Appendix A

Excess Surplus Review hearing of
Group Hospitalization and Medical Services, Inc.

District of Columbia Department of Insurance, Securities, and Banking

Rebuttal Statement – Applying the Medical Insurance Empowerment Amendment Act

Legal analysis by
Covington and Burling, LLP

Prepared for the DC Appleseed Center for Law and Justice, Inc.
November 2, 2009

APPLYING THE MEDICAL INSURANCE EMPOWERMENT AMENDMENT ACT

I. INTRODUCTION

During the recent hearing held by the D.C. Insurance Commissioner, GHMSI's CEO and legal counsel posited a new (and flawed) interpretation of the Medical Insurance Empowerment Amendment Act ("MIEAA") that would enable GHMSI to sidestep the framework for accountability that the D.C. Council so carefully crafted when requiring an annual review of GHMSI's surplus. Instead of acknowledging its obligation to engage in community health reinvestment "to the maximum feasible extent consistent with financial soundness and efficiency," which Section 6a, entitled "Community health reinvestment," states GHMSI "shall" do,[1] GHMSI attempts to redefine the standard. This memorandum responds to questions raised by the hearing panel regarding the proper application of the Section 6a "maximum feasible" standard.[2]

GHMSI urges that its community health obligation is triggered if and only if the Commissioner makes a threshold determination that the surplus is "unreasonably large." And GHMSI suggests that the statute offers no guidance concerning the definition of "unreasonably large"—the Commissioner is to somehow make that determination in a statutory vacuum, without regard to the central purpose of the MIEAA, expressed in the Section 6a obligation. Inventive though GHMSI's theory may be, it is absurd. It cannot be reconciled with the Council's intent in enacting the MIEAA (as evidenced by the plain language of the statute, as well as its legislative purpose and history), canons of statutory construction, and GHMSI's own charter (as well as related case law). As the Committee report on the MIEAA states, the Commissioner is to determine the "appropriate surplus range" for GHMSI "after a thorough review" and in a manner "set to be consistent with financial soundness and efficiency."[3]

Nor did GHMSI correctly *apply* the Section 6a obligation to the surplus review. The "maximum feasible" and "financial soundness and efficiency" standards work together. "Maximum feasible" literally applied would require that the ceiling on allowed surplus be set at the lower boundary of an efficient range—maximizing community reinvestment necessarily means minimizing the level of surplus so long as it remains within an efficient range. While that would be a permitted reading of the statute, we suggest that it would also be a permitted

---

[1] *See* Medical Insurance Empowerment Amendment Act of 2008 ("MIEAA"), D.C. Law 17-369, Sec. 2(e); now codified at, D.C. Official Code § 31-3501 et seq.

[2] In Part II of this memo, we disprove GHMSI's contention that the "maximum feasible" and "consistent with financial soundness and efficiency" principles need never apply. *See* Sept. 10, 2009 Hearing Transcript at 203-205. In Part III, we discuss how those principles actually apply.

[3] Council of the District of Columbia, Committee on Public Services and Consumer Affairs, Report from Chairperson Mary M. Cheh re Bill 17-934, "Medical Insurance Empowerment Amendment Act of 2008" ("Committee Report") (Oct. 17, 2008), at 11.

interpretation, and appropriately prudent, to set the ceiling toward the lower end of an efficient range, even if not at the exact lower end of the range. If GHMSI's opposite view prevails—if GHMSI is allowed to set surplus at a theoretically "optimal" level that takes no account of the obligation to maximize community reinvestment—which is exactly what Milliman did in evaluating GHMSI's surplus for CareFirst—the balance will inevitably be different from the one that the Council contemplated.

Finally, GHMSI proposes a self-serving method of attributing surplus to the District that is inconsistent with both industry practice and GHMSI's own current practice. Neither the language of GHMSI's federal charter, nor a "plain reading" of the MIEAA, requires attribution based on residence, nor does relevant case law mandate such a result. It is clear that GHMSI's entire position on attribution is based on an erroneous reading of the statute and a desire to make the attribution match its plan for spending down excess surplus.

II. GHMSI'S SURPLUS MUST BE EVALUATED IN LIGHT OF ITS OBLIGATION TO ENGAGE IN COMMUNITY HEALTH REINVESTMENT TO THE MAXIMUM FEASIBLE EXTENT CONSISTENT WITH FINANCIAL SOUNDNESS AND EFFICIENCY.

Contrary to GHMSI's self-serving interpretation, there is but a single overarching legal standard under the MIEAA as to what GHMSI "shall" do: engage in community health reinvestment to the maximum feasible extent consistent with financial soundness and efficiency. "Unreasonably large" must be applied hand in glove with that overarching obligation, because it is through the surplus review that the Commissioner implements and enforces the overarching obligation. This reading of the MIEAA necessarily flows from the statute's plain language and legislative purpose and history, as well as canons of statutory construction, and gives full effect to GHMSI's Congressional charter. GHMSI's contrary reading would mean that the surplus review, designed by the Council to ensure compliance with the maximum feasible community health reinvestment obligation, would instead provide an escape hatch from it. GHMSI's suggested threshold determination of an unreasonably large surplus could prevent the Commissioner from ever reaching the issue of its charitable obligation. The central purpose of the statute would not be applied in the very proceeding designed to ensure that it is fulfilled.

