. Loss of the licenses would mean that BCBSA could appoint another BCBSA licensee to do business in GHMSI's Blue service area. *Id*. BCBSA also would assign GHMSI's approximately 365,000 Federal Employee Program ("FEP") members – representing 33% of GHMSI's total enrollment – to another BCBSA licensee. *Id.* at 9-10. In addition, most of GHMSI's National Account business – approximately 290,000 members, representing 29% of its total enrollment – would be transferred to the other BCBSA licensees. *Id.* at 10. Finally, if the BCBSA were to revoke GHMSI's licenses, all of GHMSI's members would lose full access to providers participating in the Blue Cross and Blue Shield networks. *Id.*

Having a surplus near or below 200% RBC-ACL also would likely cause significant concern among GHMSI's policyholders and other customers, possibly leading them to seek another, more stable insurer or administrator, which would further weaken the company. Tr.128:5-18. The Commissioner concurs with Rector's estimation that having GHMSI's surplus drop to 200% RBC-ACL would cause "extreme distress" in the District's health insurance market, and given GHMSI's dominance in the District market, be far more troubling and disruptive than if such a loss were sustained by a similarly sized health insurer with a more modest share of the market. Tr.39:20 - 40:3.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

b) Modeling Risks and Contingencies

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

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

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

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

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

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

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

c) Risk Factors

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

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

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

(1) Premium Growth Rate

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Table 1. Commissioner's Requested Premium Growth Probability Distributions

Non-FEP Business		FEP Business	
Growth Rate	**Probability**	**Growth Rate**	**Probability**
4.5%	25%	6.5%	25%
8.0%	50%	7.5%	50%
12.2%	25%	8.4%	25%

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

(2) Equity Portfolio Asset Values

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

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

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

(3) Rating Adequacy and Fluctuation

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

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

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

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

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

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

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

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

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

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

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

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

(4) Unpaid Claims Liabilities and Other Estimates

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

(5) Change in Interest/Discount Rate

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

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

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

(6) Bond Portfolio Impairment

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

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

(7) Overhead Expense Recovery and Other Business Risks

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

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

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

(8) Catastrophic Events

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

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

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

(9) Unidentified Growth and Development

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

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

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

d) Rector Conclusions Based on Modified Milliman Model

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

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

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

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

e) Post-Hearing Modeling

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

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

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

f) Assessing Appleseed's Recommended Surplus Level

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

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

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

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

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

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

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

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

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

4. 2011 Surplus Level Conclusions

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

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

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

D. Allocation of Surplus to the District of Columbia

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

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

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

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

> shall mean the process used by the Commissioner to allocate the portion of the surplus of a hospital and medical services corporation that is derived from the company's operations in the District of Columbia based on the following factors:
>
> (a) The number of policies by geographic area;

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

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

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

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

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

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

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

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

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

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

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

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

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

Table 2. Summary of Schedule T Reported Premiums

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

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

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

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

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

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

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

Table 4. Weighted Premium Percentages

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Table 7. Allocation Factors and Weight

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

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

E. GHMSI's Community Health Reinvestment

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

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

1. Corporate Giving

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

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

and safeguards public health and benefits current and future subscribers of GHMSI residing in the District. *Id.* at 35-36.[33]

2. Open Enrollment Subsidies

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

3. Public-Private Partnerships

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

4. Premium Rate Reductions

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

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

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

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

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

5. Premium Taxes

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

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

6. 2011 Community Health Reinvestment Expenditures

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

Table 8. GHMSI's Quantifiable Community Health Reinvestment in 2011

Corporate giving	$ 3.4 million
Open enrollment subsidies	$ 4.5 million
D.C. Healthcare Alliance funding	$ 5.0 million
Total	**$12.9 million**

F. Coordination with Other Jurisdictions

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

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

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

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

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

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

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

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

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

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

G. Requirements for GHMSI Plan

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

V. ORDER

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

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

Dated: December 30, 2014

Chester A. McPherson, Acting Commissioner

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Exhibit 1 – Hearing Record Index for GHMSI 2011 Surplus Review

"the surplus-related material posted on DISB's website will be the official record for this proceeding."
Transcript, *District of Columbia Department of Insurance, Securities and Banking – Group Hospitalization and Medical Services, Inc. Surplus Review Hearing* at 11 (June 25, 2014).

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

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

GHMSI Financial Statements, http://disb.dc.gov/publications-list?after[value][date]=&before[value][date]=&keys=HFAS&type=79&sort_by=field_date_value&sort_order=DESC

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

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

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

GHMSI Rate Filings, http://disb.dc.gov/publications-list?after[value][date]=&before[value][date]=&keys=GHMSIRF&type=79&sort_by=field_date_value&sort_order=DESC

GHMSI Financial Statements [see "Review of CareFirst's 2011 Surplus" for link]

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

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

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

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

Exhibit 1 – Hearing Record Index for GHMSI 2011 Surplus Review

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

Exhibit 1 – Hearing Record Index for GHMSI 2011 Surplus Review

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

Exhibit 1 – Hearing Record Index for GHMSI 2011 Surplus Review

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

Exhibit 1 – Hearing Record Index for GHMSI 2011 Surplus Review

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

Exhibit 1 – Hearing Record Index for GHMSI 2011 Surplus Review

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