A. The MIEAA's Plain Meaning Compels the Conclusion that the "Maximum Feasible Extent" Standard Must Apply.

Applying the standard "maximum feasible extent consistent with financial soundness and efficiency" is the central purpose of the MIEAA's surplus review.[4] It is clearly

---

[4] As discussed below, the obligation to engage in community reinvestment "to the maximum feasible extent" is not unbounded. The second part of Section 6a is vitally important—GHMSI's community health reinvestment must be done in a manner "consistent with financial soundness and efficiency." No one wishes to see GHMSI fail to go forward as a financially sound and efficient entity. Under MIEAA, the D.C. Insurance Commissioner must find the point that fulfills both "maximum feasible extent" and "consistent with financial soundness and efficiency."

set forth at the outset of the amendments related to surplus review, in newly added Section 6a (D.C. Official Code § 31-3505.01). Moreover, this overarching legal standard is not permissive. To the contrary, Section 6a states that GHMSI "*shall* engage in community health reinvestment" according to this standard.[5]

The legal obligation codified in Section 6a finds its implementation (by the Commissioner) in the section that follows—Section 7 (D.C. Official Code § 31-3506). The new subsections added to Section 7 specify that "the Commissioner shall review the portion of the surplus of [GHMSI] that is attributable to the District and shall issue a determination as to whether the surplus is excessive."[6] Section 7 further specifies that GHMSI's surplus is considered excessive only if (1) it exceeds 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 GHMSI's obligation under Section 6a—i.e., its obligation to meet the "maximum feasible extent" standard.[7]

As GHMSI would have it, the Commissioner is to apply "unreasonably large" as if the statute did not mention "maximum feasible . . . consistent with." It is, of course, true that the Commissioner might find a surplus to be "unreasonably large" solely for reasons that would apply even if the statute did not impose the "maximum feasible" obligation.[8] But in this statute there clearly is an additional dimension to "unreasonably large." It takes into account not only actuarial issues but the "maximum feasible . . . consistent with" standard; "unreasonably large" must be informed by that obligation because it is the overarching purpose of this statute. Thus, the application of these provisions entails more than the standard battle of experts. Where two opposing technical analyses might otherwise be considered reasonable, the Commissioner is to be guided in her resolution of the contested issue by the plain language and central purpose of the statute itself.

The structure of the MIEAA is to set a standard (Section 6a) and then identify two factors the Commissioner considers to determine whether the standard has been met (Section 7). It defies logic to ignore the legal standard and instead focus on one of those factors to see whether the legal standard even applies. To read "unreasonable" as GHMSI suggests would simply ignore the structure of the statute.

GHMSI would have the Commissioner negate the mandate of the statute to find the point on the maximum-minimum spectrum that achieves "maximum" community reinvestment and the logically corresponding "minimum" surplus that is still within the efficient

---

5 MIEAA § 2; D.C. Official Code § 31-3505.01 (emphasis added).

6 *Id.* § 31-3506(e).

7 *Id.*

8 Such would be the case where GHMSI builds in assumptions that are simply unsupportable as a matter of fact or proper actuarial analysis. In fact, ARM demonstrates that GHMSI has utilized such assumptions here in a number of material respects.

range. (As we have already noted, we believe it would be permissible to choose a maximum that it not necessarily at the lower boundary of an efficient range.) The mandate to find that point guides both the determination of the efficient range, and the setting of the ceiling within that range. In other words, it is the "maximum feasible" language that must guide both where the range of efficient surplus is set, and where within that range the appropriate surplus level under MIEAA must be. Where "unreasonable" in the abstract might be read to allow assumptions designed to generate an "optimal" surplus range (or, indeed, any surplus so long as it is not above the very highest end of an efficient range), that reading obviously cannot be the proper reading under MIEAA. "Optimal"—which the GHMSI reading and Milliman analysis are designed to achieve—is simply nowhere mentioned in the MIEAA.[9]

Several cases support this view. The D.C. Circuit has explained that, even if a rate falls within the zone of reasonableness, it may be challenged on other grounds. So, for example, "[the Federal Energy Regulatory Commission's] responsibility under the Federal Power Act does not end with a determination that a proposed rate is reasonable, for it may be unlawful on other grounds."[10] Similarly, in *Interstate Commerce Commission. v. Inland Waterways Corp.*, the Supreme Court stated: "[T]rue, the Commission found that the proposed schedules are shown to be just and reasonable. But this does not constitute a finding that the rates were lawful; they may lie within the zone of reasonableness and yet result in undue prejudice or otherwise violate the Act."[11] So here, even if the Commissioner determines that there is a range of operating surplus to meet the "financial soundness and efficiency" part of the governing legal standard, it would not satisfy the statute to set the surplus at the middle or higher end of that range (and even if doing so would not result in "unreasonably large" surplus). To do so would ignore the "maximum feasible extent" part of the governing legal standard. Accordingly, when viewed in its entirety, the legal standard requires that the surplus be set toward the lower end of the range.

The record in this case illustrates how the "maximum feasible" standard can inform "unreasonably large." ARM has identified assumptions in the Milliman analysis that are unreasonable as a matter of sound actuarial analysis.[12] But even if, contrary to the facts here,

---

[9] It is evident, moreover, from the history of GHMSI's repeated resistance to its charitable and benevolent obligation, which resistance gave rise to the enactment of the MIEAA, that GHMSI's year-end surplus for 2008, which it had accumulated over a period of years, was accumulated in a manner that was inconsistent with its "maximum feasible" obligation. As a result, that surplus is "unreasonably large."

[10] *Alabama Elec. Coop., Inc. v. FERC*, 684 F.2d 20, 27 (D.C. Cir. 1982) (further noting that, "as the Supreme Court established long ago, 'rates may lie within the zone of reasonableness and yet result in undue prejudice'").

[11] 319 U.S. 671, 687 (1943).

[12] For example, "Milliman's model and report is fundamentally based on the possibility of a multi-year cycle underwriting loss." ARM Rebuttal, p. 12. ARM demonstrates that the likelihood of a multi-year loss cycle can be mathematically calculated as extremely remote. *Id.* ARM points out that, not only has GHMSI had "ten consecutive years of significant (continued...)

those assumptions might be reasonable for an actuarial analysis conducted in the abstract, they cannot be squared with the "maximum feasible" obligation where there is an actuarially reasonable alternative assumption that is consistent with financial soundness and efficiency. Milliman's assumptions result in a permitted range of surplus that it not the lowest reasonable range, and they allow a level of surplus within the range that is not the lowest that is "consistent with" financial soundness and efficiency.[13]

In sum, the structure of the MIEAA and its plain language requires that the overarching Section 6a "maximum feasible . . . consistent with" standard apply as a necessary part of the Commissioner's surplus evaluation. It is not the case, as GHMSI argues, that this standard applies only after there has been a determination that its surplus is "unreasonably large," a determination that under GHMSI's view would be made in isolation from the statute's language and purpose, and would have no standard to guide its application. And, to the extent that the Commissioner believes that some of Milliman's contested assumptions might not be unreasonable in the abstract, the statute makes clear that they are unreasonable under the MIEAA read as a whole.

B. GHMSI'S Interpretation of the MIEAA Ignores Several Principles of Statutory Construction, Including that All Provisions Must Be Given Meaning.

GHMSI's reading of the MIEAA, moreover, ignores several well-established principles of statutory construction. Most importantly, statutory construction is a holistic endeavor.[14] "[A] statute is to be read as a whole . . . since the meaning of statutory language, plain or not, depends on context."[15] Moreover, "[a] provision that [seems] ambiguous in isolation is often clarified by the remainder of the statutory scheme—because the same terminology is used elsewhere in a context that makes its meaning clear or because only one of the permissible meanings produces a substantive effect that is compatible with the rest of the law."[16] To the extent that section 7(e)(2) is ambiguous as to whether it requires the Commissioner to make separate determinations that the surplus is "unreasonably large" and "inconsistent with" the corporation's obligation under section 6(a) (and we do not believe that it is ambiguous), reading this provision in the context of the MIEAA as a whole makes clear, for

---

underwriting gains," but the "health insurance industry as a whole has not seen any evidence of the historic underwriting cycle in 15 years or even a new discernable loss pattern." *Id.*

[13] Milliman would require a 95% probability that GHMSI's surplus not fall below the 375% reporting requirement to the Blue Cross Blue Shield Association. Whatever might be the validity for a reporting requirement to an industry association of that degree of probability in other contexts, it is not appropriate under the "maximum feasible . . . consistent with" standard.

[14] *United Sav. Ass'n of Texas v. Timbers of Inwood Forest Assocs., Ltd.*, 484 U.S. 365, 371 (1988).

[15] *King v. St. Vincent's Hosp.*, 502 U.S. 215, 221 (1991) (internal citation omitted).

[16] *United Sav. Ass'n*, 484 U.S. at 371 (internal citations omitted).

the reasons already stated, that these considerations are part of the same determination that GHMSI has not satisfied the "maximum feasible extent" standard.

A related canon of statutory construction cautions against "interpreting a statute in such a way as to make part of it meaningless."[17] A surplus that is unreasonably large will almost never be consistent with GHMSI's obligation to engage in community health reinvestment to the maximum feasible extent. Thus, inasmuch as GHMSI has carved a two-part test out of a single inquiry, its reading of the statute not only leaves the Commissioner without any standard to guide the "unreasonably large" determination, it also renders the second prong of the test essentially meaningless.[18] The Commissioner should reject this reading. Instead, the only sensible reading of section 7(e)(2) is that the Commissioner makes a single determination that the statute is both unreasonably large and inconsistent with the GHMSI's "maximum feasible extent" obligation and that each factor informs the other.

C. The MIEAA Was Enacted to Create an Enforcement Scheme to Ensure GHMSI Meets Its Obligations as a Charitable and Benevolent Non-Profit Organization.

Section 8 of GHMSI's charter declares that it is a "charitable and benevolent institution." The Section 8 margin notes of the charter say "Purposes declared."[19] Case law establishes that these margin notes indicate the intent of Congress.[20] It thus follows that the very purpose of creating GHMSI was to create a "charitable and benevolent" institution.

In establishing the standard set forth in the MIEAA (*i.e.*, that GHMSI must engage in community health reinvestment to the "maximum feasible extent"), the Council clearly intended to codify GHMSI's legal obligation as a charitable and benevolent institution. As Councilmember Cheh explained: "[The bill] establishes a framework, with all due consideration for CareFirst's financial soundness and efficiency, to settle this question of community health care benefits. Of course this Committee, this Council, wants CareFirst to remain a robust and prosperous participant in the District's health insurance market. But there is a real need for

---

17 *Abourezk v. Reagan,* 785 F.2d 1043, 1054 (D.C. Cir. 1986)).

18 *See Chisom v. Roemer*, 501 U.S. 380, 397 (1991) (rejecting interpretation that would require the court to "distort the plain meaning" of a statute and "substitute the word 'or' for the word 'and'). GHMSI's attempt to try to provide meaning to "inconsistent with" (*see* Sept. 11, 2009 Hearing Transcript at 203-205) also falls flat in that it could never operate to find a surplus that is unreasonably high but rather would operate only to find acceptable an otherwise unreasonably large surplus. This, of course, makes no sense given the focus of the statute to ensure consistency (and compliance) with the Section 6a standard.

19 53 Stat. 1414 (1939).

20 *See Motorola v. United States*, 729 F. 2d 765, 771 (Fed. Cir. 1984) (noting that margin notes "may be referred to as indicating the intention of Congress").

accountability, and I think this legislation will fill that need."[21] Yet under GHMSI's approach, the intended accountability would never occur.

GHMSI's proposed interpretation of the MIEAA (*i.e.*, that the Commissioner should make an initial determination regarding reasonableness of GHMSI's surplus without considering the "maximum feasible extent" standard) effectively writes GHMSI's obligation as a charitable and benevolent institution out of both the charter and the MIEAA. GHMSI's interpretation also ignores the reality that the surplus will necessarily be unreasonably large when the company fails to meet the Section 6a "maximum feasible extent" standard. To give full effect and meaning to GHMSI's overarching charitable obligation, as well as the plain language of the MIEAA, the maximum feasible extent standard must control, and whether or not GHMSI meets it will determine whether its surplus is unreasonably large and thus require remedial action by the Commissioner.

D. GHMSI'S Reading of the MIEAA Is Inconsistent with its Legislative History Which Makes Clear that the "Maximum Feasible" Standard Must Govern.

In matters of statutory construction, the legislative history and purpose must be considered.[22] "The words of a statute should be read in context, the statute's place in 'the overall statutory scheme' should be considered, and the problem [the legislature] sought to solve should be taken into account."[23] With respect to the MIEAA, each of these considerations unequivocally evidences that the Section 6a "maximum feasible extent" standard was intended to govern the Commissioner's surplus determination.

The MIEAA was passed in an atmosphere rife with frustration resulting from years of unsuccessful efforts by District authorities to hold GHMSI accountable to its charitable and benevolent purpose.[24] It is beyond dispute that GHMSI has long failed to even recognize,

---

21 Public Hearing, Committee on Public Service and Consumer Affairs, Remarks of Councilmember Mary Cheh (Oct. 10, 2008), *available at* http://oct.dc.gov/services/on_demand_video/channel13/October2008/10_10_08_PUBSVRC_2.asx. *See also* Mike DeBonis, "Care First, But Always Politics," Wash. City Paper (May 21, 2008), *available at* http://www.washingtoncitypaper.com/display.php?id=35612 (noting that "Cheh, shortly after coming on the council in January 2007, privately expressed early interest in investigating whether CareFirst needed to do more for the District in return for the tax breaks it's been given over the years"). While GHMSI no doubt wishes that the MIEAA is not the law, the fact remains that ten Councilmembers co-sponsored the bill that became the MIEAA. As far as the D.C. Council was concerned, whether to impose a framework for accountability was not a close call.

22 *United States v. District of Columbia*, 703 F. Supp. 982, 988 (D.D.C. 1988).

23 *PDK Laboratories, Inc. v. DEA*, 362 F.3d 786, 796 (D.D.C. 2004) (internal citations omitted).

24 The record is replete with references to GHMSI's failings in this regard, and it would not be practical to repeat each statement here. By way of illustrative example, however, statements by former D.C. Insurance Commissioner Lawrence H. Mirel, among others, provide important (continued...)

much less voluntarily satisfy, its community reinvestment obligation. Indeed, the current D.C. Attorney General was so concerned about GHMSI's apparent contempt of its charitable mission, he elected to sue GHMSI during the summer of 2008 to force GHMSI to comply with its obligations.[25] That suit was later withdrawn following passage of the MIEAA, which codifies GHMSI's legal obligation and thus provides for the accountability that the D.C. Attorney General sought to achieve by way of litigation.[26]

The District is not alone in recognizing GHMSI's utter disregard for its community reinvestment obligation. The Maryland Insurance Commissioner and Attorney General have likewise criticized CareFirst, GHMSI's corporate parent, for failing to fulfill its public health mission as a nonprofit company.[27]

---

historical context for the MIEAA. *See, e.g.*, Lawrence H. Mirel, Report of the District of Columbia Department of Insurance, Securities, and Banking In the Matter of: Inquiry into the Charitable Obligations of GHMSI/CareFirst in the District of Columbia, at 2 (May 15, 2005) (GHMSI "can and should do more to promote and safeguard the public health"). GHMSI's surplus has continued to grow over the past several years, however, despite the finding by former Insurance Commissioner Mirel that GHMSI could "reduce its (then current) surplus level without negatively impacting its financial strength and viability" and should do so by "increasing financial contributions to organizations, activities, or joint efforts that will advance the public health in the District of Columbia." *Id.* at 21.

[25] *See District of Columbia v. Group Hospitalization and Medical Services, Inc.*, Case No: 1:08-cv-01218 (D.D.C. 2008).

[26] A former D.C. Attorney General likewise determined that GHMSI could not be entrusted to voluntarily acknowledge its community health obligation. *See, e.g.*, Letter from Robert J. Spagnoletti, Attorney General, to Robert Bobb, City Administrator, at 2 (Aug. 4, 2005) ("Until GHMSI acknowledges its obligations as a 'charitable and benevolent institution' to operate for the benefit of the public, one cannot presume that its corporate decisions will be based on . . . how best to fulfill the corporation's charitable purposes.") This sentiment applies with equal force today.

[27] In 2003, then-Maryland Insurance Commissioner Steve Larsen issued an opinion denying CareFirst's conversion application. In his opinion, Commissioner Larsen determined that CareFirst had disregarded its public health mission, explaining that other nonprofit Blues had been able to "not only survive but also thrive as a social mission oriented nonprofit" and that CareFirst had failed to consider whether it could do the same. Steve Larsen, Report of the Maryland Insurance Administration, Steven B. Larsen, Commissioner, Regarding the Proposed Conversion of CareFirst, Inc. to For-Profit Status and Acquisition by WellPoint Health Networks Inc. (Mar. 5, 2003). The Maryland Attorney General has echoed these sentiments. In evaluating the compensation package of CareFirst's former CEO, Mr. Jews (a staggering $17,650,000), an expert engaged by the Maryland Insurance Agency concluded that "CareFirst and its predecessors have little allegiance to nonprofit, community health goals." Maryland Insurance Administration's Expert Report, *Md. Ins. Admin. v. CareFirst, Inc.*, MIA No. 2007-10-027 12 (Mar. 31, 2008).

Legislative history further indicates that the D.C. Council crafted the MIEAA to create a statutorily-mandated enforcement mechanism by which GHMSI's surplus would be evaluated annually in a manner that faithfully reflected its unique status as a Congressionally chartered, charitable and benevolent, non-profit health insurer. As the Committee report on the MIEAA indicates, "CareFirst's history of straying from its public health mission, combined with unmet expectations and a lack of a clear framework for accountability to its mission, call for a legislative response." This "legislative response" (*i.e.*, the MIEAA) dictates that the Commissioner must undertake "a thorough review" of GHMSI's surplus and "set [an appropriate range] to be consistent with financial soundness and efficiency."[28]

This legislative history unquestionably establishes that the Council believed that GHMSI would not voluntarily comply with its community health reinvestment obligation absent such a framework and that the standard set forth in Section 6(a) of the MIEAA must govern this surplus review. It thus makes no sense to argue, as GHMSI does, that the very piece of legislation the Council passed to ensure that GHMSI meets its charitable obligation relies on a legal standard (*i.e.*, "maximum feasible extent") that may or may not apply.[29] Rather, as we have shown, not only did the Council intend that standard to apply, but that standard is the centerpiece of the accountability scheme the Council established. We next address how that standard should apply in this proceeding.

III. THE MIEAA REQUIRES GHMSI TO SET SURPLUS AT THE MINIMALLY EFFICIENT LEVEL IN ORDER TO MAXIMIZE COMMUNITY REINVESTMENT.

As noted above, the MIEAA requires GHMSI to engage in community health reinvestment *to the maximum feasible extent consistent with financial soundness and efficiency.* Thus, to the extent that GHMSI's surplus is greater than the appropriate risk-based capital requirements, even by a small amount, the Commissioner must consider whether GHMSI could and should increase its community health reinvestment activities while still remaining financially sound and efficient. In our view, the Commissioner should accomplish this in two steps: first determine an appropriate surplus range for GHMSI that meets the "sound and efficient" requirement; then select a point in that range that will comply with the "maximum feasible" requirement.

A. GHMSI's Statutory Obligation Requires the Company to Maintain an Efficient Surplus That Is Sufficient to Weather Ordinary Market Changes.

In setting the Section 6a "maximum feasible extent consistent with financial soundness and efficiency" standard (emphasis added), the Council was mindful of the lessons

---

[28] Committee Report at 11.

[29] Despite GHMSI's statement at the hearing that it believed its obligations flow only to its current subscribers, the MIEAA is explicit in defining "community health reinvestment" as "expenditures that promote and safeguard the public health or that benefit current *or future subscribers*...." MIEAA § 2; D.C. Official Code § 31-3501(1A) (emphasis added).

learned from similar proceedings conducted in Pennsylvania. In the Pennsylvania proceedings, the word "efficient" was used as the yardstick for setting the appropriate surplus levels for the Pennsylvania Blues. Specifically, in response to the Pennsylvania Insurance Commissioner's inquiry, Highmark, one of the two largest Blues in Pennsylvania, commissioned and submitted a report by Milliman, as CareFirst has done here.[30] Milliman found that a "reasonable" range for Highmark's surplus was 650-950% of risk-based capital (RBC).[31] The Pennsylvania Insurance Commissioner flatly rejected this finding and instead found the "efficient" range to be much lower: 550-750%.[32]

There, as here, Milliman and the Pennsylvania Blues argued that surplus had to be large enough to cover catastrophic events. "Prudence *dictates*," Milliman insisted, that surplus had to be sufficient to cover terrorism, epidemics, pandemics, natural or other disasters, and extraordinarily high damage awards from litigation.[33] Milliman repeats this contention in its report for CareFirst.[34] CareFirst echoes it as well.[35]

The Pennsylvania Insurance Commissioner rejected this contention unequivocally. While agreeing that such risks are real, the Commissioner stated that

> their low probability of occurrence or unforeseeable or catastrophic nature recommend that they are most efficiently prepared for through a combination of government, industry-wide, societal and individual company specific initiatives. The reality is, *no individual insurer can or should be permitted to collect or*

---

30 The Milliman report submitted in Pennsylvania is available as an attachment beginning at page 00628 of the Highmark submission to the Commissioner, which is available at http://www.ins.state.pa.us/ins/lib/ins/whats_new/2004bc/Highmark.pdf ("2004 Milliman Report").

31 *Id.* at 48.

32 *In Re: Applications of Capital BlueCross, Highmark Inc., Hospital Service Association of Northeastern Pennsylvania d/b/a Blue Cross of Northeastern Pennsylvania and Independence Blue Cross for Approval of Reserves and Surplus*, Misc. Dkt. No. MS05-02-006, *available at* http://www.ins.state.pa.us/ins/lib/ins/whats_new/2004bc/BCBS_DETERMINATION.pdf (hereinafter, "Pennsylvania Surplus Decision"). The decision was judicially reviewed and affirmed on a purely procedural challenge. *See City of Philadelphia et al. v. Pa. Ins. Dept.*, 889 A.2d 664 (Pa. Commw. Ct. 2005). The annual determination for 2008 is available at http://www.ins.state.pa.us/ins/lib/ins/whats_new/2004bc/Surplus_Statement.pdf.

33 2004 Milliman Report, *supra* note 30, at 9 (emphasis added); *see also id.* at 33, 37.

34 2008 Milliman Report, at 12, *available at* http://disb.dc.gov/disr/frames.asp?doc=/disr/lib/disr/pdf/miliman_report.pdf; *see also* Sept. 10, 2009 Hearing Transcript at 58 ("catastrophic events")..

35 2008 CareFirst Report, at 2, *available at* http://disb.dc.gov/disr/frames.asp?doc=/disr/lib/disr/pdf/carefirst_7_09_report_2.pdf

accumulate enough premiums to cover any and all catastrophic events no matter how remote of unforeseeable.[36]

An economically efficient level of surplus is the level at which "a Blue Plan does not face solvency issues from *routine* fluctuations in factors such as underwriting results and returns on its investments."[37] This is not the standard Milliman used either in the Pennsylvania proceeding or in this one. It is the standard that ARM used and that the Commissioner should apply here.

As noted above, this concept of "efficient" levels of surplus (i.e., sufficient to weather ordinary fluctuations in the marketplace) found its way into the MIEAA—indeed, it is part of the governing legal standard of Section 6a. The MIEAA does not refer to "optimal" surplus, but rather to setting efficient levels of surplus while bearing in mind the obligation to engage in community health reinvestment to the maximum feasible extent. Thus, the MIEAA incorporates this concept of "efficiency" embraced by the Pennsylvania Insurance Commissioner (and in contrast to the highest surplus range that could be said to be "reasonable" that was sought by the Pennsylvania Blues and their consultant, Milliman). Here, GHMSI has completely failed to acknowledge a fundamental element in the analysis of GHMSI's surplus, namely GHMSI's statutory obligation to "engage in community health reinvestment *to the maximum feasible extent consistent with financial soundness and efficiency.*"[38] Instead, GHMSI asks the Commissioner to simply accept its "optimal" surplus determination calculated by its consultants while ignoring entirely the legal standard governing surplus review. Indeed, GHMSI asks the Commissioner to ignore entirely not only the governing legal standard, but the fact that it is a charitable and benevolent nonprofit with obligations under a binding Congressional charter.

It is clear that the D.C. Council was aware of the principle of "efficient" surplus, and it is telling that the Council adopted that language in specifying the Section 6a obligation to incorporate this principle.[39]

---

36 Pennsylvania Surplus Decision, *supra* note 32, at 12 (emphasis added).

37 *Id.* at 17 (emphasis added).

38 MIEAA, § 2(c); D.C. Code § 31-3505.01 (emphasis added).

39 Notably, in discussing efficient surplus, the Pennsylvania Insurance Commissioner stated that "[t]he Department is well aware of the intense regulatory environment in which health entities operate, and of the corresponding requirement for surplus monies to fund, for example, product initiatives, wellness initiatives, mandated benefits, and technological advances—whether required by law or mandated by efficient business operations. However, surplus is not necessarily diminished by such ventures. In fact, improving technology or other operational efficiencies or investing in another company via acquisition is simply an alternative way to invest surplus. Such an investment often is a vehicle for diversification. Diversification can, in fact, reduce risk and augment surplus." Pennsylvania Surplus Decision, *supra* note 32, at 18-19. Thus, the Pennsylvania Insurance Commissioner expressly recognized the need for the Blues to operate at an efficient surplus level, which contemplates the ability of the Blues to invest surplus such fashion as to achieve *greater* operative efficiency. Similarly, the MIEAA contemplates GHMSI operating at an efficient surplus level, which necessarily will permit GHMSI to continue (continued...)

B. The Commissioner Should Establish a Reasonable Initial Range for GHMSI's Surplus, and then Set a Maximum That Is Toward the Lower End of that Range to Meet the "Maximum Feasible" Standard.

There is, undoubtedly, a range of operating surplus that would be appropriate for GHMSI to remain financially sound and efficient. In determining whether GHMSI's surplus falls within the appropriate range, however, the Commissioner must be guided by the MIEAA, as we have already discussed. Given that the MIEAA specifies that GHMSI's over-arching obligation is to engage in community health reinvestment "to the maximum feasible extent," it necessarily follows that GHMSI's maximum permitted surplus should be set toward the lower end of its efficient range. GHMSI's reading of the MIEAA (i.e., that the Commissioner must first decide whether its surplus is excessive) is inconsistent with the notion that reasonableness is contextual and, in this case, informed by other mandates in the statute.

The Commissioner can find further support for setting surplus toward the lower end of the range in the Pennsylvania example.[40] The Pennsylvania Insurance Commissioner emphasized that a range of efficient surplus represents a "continuum of efficient levels of surplus ranging from the lowest point to the highest."[41] The implication for this proceeding under the "maximum feasible" standard (that Pennsylvania does not have) is that, because no point in an efficient range would constrain GHMSI to an insufficient surplus, any upper end within an efficient range is "consistent with" financial soundness and efficiency. Given the obligation to expend the "maximum feasible" amount on community health reinvestment, the upper end of allowed surplus should be set toward the lower end of the efficient range. GHMSI need not as a matter of efficiency—and should not as a matter of statutory interpretation—be permitted to accumulate surplus at the upper end of its efficient range. An upper limit set toward the lower rather than the upper end of that efficient range would be entirely "consistent with" GHMSI's financial soundness and efficiency.

IV. THE ATTRIBUTION METHOD SHOULD BE BASED ON WHERE THE INSURANCE CONTRACT WAS WRITTEN.

For the reasons stated in D.C. Appleseed's submission of September 10, 2009 (at Exhibit B), the appropriate measure of GHMSI's surplus reasonably attributable to the District must include the proportion of premiums from all sources related to business that originates in

---

to engage in these kinds of business initiatives. As Milliman's Dr. Dobson recognized at the hearings, however, surplus in relation to investment is for "unanticipated" needs. Sept. 10, 2009 Hearing Transcript, at 58. Capital expenditures under sound management are ordinarily planned for, not unanticipated. ARM Rebuttal, at 17.

[40] Although the Pennsylvania Blues were by statute deemed to be charitable and benevolent organizations (40 Pa. Cons. Stat. §§ 6103(b), 6307(b)), Pennsylvania had not imposed a specific "maximum feasible" obligation. Thus, there was no occasion for the Pennsylvania Insurance Commissioner to determine the implications of such an obligation for the proper limits of surplus.

[41] Pennsylvania Surplus Decision, *supra* note 32, at 15.

the District—i.e., surplus should be attributed based on the jurisdiction in which the insurance policy was written. For most employer-sponsored group insurance policies, the surplus will therefore be attributed to the jurisdiction where the employer is principally located. For individual policies, the surplus will be attributed to the jurisdiction in which the individual resides. This approach comports with standard practice in the industry, including the practice currently followed by the Maryland Insurance Administration and GHMSI itself. Also, it is necessarily easier to attribute premiums based on where the contract is written because that information is readily available and more likely to be current and accurate than other methods.

GHMSI suggests an approach based on residence of subscribers that is inconsistent with its current method of revenue attribution. Rather than allocating surplus based on contract situs GHMSI advocates for allocation based on residency, and Milliman's analysis is based on this method of allocation.[42] According to GHMSI, allocation in this manner is appropriate because a finding by the Commissioner that GHMSI's surplus is excessive would require any spend-down to go to District residents only.[43] GHMSI's arguments are simply devoid of merit. MIEAA requires only that GHMSI to "submit a plan for dedication of the excess to community health reinvestment in a fair and equitable manner."[44] There is no requirement that the excess surplus be spent on initiatives that are limited to the District. GHMSI's proffered allocation is a misguided deduction from an erroneous interpretation of the statute.[45] Its approach is, of course, backwards. The Commissioner should follow the dictates of the statute, as well as past industry and company practice, and adopt the allocation method that rests on its own sound basis, rather than developing an allocation method that suits the company's intended remedial action. Absent any legitimate reason to depart from the current practice of attributing revenue, and any surplus generated by that revenue, allocation should therefore be conducted according to the place where the contract is written.

---

[42] In its August 31, 2009 Pre-Hearing Report, GHMSI argues (at p. 35) that an allocation on the basis of residency is appropriate because any community health reinvestment is to benefit current subscribers only. But the MIEAA expressly states that community health reinvestment is not limited to current subscribers (MIEAA, § 2(a); D.C. Code § 31-3501(a)(1A)), which invalidates GHMSI's purported justification of a resiodency-based allocation method.

[43] Transcript of D.C. Appleseed Teleconference with CareFirst, 29:15-18 (Sept. 29, 2009) (explaining that "the only appropriate way to [allocate], given that the amounts would go to the benefit of residents of the District, is to allocate based on residency). *See also id.* at 29:6-10 (noting that "if there were ever any excess that our plan that we would submit to DISB would be specific to taking that excess and giving it back to those subscribers that are residents of the District").

[44] MIEAA, § 2(g); D.C. Code § 31-3506(g)(1).

[45] Transcript of D.C. Appleseed Teleconference with CareFirst, *supra* note 43, 29:6-10 (noting that "if there were ever any excess that our plan that we would submit to DISB would be specific to taking that excess and giving it back to those subscribers that are residents of the District").

V. CONCLUSION

As demonstrated above, after careful deliberation the Council passed the MIEAA to establish a framework for accountability by requiring GHMSI to adhere to an overarching standard to engage in community health reinvestment "to the maximum feasible extent consistent with financial soundness and efficiency." GHMSI's strained interpretation of the MIEAA (which finds no basis in the language of the statute itself, its legislative history, GHMSI's charter or the applicable case law) attempts to sidestep that standard, and reflects GHMSI's continuing effort to ignore the "charitable and benevolent" purposes for which it was chartered by Congress. But the Council has passed legislation that establishes a process for review of GHMSI surplus, and sets a clear standard that applies to that evaluation, GHMSI's "creative" interpretation to eviscerate that standard notwithstanding.

GHMSI's argument that it should be permitted to choose any surplus level that falls within the "optimal" level established by its own experts is wrong. As demonstrated above, "maximum feasible extent consistent with financial soundness and efficiency" means that the range of efficient surplus, and the ceiling within that range, must reflect that standard. In that way, the overarching purpose of the MIEAA will be realized, namely, to elicit GHMSI's community health reinvestment to the "maximum feasible extent."

Finally, GHMSI's attempt to thwart the Council's accountability framework based on GHMSI's new proposed attribution method (residence) finds no basis in the law or in the past practices of GHMSI and the insurance commissioners who regulate it. GHMSI for many years has successfully avoided having to own up to its community health reinvestment obligations. In view of the MIEAA, GHMSI can do so no more.